Bret J. Rodgers, MD, FACS

Date _____

PATIENT INFORMATION

Name: _____
(Last name) (First name) (Middle initial)

Address: _____
(Street) (City) (State) (Zip)

Home Telephone Number :(____) _____ - _____ **Cell Number** :(____) ____-_____

E-Mail: _____

Social Security Number: _____-_____-_____ **Birthdate**: ____/ ____/ ____ Age: ___ Sex: ___

Employer: _____ Work Phone Number: (____) ____-_____

Emergency Contact Name _____Phone # _____Relationship _____

RESPONSIBLE PARTY INFORMATION

Name: _____
(Last name) (First name) (Middle initial)

Address: _____
(Street) (City) (State) (Zip)

Home Telephone Number :(____) _____ - _____ **Birthdate**: ____/ ____/ ____ Age: ___ Sex: ___

Social Security Number: _____-_____-_____

Employer: _____ Work Phone Number :(____) ____-_____

Spouse's Name: _____ Birthdate: ____/ ____/____ Age: ____

HEALTH INSURANCE ***Have your insurance cards available for copying by receptionist.

Primary Insurance: _____ID # _____
(Name of Ins)

Cardholder: _____Group # _____ **Birthdate**: ____/ ____/ ____Co-pay $_____

Secondary or Supplemental Insurance: _____ ID # _____
(Name of Ins)

Cardholder: _____Group # _____ Birthdate: ____/ ____/ ____ Co-pay $_____

FOR OFFICE USE ONLY

_____ NP _____ UPDATED _____ COSMETIC _____SCANNED

Bret J. Rodgers, MD, FACS
Medical History

Patient Name: _____ Doctors Name: _____

When was your last physical exam? _____ By whom? _____

Do you have any neurological conditions? Yes No _____

Do you have any chronic heart conditions including high blood pressure or mitral valve prolapse? Yes No

_____

Do you have any lung conditions? Yes No _____

Do you have any urinary or kidney disease? Yes No _____

Do you have diabetes or insulin resistance? Yes No _____

Do you have any liver conditions? Yes No _____

Do you have any problems with your eyes/vision? Yes No _____

Do you have stomach or reflux problems? Yes No _____

Do you have thyroid problems? Yes No _____

Do you have anemia, HIV, or any blood disorders? Yes No _____

Do you have problems with bruising easily or bleeding? Yes No _____

Do you have any chronic skin conditions including latex allergy/sensitivity? Yes No _____

Do you have a history of frequent cold sores or fever blisters? Yes No _____

Do you have any gynecological problems? Yes No _____

Are you presently pregnant? Yes No _____

Do you have problems with healing? Yes No _____

Do you have any psychiatric conditions? Yes No _____

Do you smoke cigarettes, cigar, or a pipe? Yes No If yes, how many per day _____

Do you drink alcohol? Yes No If yes, frequency and quantity_____

Please list any other medical conditions you suffer from:_____

_____

Please list all medications you take including vitamins or herbal:_____

_____

Please list any surgeries you have had, date of surgery, and complications from surgery:_____

_____

List any medications you are allergic to and explain the reaction after taking the medication:_____

_____

Patient/Guardian Signature: _____ Date:_____

Physician Signature: _____ Date: _____

Welcome to the Office of Bret Rodgers, MD, FACS

Patient Financial Agreement

We would like to make you aware of our office financial policies as follows:

Required Payments: Any co-payments required by an insurance company must be paid at the time of service.

Insurance: Insurance coverage is controlled by the contract between you and your insurance company. We will bill your primary insurance company as a courtesy to you. We anticipate sending your first invoice to you **after** your insurance has responded to our office; therefore you may not receive an initial invoice for a period of months. We want you to know that we will **not** consider your account delinquent during the insurance-reconciliation period.

Your insurance company will make the final determination of your eligibility and insurance benefits depending upon your contract. You agree to pay any portion of the charges for services rendered not covered by insurance. If your insurance inadvertently remits payment to the patient or insured for services rendered at our office, you agree to remit this amount to our office within one week of receipt.

Past Due Accounts: If your account becomes past due, we will take steps outside our office to collect this debt. Should it becomes necessary to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred.

Missed Appointments: Because your appointment has been reserved exclusively for you and/or your family members, please understand that you are required to provide at least 24 hours advance notice if unable to keep the scheduled appointment. A $25 fee will be assessed for missed appointments.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization.

Effective Date: Your signature on this agreement indicates that you agree to all of the terms and conditions contained in the agreement. The agreement is effective as of the date below.

Patient's or Guardian's Signature _____ **Date** _____

Primary Insurance and/or Medicare Supplement Authorization

My insurance company is: _____and I assign all medical benefits directly to Dr Bret J Rodgers. I understand my signature requests payment and authorizes release of medical information necessary to process the claim. I understand that I am responsible for the deductible, coinsurance, and non-covered services. Co-insurance and the deductible are based upon your contract with your insurance carrier.

Signature of Insured/Guardian _____ Date _____

Medicare Authorization

I request that payment of authorized Medicare benefits be made on behalf of Dr Bret J Rodgers for any services rendered by Dr Rodgers. I understand my signature requests payment and authorizes release of medical information necessary to process the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 (insurance billing) form, or elsewhere on the approved claim form or electronically submitted forms, my signature authorizes the release of information at the determination of the Medicare carrier as the full charge. I understand that I am responsible for the deductible, coinsurance, and all non-covered services. Co-insurance and the deductible are based upon your contract with your Medicare carrier.

Beneficiary Signature _____ Date _____

Bret J. Rodgers, MD, FACS

6077 North Eagle Road
Boise, ID 83713

Acknowledgement of Receipt of Notice of Privacy Practices
You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's

Notice of Privacy Practices.

_____ _____
(Signature) (Date)

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES, BUT ACKNOWLEDGEMENT COULD NOT BE OBTAINED FOR THE FOLLOWING REASON:

_____Individual refused to sign

_____An emergency situation prevented us from obtaining acknowledgement

a. **_____ Notice sent to patient via mail for signature**

_____Other (specify)
