Dr. Joel A. Rodriguez

Dr. David J. Straus

GENERAL PATIENT PAPERWORK

CONFIDENTIAL INFORMATION

Acct: SSN#: - -	Phone: ( ) Cell: ( )
Last Name:	Date of Birth: / / Age:
First Name: Middle:	Patient Employer:
Address:	Occupation:
City:	Phone Number: ( )
State: Zip: County:	☐ Single ☐ Married ☐ Divorced ☐ Widowed
Spouse:	E-Mail:
Primary Care Physician:	Which Doctor Referred you?
PCP Phone Number: ( )	Preferred Language: □ English □ Spanish □ Other
Race: □ White □ Native Hawaiian or Pacific Islander □ American Indian or Alaska Native □ Asian □ Black or African American □ Choose to not answer	Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Choose to not answer

Primary Insurance:	**Secondary Insurance:**
ID#: Group#:	ID#: Group#:
Policy Holder:	Policy Holder:
Relationship: ☐ Self ☐ Spouse ☐ Child	Relationship: ☐ Self ☐ Spouse ☐ Child
SSN#: DOB: / /	SSN#: DOB: / /
Employer Name:	Employer Name:

IN CASE OF AN EMERGENCY CONTACT: Name:	Name:
Phone: ( ) Relation:	Phone: ( ) Relation:

AGREEMENTS OF BENEFITS:

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH PLANS, TO DR. JOEL RODRIGUEZ AND/OR DR. DAVID STRAUS. I UNDERSTAND THAT I AM RESPONSIBLE FOR FOLLOWING UP ON ANY DISCREPANCY IN COVERAGE WITH MY INSURANCE PLAN. I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE. I HEREBY AUTHORIZE DR. JOEL RODRIGUEZ AND/OR DR. DAVID STRAUS TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

SIGNATURE: _____ **DATE:** _____/_____/_____

PATIENT/GUARANTOR FINANCIAL AGREEMENT

Have you ever been treated by Dr. Joel A. Rodriguez or Dr. David J. Straus before? Yes / No (Circle One)

If yes, when and where were you last seen? _____

(Please Initial)

____ I confirm that **all** personal information, as well as insurance information, is valid and correct.

____ I understand that if any information provided is incorrect, I will be responsible and liable for **all** charges incurred by me for any and all medical care provided by Dr. Joel A. Rodriguez and/or Dr. David J. Straus.

____ I understand that all co-payments must be paid **prior** to my appointment with Dr. Rodriguez and/or Dr. Straus. (*Please make checks payable to: Joel A. Rodriguez, M.D.*)

____ I understand that I will be responsible for contacting Dr. Joel A. Rodriguez and/or Dr. David J. Straus, and their staff, if I need to **cancel** a scheduled surgery **within 48 hours** of said surgery or procedure. I understand that failure to do so will result in a **cancellation fee** of $100.00, which will be required to be paid by me, **prior** to any additional appointments or being able to rescheduled said surgery or procedure.

____ I understand that the Office of Dr. Joel A. Rodriguez and Dr. David J. Straus reserves the right to reschedule appointments if the following items are **not** adhered to:

* Unpaid Co-Payments
* Invalid proof of Insurance/Invalid State Issued ID or Driver's License
* Non-Payment for services, if no insurance coverage provided.
* No/Invalid PCP referral provided

____ I understand it is my responsibility to ascertain that all laboratories and testing facilities are in network or contracted with my insurance **prior** to obtaining services.

____ I understand that I will be charged a **$25.00 fee** for all **Disability** and **FMLA** paperwork, to be paid in advance, for a 2-3 business day turn around; or a **$50.00 fee** for same business day completion**.** These forms will be filled out at the time of my post-operative visit**.**

____ I understand that payment for any medical care provided due to the result of a personal injury accident, is due at the time that services are rendered, even if I am consulting with an attorney. A certified letter of protection **MUST** be provided by an attorney if Dr. Joel A. Rodriguez and/or Dr. David J. Straus agrees to accept my case.

____ I understand that **WORKER'S COMPENSATION INJURIES** cannot be billed to my private insurance, therefore, I must report any such injuries to my employer **prior** to receiving medical care.
The following is required **before** you will be seen by the physician:

- Claim Number, Date of Injury, Employer's Name and Address.

____ I understand that I will be responsible for **any denied charges** or **unpaid claims** due to inaccurate information provided.

_____ _____/_____/_____

PRINTED NAME DATE

_____

SIGNATURE

PATIENT ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.
I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that the NOTICE OF PRIVACY PRACTICES, containing a more complete description of the uses and disclosures of my health information, are available to me should I request them. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this office at any time to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request, in writing, that this office restricts how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand this office is not required to agree to my requested restrictions, but if they choose to agree, then they are bound to abide by such restrictions.

Person(s) who can receive my private information: Name, Relationship, Phone Number

I understand that I may revoke this consent in writing at any time.

_____ _____/_____/_____
PRINTED NAME DATE

_____
SIGNATURE

Relationship to patient (if signed by personal representative of patient):

RELEASE OF INFORMATION

Patient Name: _____ **DOB: _____/_____/_____**

Appointment Date: _____/_____/_____ Surgeon(s): Joel A. Rodriguez, MD
David J. Straus, MD

Release of Information:
I authorize the release of any medical information necessary to Joel A. Rodriguez, MD or David J. Straus, MD to process this claim or provide medical information to any physician or medical facility.

Specific release for Mental health, drug or alcohol abuse, and/or HIV information:

1) I hereby specifically authorize information that may include mental health, drug or alcohol abuse, and/or HIV and related diseases, to release any and all information contained in my past or current medical records to the persons and organizations and for the purpose stated in Release of Information above.
2) By **initialing** the diagnosis (es)/condition(s) below, I do not consent to the release of such medical information, if any, to third party payors and understand I am personally responsible for payment.
   Mental Health_____ Drug and Alcohol Abuse_____ HIV_____
   (Please Initial) *(Please Initial)* *(Please Initial)*

Disclosure is limited to:

□ No limitations placed on dates, history of illness, or diagnostic and therapeutic information.

□ Records regarding admission and treatment for the following medical condition or injury:

_____

□ Records for the period from (dates): _____ to _____

□ The following specified information:

_____

1. I understand that this authorization is **voluntary** and that I may **refuse** to sign this authorization. My refusal to sign **will not** affect my ability to obtain treatment, except as provided in numbers 2 and 3 on this form.
2. If the purpose of this authorization is for an organization such as a health plan for a Life Insurance Company to determine eligibility before enrollment, the requested use or disclosure is not for psychotherapy notes and I may refuse to sign this authorization. The organization reserves the right to deny enrollment of eligibility for benefits.
3. If the purpose of this authorization is to disclose health information to another party based on healthcare that is provided solely to obtain such information, and I refuse to sign this authorization, Joel A. Rodriguez, MD and/or David J. Straus, MD reserves the right to deny that healthcare.
4. I authorize that I may inspect or receive a copy of the information used or disclosed.
5. I understand that I may revoke this authorization **at any time** by **notifying** this office in **writing**, except to the extent that action has already been taken in reliance of the authorization or
6. If this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself

_____ _____/_____/_____
PRINTED NAME (Or Patient's Legal Authorized Representative) Date

_____
SIGNATURE (Or Patient's Legal Authorized Representative)