RIVKA ANN SANDERS, MD
540 Catalina Drive, Ashland OR 97520

PATIENT REGISTRATION - PRIMARY CARE

_____	____/____/____ _Male _Female
PATIENT full legal name	Date of Birth
_Single _Married _Div _Sep _Widow(er) _Partner	Patient: _____ _Cell _Landline
_____	_____ _____
GUARDIAN (if patient is a minor or incapacitated)	Relationship _Cell _Landline
_____	_____
Residence Street	City State Zip Code
_____	_____
Email	Referred to or learned of Dr. Sanders by
_____	_____
Preferred PHARMACY Location	Previous primary care physician
_____	_____ _____
EMERGENCY contact	Relationship _Cell _Landline

PATIENT / GUARDIAN ACCEPTANCE OF TERMS. READ CAREFULLY BEFORE SIGNING.

For services rendered by Rivka Ann Sanders, MD, I read, understand, and accept that:

- Dr. Sanders is a primary care physician, providing non-emergency services only.
  I will call 9-1-1 or go to a hospital emergency room in the event of a health care emergency.
- I have the right to a copy of Dr. Sanders' Notice of Privacy Practices by request.
  (It can also be viewed and downloaded on the web at RAS.MD.)
- I have the right to informed consent prior to acceptance or refusal of any recommended procedure.
- I have the right to prior notice of the fee or fees for any recommended service or procedure.
- If applicable, Dr. Sanders will file insurance claims for me. Some services may not be covered.
- I will pay my account balance in full when due. A late fee is applicable to delinquent accounts..

By my initials here _____, I acknowledge services rendered via telephone or internet will incur applicable fees.

By my initials here _____, I acknowledge and agree that under no circumstances will I accept phone calls from, read text from, make phone calls to, or send texts to Dr. Sanders or her office while operating a motor vehicle.

Optional: By my initials here _____, if my spouse, _____, is or becomes Dr. Sanders' patient, I authorize our fee and payment transactions to be combined into a single household account if and when my spouse also authorizes the same. I may rescind this authorization at any time.

_____ _____
Patient / Guardian Signature Date

Internal Use: Pt _____ Acct _____