



RIFE & ASSOCIATES

FAMILY HEALTH CARE

Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____ City State Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Check if Ok to leave message at: Home# _____ Cell # _____ Work # _____ Email Address: _____

How do you prefer to be contacted for your appointment reminder?

Check all you'd prefer: Phone _____ Text _____ Patient Portal _____

Sex: _____ Social Security: _____ Marital Status: S M W D Sep Spouse: _____

Race: (please Circle One): American Indian, Alaskan, Asian, African American, Caucasian, Hawaiian-Pacific Islander, Latino

Ethnicity: (Please Circle One) Hispanic or Non Hispanic Preferred Language: _____

Preferred Pharmacy: _____ Location: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Responsible Party: Name: _____ Date Of Birth: _____

Address: _____ City/State/Zip _____

Home Phone: _____ Work Phone: _____ Relationship: _____

Assignment of Insurance Benefits: I hereby authorize direct insurance carrier payment of surgical/medical benefits to Dr. Rife and associates family Medicine, S.C. for services rendered by her/him in person or under her/his supervision. I understand that I am financially responsible for any balance not covered by my insurance

Authorization to Release Information: I hereby authorized Dr. Rife and Associate in Family Medicine, S.C. to release any medical or incidental information that may be necessary for either medical care or in processing application for financial benefits.

Medicare/Medicaid: I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request payment of authorized benefits be made on my behalf.

Acknowledgement/acceptance of No Show/24 Hour Cancellation: I hereby agree to the terms that if I am not able to keep my schedule appointment and do not call to cancel my appointment with 24 hours prior to my appointment I will be charged a no show/24 hr. cancellation fee for that missed appointment. A photo copy of these assignments shall be valid as the original.

Patient Name: _____

Patient/Parent/Guardian: Signature _____ Date: _____

NAME: _____ Today's Date: _____
 Date Of Birth: _____ Age: _____ Sex: Male _____ Female _____ Height: _____
 Martial Status: S M D Occupation: _____ Height: _____ Weight: _____

☐ AIDS
☐ Alcoholism
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Breast Problems
☐ Blood Transfusion
☐ Cancer
☐ Chemical Dependency
☐ Chest Pain
☐ Depression
☐ Diabetes
☐ Drug Abuse
☐ Eating Disorder
☐ Emphysema
☐ Epilepsy
☐ GI (stomach) Problems
☐ Colonoscopy
 Date: _____
 Results: _____
☐ Hay Fever/Allergies
☐ Headaches
☐ Heart Disease
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disease
☐ Osteoporosis
☐ Pneumonia
☐ Rheumatic Fever
Sleep Disturbance
☐ Can't Fall Asleep
☐ Early Awakening
☐ Drowsy In Daytime
☐ Stroke
☐ Thyroid
☐ TB
☐ Ulcers
☐ Venereal Disease
 Other: _____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

all allergies (i.e. Medications, Foods, environmental, etc.)
and write down your reaction

<u>Year</u>	<u>Hospital</u>	<u>Surgery or Reason for Hospitalization</u>

Check the box if your blood relatives have had the following:

[illegible]

RIFE & ASSOCIATES
FAMILY HEALTH CARE

Medical History Form (Please complete all sections front and back)

YOUR HABITS Please check if appropriate: Smoking Y ___ N ___ Packs per Day: _____ _____ Desire to Quit Y ___ N ___ u Caffine: Y ___ N ___ Daily Intake: _____ Alcohol: Y ___ N ___ If Daily Consumption: _____ 1-2 Drinks Per Day _____ 3-4 Per Day _____ 5-6 Per Day _____ 7 or more Per Day If Monthly or less: _____ 4 or more drinks per week _____ 2-3 drinks per week _____ 1-4 per month or less	FEMALES ONLY (13 and over) Please check if you've had the following: <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Abnormal Periods</td> <td style="width: 33%;">Age Period Started _____</td> <td style="width: 33%;">Mammogram</td> </tr> <tr> <td><input type="checkbox"/> Abnormal Bleeding</td> <td>Date of Last Period _____</td> <td>Results? _____</td> </tr> <tr> <td><input type="checkbox"/> Breast Lump</td> <td>Date of Last Pap _____</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Nipple Discharge</td> <td>Results? _____</td> <td>Where? _____</td> </tr> <tr> <td><input type="checkbox"/> Painful Intercourse</td> <td>Where? _____</td> <td></td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Pregnancy Complications</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Vaginal Discharge</td> </tr> <tr> <td colspan="3">Other _____</td> </tr> <tr> <td colspan="3">Method of Birth Control _____ Number of Children _____</td> </tr> </table> MALES ONLY Please check if you've had the following: <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Erection Difficulties</td> <td style="width: 33%;"><input type="checkbox"/> Penis Discharge</td> </tr> <tr> <td><input type="checkbox"/> Lump In Testes</td> <td>Other _____</td> </tr> </table> Immunization History Date of Last Tetanus: Month _____ Year _____ Never <input type="checkbox"/> Date of Last Pneumonia Shot Month _____ Year _____ Never <input type="checkbox"/> Date of Last Flu Shot Month _____ Year _____ Never <input type="checkbox"/> Where did you get your flu shot? _____ Do you get a flu shot each year? Yes ___ No ___	<input type="checkbox"/> Abnormal Periods	Age Period Started _____	Mammogram	<input type="checkbox"/> Abnormal Bleeding	Date of Last Period _____	Results? _____	<input type="checkbox"/> Breast Lump	Date of Last Pap _____		<input type="checkbox"/> Nipple Discharge	Results? _____	Where? _____	<input type="checkbox"/> Painful Intercourse	Where? _____		<input type="checkbox"/> Pregnancy Complications			<input type="checkbox"/> Vaginal Discharge			Other _____			Method of Birth Control _____ Number of Children _____			<input type="checkbox"/> Erection Difficulties	<input type="checkbox"/> Penis Discharge	<input type="checkbox"/> Lump In Testes	Other _____
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<input type="checkbox"/> Vaginal Discharge																																
Other _____																																
Method of Birth Control _____ Number of Children _____																																
<input type="checkbox"/> Erection Difficulties	<input type="checkbox"/> Penis Discharge																															
<input type="checkbox"/> Lump In Testes	Other _____																															
NUTRITION AND DIET How many times a week do you eat the following? Sweets/Candy _____ Soda _____ Fried Foods _____ Caffinated Beverages _____ Fast Foods _____ Dairy Products _____ Meat _____ Fish _____ Bread/Cereal _____																																
OCCUPATIONAL HISTORY Please check if appropriate: <input type="checkbox"/> Stress <input type="checkbox"/> Contact With body fluids <input type="checkbox"/> Heavy Lifting <input type="checkbox"/> Hazardous Substances Number of hours worked per week _____	WHOOLEY DEPRESSION SCREENING Please circle Yes or No During the past month have you often been bothered by feeling down, depressed, or hopeless? YES NO During the past month have you often been bothered by having little interest or pleasure in doing things? YES NO																															

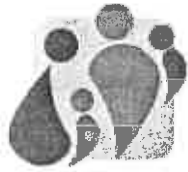
I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions I may have made in completing this form.

PATINET SIGNATURE _____ DATE _____

PHYSICIAN USE ONLY

Physical Activity	<input type="checkbox"/> Patient advised on physical activity
	<input type="checkbox"/> Patient given educational material on physical activity
Alcohol Assessment	<input type="checkbox"/> Patient advised on health effects of alcohol
	<input type="checkbox"/> Patient given educational material on alcohol intake and health
Smoking Assess	<input type="checkbox"/> Patient advised on health effects of smoking and advised to quit
	<input type="checkbox"/> Patient given educational material concerning smoking and health
Nutritional Assess	<input type="checkbox"/> Patient advised on nutrition
	<input type="checkbox"/> Patient given educational material concerning nutrition

Physician Signature _____ Date: _____



RIFE & ASSOCIATES

FAMILY HEALTH CARE

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Rife & Associates Family Medicine ("the practice") may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Rife & Associates Family Medicine reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Robert Rife, Director of Operations, Rife & Associates Family Medicine, 10755 163rd Place, Orland Park, Illinois, 60467.

With my consent, and in accordance with Illinois law, Rife & Associates Family Medicine staff may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including test results among others.

With my consent, Rife & Associates Family Medicine may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, the practice may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the practice restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the practice's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the practice may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date

Patient or guardian Name (Please print)

I would like my medical records released to:

I do not want my medical records released to:

(Rev. 1-2015)



RIFE & ASSOCIATES

FAMILY HEALTH CARE

Susan Rife D.O.
Lindsay Gnade, P.A.

Mark McKeigue, D.O.
Joelle Rickey, PA

Catie Dahl, P.A.

Cory Cunningham, P.A.

10755 W. 163rd Place
Orland Park, IL 60467

Telephone: 708-873-1187

Fax: 708-364-9307

NOTICE OF PRACTICE POLICIES

APPOINTMENT CONFIRMATION AND SPECIAL CHARGES

A call confirming your scheduled appointment will be made prior to your appointment. A message may be left on your answering machine/ voice mail, if no one answers your phone.

If this is not acceptable, please notify us in writing of alternative appointment confirmation methods. A \$50.00 NO SHOW FEE will be made to all patients who fail to show up for a scheduled appointment (24-hour cancellation notice) without notifying our office.

MEDICATIONS

- * **Refills** – Allow 2-3 business days for refills. Contact your pharmacy 5 days before running out of your medication, and ask them to send us an electronic refill request. Or you may send us a refill request through your patient portal.
- * Physicians covering for PA's do not authorize refills on weekends.
- * For your safety, you may be required to make an appointment in order to get a refill.
- * **Controlled Substances Prescriptions** – Must be picked up in person, a photo ID must be presented.
- * If a family member will be picking up a prescription the office must have that person's name in advance.
- * No narcotics or controlled substances will be refilled on Friday, Saturday, Sunday, or holidays.
- * Name of the person picking up prescription will be documented in the medical record.
- * **Medications Requiring Prior Authorizations** – Note that some medications now require prior authorization from your insurance company, and we will no longer issue prescriptions for those medications. Please contact your insurance company for medications that require prior authorization and let your provider know so that they can recommend a suitable substitute. The increasing number of insurance plans and variations on formularies they dictate have forced us to set this policy. We apologize for any inconvenience.

REFERRALS

Any type of referral requires 5-7 business day turnaround time. Referrals are the patient's responsibility and need to be requested prior to having the services rendered. Referrals will not be faxed – they must be picked up by the patient or mailed. Referrals will not be processed if patient is calling on the day of their appointment with specialist/testing. Patient will be expected to reschedule.

PLEASE NOTE

We do submit claims under our insurance contracts with insurance companies. For all self-pay and non-contracted insurance, payment must be paid at time of service. Any balance after insurance payment must be paid in full within 30 days.

I understand and agree that it is my responsibility to know if my insurance has a deductible, co-payment, co-insurance, out-of-network benefits, usual and customary limit, prior authorization requirements or any other type of benefit limitations for the services I receive. I agree to make any payment acquired during my visit in full.

I understand that I am responsible for knowing what facilities are covered by my insurance which may include hospitals, labs and testing facilities.

I understand that I am responsible for knowing my benefits with my insurance, which may include coverage for any tests ordered.

SERVICE FEES

A \$30 service fee will be assessed for all returned checks.

A \$75 service fee will apply to complete disability form from private agencies.

A 25% fee will be added to your balance if your account is sent to a collection agency and future payments will be on a cash basis.

Your insurance will be billed a "Late or Weekend hours visit charge" if your appointment time is 5pm or later or on Saturday.

CASES OF DIVORCE OR SEPARATION

The parent or guardian who brings the patient in for a visit will be responsible for co-pays, and for any balances after insurance is filed.

WORK COMP VISITS

It is the patient's responsibility to provide ALL the insurance information and business information if your visit is due to an injury sustained from a job or place of business. You must have this information released to the front desk prior to your scheduled appointment. If you fail to provide the office with this information, you will need to pay for your visits or reschedule.

AUTO INJURIES AND ACCIDENTS

If your visit is the result of an automobile accident/injury, note that we will only submit claims to your medical insurance that is in your chart. If you do not want this to occur, then you must pay for your office visit and then you can submit this claim to the auto insurance policies. We do not submit claims to auto insurance plans. You may pay by check, or charge or debit card on the day of your visit.

TRANSFER OF MEDICAL RECORDS

All transfer requests must be on the request form. We will need 7 to 10 working days to process your request. There is a fee required to copy your chart. That fee is based on a services fee dictated by state law, in addition to a charge per page fee. Your copies will be released once final payment is received. Also, accounts must be paid in full before your copied record will be released.

ILLINOIS IMMUNIZATION REGISTRY

By signing the agreement below, I agree to have my immunization record included in the Illinois Immunizations Registry. If you do not want your data available in the registry, please ask us and we will provide you with an opt-out of registry form to sign.

ASSIGNMENT AND RELEASE

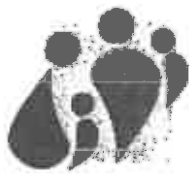
I hereby authorize that my insurance benefits be paid directly to Rife and Associates Family Health Care. I will be financially responsible for all non-covered services (co-pays, deductibles, cosmetic procedures, immunizations, etc.). I also authorize the practice to release any information required to process this claim to the insurance company or third party payer.

- This release may be revoked at any time if written authorization is received stating the reason for such an action.
- Patients not in good financial standing with this practice may be dismissed (disengaged).
- HIPPA rules are complied with in this office.

Please acknowledge your acceptance of these terms by signing and dating the form below.

NAME _____

RELATIONSHIP (if other than the patient) _____ DATE _____ (Rev.4/2018)



RIFE & ASSOCIATES

FAMILY HEALTH CARE

*10755 W. 163rd Place
Orland Park, IL 60467
(708) 873-1187 F. (708) 364-9307*

Financial Waiver Form

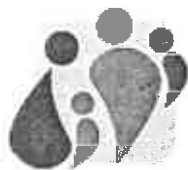
I understand that in the event that my health insurance, my Medicare insurance carrier, or work comp is not active or current, and/or they deny payment for any current or past visits, I will be responsible for any and all balances due on my account/my family's accounts.

This shall include, but is not limited to any and all deductibles, co-pays, or services that are not covered under my plan. Payment will be submitted in full to the office immediately.

Signature

Date

Please Print Name



RIFE & ASSOCIATES

FAMILY HEALTH CARE

Susan Rife, D.O.
Mark McKeigue, D.O.
Lindsay Gnade, P.A.-C
Joelle Rickey, P.A.-C
Catie Dahl, P.A.-C
Cory Cunningham, P.A.-C

10755 W. 163rd Place
Orland Park, IL 60467
(708) 873-1187 F. (708) 364-9307

DEFINITION OF WELLNESS CARE, ILLNESS CARE, AND YOUR INSURANCE (Non-Medicare)

It may seem like wellness and illness care are part of the same service, but routine health maintenance is different than treating an existing condition or a new illness.

We recommend that patients schedule separate visits for wellness and illness (including medication refills). If you have concerns you want to have addressed, we prefer to see you for those concerns first, then reschedule the wellness visit. If you decide to discuss an illness condition at your wellness visit, or if we find an unexpected condition during the visit, we will charge an additional evaluation and management (E & M) code. This situation would be considered two visits, one illness and one wellness, and you will be responsible for any copays or deductible amounts for the visits.

What is a wellness visit?

Wellness services are evaluations and advice to keep you well, including screening for such things as depression or diabetes, or for women, a pap smear or a mammogram. We update your health history, allergies, family health history, diet, exercise, and substance use habits. We may offer immunizations, advice on improving your health habits, and how to prevent disease.

What is an illness visit?

An illness visit is for a new illness or for chronic conditions that have already been diagnosed (such as diabetes, high blood pressure or arthritis). There is added thought, work, and follow up involved; detailed questions, examination, tests, referrals, therapy, advice, or prescriptions. An example would be diabetic care or blood pressure control where you often need to be seen on a regular basis. Remember, insurance plans vary in terms of coverage, and can change over time. It is the patient's responsibility to understand his/her coverage.

If you have any questions on your wellness visit, please ask our staff before your visit.

I, _____ understand and agree to abide by this policy.
(print name)

_____/_____/_____
(signature)

(rev 3-2018)

Dr. Susan Rife & Associates Family Medicine

Susan Rife, D.O.

Mark McKeigue, D.O.

Marianne Laff, C.N.P

Lindsay Gnade, P.A Joelle Rickey, P.A.

10755 W. 163rd Place

Orland Park, IL 60467

(708) 873-1187 F. (708) 873-1204

Welcome to MEDICARE & Annual Wellness Evaluation

It may seem like wellness and illness care are part of the same service, but routine health maintenance is different than treating an existing condition or a new illness.

We want you to receive wellness care – health care that may lower your risk of illness or injury. Medicare pays for some wellness care, but may not pay for all the care you need. We want you to know about your Medicare benefits and how we can help you get the most from them.

A wellness visit does not deal with new or existing health problems. If you have other concerns you want to have addressed, we prefer to see you for those concerns first, then reschedule the wellness visit. If you decide to discuss an illness at your wellness visit, or if we find an unexpected condition during the visit, there will be an additional charge for the evaluation and management of the illness. This situation would be considered to be two visits, one illness and one wellness, and you will be charged accordingly.

What is a wellness visit?

The term “physical” is often used to describe wellness care. But Medicare does not pay for a traditional head-to-toe physical, except during the Welcome to Medicare exam. Wellness services are evaluations and advice to keep you well, including screening for such things as depression, risk for falling, and advanced directives. We check your blood pressure, weight, vision and other things depending on your age, gender, and level of activity, and will make recommendations for other wellness services and healthy lifestyle changes. There is no examination involved, we make a treatment plan for further preventative testing or diagnostics.

What is NOT considered a wellness visit?

A visit for a new illness or for a chronic condition that have already been diagnosed (such as diabetes, high blood pressure, or arthritis). That would be a separate service and requires a longer appointment. Please let our staff know if you need the provider's help with a related problem, a medication refill, or something else. We may need to schedule a separate appointment. A separate charge applies to these services, whether provided on the same date or a different date than the wellness visit, and a deductible or copay may be required.

Remember, Medicare insurance plans can vary in terms of coverage. It is the patient's responsibility to understand his/her coverage.

**I, (Print Name) _____ understand and agree to abide by this policy.
(Signature) _____ (Date) ____/____/____**

Dr. Susan Rife Family Medicine General Patient Portal Consent Form

This form must be completed to provide patients access to their on-line medical records. A new Dr. Susan Rife Patient Portal account will be established for those requesting access with the email address provided below.

I agree to the following:

1. I must log into Dr. Susan Rife Family Medicine Patient Portal with my own user ID and password.
2. I will abide by the terms and conditions of the Dr. Susan Rife Family Medicine Patient Portal site.
3. Dr. Susan Rife Family Medicine has the right to revoke on-line access at any time.

I also understand that:

- For medical emergencies, dial 911. Dr. Susan Rife Family Medicine Patient Portal is NOT to be used for urgent needs.
- All communication is sent to the nursing staff in the department, not directly to the Provider. The message will be reviewed and responded to or forwarded appropriately.
- I will receive a Dr. Susan Rife Family Medicine Patient Portal email notifying me when access is available with login credentials. This is normally sent within 3 business days after the consent form is received by the Dr. Susan Rife Family Medicine.

Please enter **YOUR** information (please print clearly):

Name: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Email Address to use: _____

I understand that Dr. Susan Rife Family Medicine Patient Portal is intended as a secure online source of confidential medical information. If I share my Patient Portal username and password with another person, that person may be able to view my health information.

I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.

I understand that my activities within Dr. Susan Rife Patient Portal may be tracked by a computer audit and that entries I make will become part of my medical record.

I understand that access to Dr. Susan Rife Family Medicine Patient Portal is provided by Dr. Susan Rife Family Medicine as a convenience to its patients and that Dr. Susan Rife Family Medicine has the right to deactivate access to Dr. Susan Rife Family Medicine Patient Portal at any time for any reason. I understand that use of Dr. Susan Rife Family Medicine Patient Portal is voluntary and I am not required to use Dr. Susan Rife Family Medicine Patient Portal.

By signing below, I acknowledge that I have read and understand this Patient Portal Consent Form and agree to its terms.

Print Name: _____

Signature: _____ Date: _____

Rife & Associates Family Health Care - Minor Patient Portal Proxy Consent Form

This form must be completed to provide parents or legal guardians access to the on-line medical records of their children who are under 12 years old. A new Rife & Associates Patient Portal account will be established for those requesting access with the email address provided below.

I agree to the following:

1. I must log into Rife & Associates Patient Portal with my own user ID and password.
2. I will abide by the terms and conditions of the Rife & Associates Patient Portal site.
3. My access will be terminated on my child's 12th birthday.
4. Rife & Associates has the right to revoke on-line access at any time.
5. Access to a child's information will be revoked if parental rights are revoked.

I also understand that:

- For medical emergencies, dial 911. Rife & Associates Patient Portal is NOT to be used for urgent needs.
- All communication is sent to the practice, not directly to the Provider. The message will be reviewed and responded to or forwarded appropriately.
- I will receive a Rife & Associates Patient Portal email notifying me when access is available with login credentials. This is normally sent within 3 business days after the consent form is received by Rife & Associates.

Please enter **YOUR** information (please print clearly):

Relationship to Child: _____

Name: _____ Account Number#: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Email Address: _____

Please enter **PATIENTS** information (please print clearly):

Date of Birth: _____

Name: _____ Account Number#: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Note: Access to child's online record is only available to parents or individuals with legal guardianship.

I understand that Rife & Associates *Practice Name* Patient Portal is intended as a secure online source of confidential medical information. If I share my Patient Portal username and password with another person, that person may be able to view my or my child's health information.

I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.

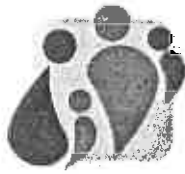
I understand that my activities within Rife & Associates Patient Portal may be tracked by a computer audit and that entries I make will become part of the patient's medical record.

I understand that access to Rife & Associates Patient Portal is provided by Rife & Associates as a convenience to its patients and that Rife & Associates has the right to deactivate access to Rife & Associates Patient Portal at any time for any reason. I understand that use of Rife & Associates Patient Portal is voluntary and I am not required to use Rife & Associates Patient Portal or to authorize a Patient Portal proxy.

By signing below, I acknowledge that I have read and understand this Patient Portal Proxy Request Form and agree to its terms.

Proxy (Your) Print Name: _____ Relationship to Patient: _____

Proxy (Your) Signature: _____ Date: _____



RIFE & ASSOCIATES

FAMILY HEALTH CARE

Release for Medical Information

TO: _____

Physician's Name

Address

City

State

Zip

Phone#

FAX#

I hereby authorize and request the release to:

Dr. Susan Rife Family Healthcare

10755 W 163rd Place

Orland Park, IL 60467

Phone 708-873-1187 Fax 708-364-9307

Please release all documents from date _____ to _____ including:

___ All Medical Care

___ Laboratory reports

___ Radiology reports

___ Other

Today's Date _____

Patient's Name _____ DOB _____

Address _____

Patient's signature _____ Date _____

Signature of Witness _____