PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name:_____ Date of Birth:_____

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Rochester Internists, PLLC or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree to remit payment at the time of service for any copays due and promptly upon receipt of a bill for any other out-of-pocket expenses that may be my responsibility. I understand that a $5 service fee will be assessed to my account if I do not pay copays at the time of the service.

MEDICARE/ MEDICAID/ CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment for me or my depenent's authorized benefits be made directly to Rochester Internists, PLLC or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the Rochester Internists HIPAA notice of Privacy Practices. I hereby authorize Rochester Internists, PLLC or physicians individually to release any of my or my dependent's medical or incident nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits. This information may be shared electronically. I understand that if an employee of Rochester Internists is exposed to my blood or body fluid, I may be tested for HIV without any additional written consent as stated in ACT 488 P.A. 1988.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mails. I hereby authorize a Rochester Internists, PLLC representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Rochester Internists,PLLC to that effect in writing.

LAB/ X-RAY/ DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason. All diagnostic tests require a 24-hour cancellation notice.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my Rochester Internists physician or designee.

PATIENT SIGNATURE:_____ DATE:_____

GUARANTOR SIGNATURE:_____ DATE:_____

GUARANTOR NAME(print):_____

Staff Signature:_____ Date:_____