PATIENT REGISTRATION for RIVKA ANN SANDERS, MD
540 Catalina Drive, Ashland OR 97520
Phone (541) 482-0061 Secure Fax (888) 869-7645

_____ ____/____/____ _Female _Male
Full legal name of PATIENT Date of Birth

Marital: _Single _Married _Divorced _Separated _Widow(er) _Partner Check: _Cell _Landline

_____ _____ _____
GUARANTOR (if patient is a minor or incapacitated) Relationship Check: _Cell _Landline

_____ _____
Street City State Zip

_____ _____
Email Referred to or learned of Dr. Sanders by

_____ _____
Preferred PHARMACY / city / street Previous primary care physician

_____ _____ _____
EMERGENCY contact Relationship Check: _Cell _Landline

_____ _____ _____
MEDICAL RELEASE authorized for (optional) Relationship Check: _Cell _Landline

_____ ____/____/____ _____
Name of INSURED (if other than patient) Date of Birth Sex

_____ _____
Name of SECONDARY INSURED (if applicable) Secondary insurance plan or program

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY BEFORE SIGNING

For professional services rendered by Rivka Ann Sanders, MD, I fully understand and agree that:

- Medical services are limited to primary care by appointment. I will call 9-1-1 in an emergency.
- I have the right to prior informed consent to, or refusal of, any recommended medical procedure.
- I have the right to prior notice of the fee for any recommended service or medical procedure.
- I have the right to a copy of the Notice of Privacy Practices by request (or available at RAS.MD).
- My protected health information may be released for medical and billing purposes.
- All rendered medical services incur fees which I am personally responsible for, not my insurance.
- My insurance may not cover some medical services, such as those via telephone or internet.
- Certain administrative services may incur a fee, such as copies of medical records, filling out forms, correspondence, teleconferences, services requested by me or on my behalf, failure to show for or cancel an appointment 24 hours in advance, and late payment of fees.
- Optional: _____ hereby has my express authorization to release the above-named patient's medical records to Rivka Ann Sanders, MD

_____ _____
Signature of patient or, if applicable, guarantor Date

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