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 _____

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
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.

ACKNOWLEDGEMENT OF HIPAA NOTICE OF PRIVACY PRACTICES

Patient Name: _____

I, the undersigned, acknowledge that I have seen and been offered a copy of Hill Country Digestive Health's Notice of Privacy Practices. I understand that this Notice describes how my health information may be used and disclosed. I further acknowledge that I have been offered a copy of the Notice of Privacy Practices. I understand that I may request a copy at any time in the future.

Signature of Patient or Personal Representative:

_____

Relationship to Patient (if signed by personal representative):

_____

Date: _____

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