



**Michael J. Rensch MD**

**Julie Taliaferro RN, MSN, FNP-C**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Social Security: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_  
Phone: Home/Cell \_\_\_\_\_ Work \_\_\_\_\_  
Email Address \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
**Primary Care Doctor** \_\_\_\_\_

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Primary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Subscriber Date of Birth \_\_\_\_\_

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

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**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/ Hill Country Digestive Health 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](http://WWW.HILLCOUNTRYDIGESTIVEHEALTH.COM)  
[HCDH11@GMAIL.COM](mailto:HCDH11@GMAIL.COM)



### PATIENT FINANCIAL RESPONSIBILITY FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

The office of Dr. Michael J. Rensch/ Hill Country Digestive Health requires this form to be signed by our patients.

We appreciate your cooperation. If you have ANY questions, please ask Front Desk Personnel.

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/ Hill Country Digestive Health  
**INITIALS OF PATIENT**\_\_\_\_\_

4. **PLEASE READ AND THEN CHOOSE YES or NO:** I consent to appointment reminders and other messages from our office.

**Email**      **Y / N**

**Text**      **Y / N**

**Phone**    **Y / N**

**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.**

**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 patients 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