

JOHN A. ROFFERS, M.D.
WELCOME TO OUR OFFICE

We will attempt to provide you with the best care possible in a timely, efficient, and professional manner. We will make every effort to see you promptly at your scheduled appointment time. Please call our office in advance if you are unable to keep your appointments.

NAME _____ SOC. SEC. # _____
ADDRESS _____ CITY _____ ZIP _____
HOME PHONE _____ CELL/ BUS. PHONE _____ DATE OF BIRTH _____
FAMILY PHYSICIAN _____ REFERRING PHYSICIAN _____
REASON FOR VISIT _____

PRIMARY INSURANCE CARRIER _____
SUBSCRIBER NAME _____ DOB _____ RELATIONSHIP TO INSURED _____
POLICY # _____ GROUP # _____

SECONDARY INS. CARRIER _____
SUBSCRIBER NAME _____ DOB _____ RELATIONSHIP TO INSURED _____
POLICY # _____ GROUP # _____

WORKER'S COMP CARRIER _____
W.C. CARRIER ADDRESS _____
CLAIM NUMBER _____ DATE OF INJURY _____
CONTACT PERSON _____ PHONE/FAX _____
EMPLOYER'S NAME _____
EMPLOYER'S ADDRESS _____

I. Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to have John A. Roffers, M.D. provide me with such medical, diagnostic, or other treatment services he judges necessary and appropriate. I consent to the use or disclosure of my protected health information by Dr. Roffers and his staff for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to carry out the healthcare operations of the practice of John A. Roffers, M.D. I understand that diagnosis or treatment of me by Dr. Roffers may be conditioned upon my consent as evidenced by my signature on this document.

II. Assignment and Agreement to Pay

I understand that I am responsible for payment for the services that I receive and guarantee payment for those services. I hereby assign to Dr. Roffers my rights and claims for reimbursement under any federal or state health care plan, insurance policy, managed care arrangement or any other similar third party payer arrangement that covers health care costs and for which payment may be available to cover the costs of services provided to me. I understand that I am responsible for any applicable co-payment, deductibles, co-insurance, and/or non-covered costs and charges. I understand that not all insurance companies pay the usual and customary fees. Therefore, when permitted by law, any outstanding balance will be my responsibility. If insurance payment for services is delayed greater than 90 days, I will be expected to pay my bill at that time. I understand that my health information will be released to my insurers, payers, or others for billing purposes.

III. Acknowledgement of Receipt of Notice of Privacy Practices

I understand I have a right to review the Notice of Privacy Practices of John A. Roffers, M.D. prior to signing this document. A copy of the Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of the health care operations of Dr. Roffers. The Notice of Privacy Practices also describes my rights and the duties of Dr. Roffers and his staff with respect to my protected health information.

Dr. Roffers reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Roffers has taken action in reliance on this consent.

Signature of Patient or Personal Representative

Date

If signed by personal representative, relationship to patient

Office Use Only:

If written acknowledgement is not obtained, our practice must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

Staff Signature

Date