Groskopp and Ryland

800 E. Main Street Medford, OR 97504

Rogue Valley Physicians, P.C.

Please fill in the following information legibly and completely

Date_____

Patient Name_____ Date of Birth_____ SSN_____-_____-_____

If minor child, please provide Mother's name_____ Father's name_____

Spouse's name_____ Phone_____

Mailing Address:_____ _____ _____ _____

Street City State Zip

Phone: Home_____ Cell_____ Work_____

Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Single ☐

Occupation_____ Employer Name / Address_____

Referred to this clinic by_____

Emergency Contact Name_____Relationship_____Phone_____

Responsible Party_____SSN_____ DOB_____

Relationship to Patient: Spouse ☐ Mother ☐ Father ☐ Other ☐

Please present your insurance card and driver's license to the front desk.
If you do not have your insurance card with you, please fill in the following:

Insurance_____ Policy #_____ Group #_____ SSN _____-_____-_____

We require co-pays, deductibles and non-covered services be paid at the time services are rendered.

Authorization to release Medical Information

I authorize Rogue Valley Physicians, P. C. to release any medical information necessary to process a claim.
I hereby assign payment directly to Rogue Valley Physicians, P. C., all payments due from my insurance company.
I understand that I am financially responsible for all charges and should it be necessary to collect monies in court, all court costs and attorney fees are my responsibility. A service fee of 1.5% may be assessed on past due accounts.

Patient Signature_____ Date_____