Michael J. Rensch MD

Julie Taliaferro RN, MSN, FNP-C

Name: _____ Today's Date: _____

Social Security: _____ Date of Birth: _____

Address: _____ City _____ State/Zip_____

Phone: Home/Cell _____ Work _____

Email address_____

Employer: _____

Emergency Contact: _____ Relationship:_____ Phone: _____

Primary Insurance_____ Policy #_____

Subscriber Name _____ Subscriber Date of Birth _____

Primary Care Doctor _____

Name of person or persons authorized to receive your medical information:

Name: _____ Relationship:_____

Name: _____ Relationship: _____

Please read carefully before signing:

I certify that the above information is correct. I consent to be treated by the staff and Dr. Rensch.
I authorize payment of benefits to Dr. Rensch and authorize them to release any information necessary to process claims. I understand that I am responsible for co-payments, deductibles, co-insurance and non-covered services at the TIME OF SERVICES.

Patient/Guarantor Signature: _____ Date _____

112 Herff Road #250 Boerne, TX 78006 830-816-5007
420 Water Street #103 Kerrville, TX 78028
PHONE 830-257-0375 FAX 830-257-0049
WWW.HILLCOUNTRYDIGESTIVEHEALTH.COM
HCDH11@GMAIL.COM

PATIENT FINANCIAL RESPONSIBILITY FORM

Name: _____ Date: _____

The office of Dr. Michael J. Rensch requires this form to be signed by our patients.
We appreciate your cooperation. If you have ANY questions, please ask the receptionist.

1. FINANCIAL RESPONSIBILITY: We are pleased to assist with your insurance. I understand that I am personally responsible for any medical fees I will incur with the office of Dr. Michael J. Rensch; I also understand that I will be responsible for any charges incurred by not providing the most current, correct insurance to the office of Dr. Michael J. Rensch. **INITIALS OF PATIENT** _____

2. AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the office of Dr. Michael J. Rensch to release medical information acquired in the course of my examination or treatment, to my insurance company, or other physicians required to participate in my care. **INITIALS OF PATIENT**_____

3. AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment for medical services provided directly to Dr. Michael J. Rensch.
   INITIALS OF PATIENT_____

4. **PLEASE READ AND THEN CHOOSE YES or NO**: If you are unavailable, may we leave medical information, such as normal blood test results or normal biopsy reports on your answering machine or with someone at your residence?

_____ **YES**

_____ **NO**

PATIENT/GUARANTOR SIGNATURE _____

FOR BILLING PURPOSES WE REQUIRE THIS FORM TO BE FULLY COMPLETED. WE RESERVE THE RIGHT TO RESCHEDULE ANY APPOINTMENT DUE TO INCOMPLETE FORMS OR TARDINESS.
THANK YOU FOR YOUR COOPERATION.

Acknowledgment of Receipt of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed: _____ Date: _____

(Patient or legal guardian)

Cancellation/No Show Policy

We understand there are times when you must miss an appointment. However, when you do not call to cancel with enough advance notice you may be preventing another patient from getting much needed treatment. As a way for us to provide the best service to our patients, we need to keep appointment cancellation and "no show" activity to a minimum. In order to do this, we are implementing cancellation and "no-show" fees that will be charged to the patient if office visits and/or procedures are cancelled without proper advance notice, or if the patient does not show up for a scheduled office visit and/or procedure.

Cancellation Notice Requirements:
Office Visit: Two business days advance notice.
Failure to provide the required advance notice will result in a **cancellation fee** of **$20.00**

Procedure Visits: Two business days advance notice.
Failure to provide the required advance notice will result in a **cancellation fee** of **$100.00**

As a courtesy, we make every effort to remind patients of their office visit 1-2 business days before the appointment date. These are not just to confirm the appointment but are to remind the patient of their appointment. It is your responsibility to provide us with the appropriate advance notice if you need to cancel an office visit. Cancellations can be made by calling 830-816-5007 or 830-257-0375.

Thank you for your cooperation in helping us to provide efficient care to all our patients.

_____ _____

Name Date