



Consent For Treatment

Joseph A. Rutz, Jr., MD, PC
77 Weaver Road, Suite B
Blairsville, GA 30512

Date: _____ **Home Phone # :** _____ **Message Number if No Phone :** _____

Name: _____ **Soc Sec # :** _____ **E-mail:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Sex: ___ F ___ M **Birth Date:** _____ **Single Married Widowed Divorced Separated**

Patient Employed By: _____ **Occupation:** _____

Business Address: _____ **Business Phone:** _____

Pharmacy Preferred: _____ *Whom may we thank for referring you?* _____

Emergency Contact Person: _____ **Relation:** _____ **Phone:** _____

Spouse Name: _____ **Birth Date:** _____ **Soc Sec #:** _____ **Employer:** _____

IF PATIENT IS A MINOR OR STUDENT:

Father's Name: _____ **Soc Sec # :** _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Mother's Name: _____ **Soc Sec # :** _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Parent/Guardian's Business Address: _____

INSURANCE INFORMATION:

Primary Insurance: _____ **Secondary Insurance:** _____

If Patient is NOT the Primary Holder Listed on Insurance Card: Primary Holder's Name: _____

Relationship to Patient: _____ **His/Her Birth Date:** _____ **Soc Sec #:** _____

Employer: _____ **Business Phone:** _____

Consent For Treatment

I, _____, authorize Joseph A. Rutz, Jr., M.D. and such assistants as they may designate to carry out diagnostic procedures including any tests, x-rays to better diagnose my condition(s) and to administer such treatments and medications as indicated. I consent to having x-rays as ordered by the physician. I also understand that if I am pregnant or think I may be pregnant, I am to inform the assistant or the provider of this before any x-ray(s) are taken and/or before any injection or medication is given.

Patient or Responsible Person's Signature: _____ **Date:** _____



Receipt of Notice of Privacy Practices

**Joseph A. Rutz, Jr., MD, PC
77 Weaver Road, Suite B
Blairsville, GA 30512**

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:

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

I have been informed by you or your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this form. 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 organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____



Permission to Share Health Information

Joseph A. Rutz, Jr., MD, PC
77 Weaver Road, Suite B
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No one other than myself, those required by law, or persons indicated below:

My Spouse _____
Name

My Parent _____
Name

My Child(ren) _____
Name

My Friend _____
Name

Patient Signature: _____

Date: _____

New Patient Information



Joseph A. Rutz, Jr., MD, PC
77 Weaver Road, Suite B
Blairsville, GA 30512

Patient Name: _____

**PLEASE ANSWER THE FOLLOWING TO AID US IN
COMPLETING OUR RECORDS AND BETTER SERVING YOU.**

Please indicate how you learned about our practice:

Friend/Family _____ Doctor _____ Yellow Pages _____ Area Phone Book _____

Number of children _____ Number of pregnancies _____

Children's ages and birth weights _____

Did you have any cesarean births? Yes ____ No ____ Your height ____ Your weight ____

Age of onset of menstrual period? _____ Date of last menstrual period? _____

Are your periods regular? Yes ____ No ____ What do you use for birth control? _____

Do you take any birth control pills or hormones? Yes ____ No ____

If yes, please list: _____

When did you last have a pap test _____ mammogram _____ colon test _____

bone mineral density test _____

Have you ever had an abnormal pap test? Yes ____ No ____

List any allergies to medicines or latex _____

List any medicines you take _____

List any recent tests you have had _____

What is your chief complaint or reason for this visit? _____



Medical History

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Have you had a problem with any of the following now or in the past, briefly describe:

- Vaginal _____
- Bladder _____
- Bowel _____
- Breast _____
- Skin _____
- Eyes _____
- Ears _____
- Nose _____
- Throat _____
- Neck _____
- Lungs/Arms _____
- Heart _____
- Abdomen _____
- Legs _____
- Muscular _____
- Nerves _____
- Emotions _____

List any surgery you have had done and the dates _____

Do you or anyone in your family have a history of --- (if so, list family members)

- Heart Disease _____
- Diabetes _____
- High Blood Pressure _____
- Cancer _____
- Thyroid Problems _____
- Anemia _____
- Seizures/Strokes _____
- Births Defects _____
- Genetic Disorder _____
- Osteoporosis _____
- Severe Arthritis _____
- Other _____

Social History:

Married _____ Single _____ Widowed _____ Divorced _____

Do you work? Yes _____ No _____ If yes, type of work? _____

Do you smoke? Yes _____ No _____ If yes, how much? _____

Do you use alcohol? Yes _____ No _____

Do you have any history of substance abuse? Yes _____ No _____

Have you been immunized against any diseases? Yes _____ No _____



Payment Authorization

Joseph A. Rutz, Jr., MD, PC
77 Weaver Road, Suite B
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INSURANCE: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your insurance as a courtesy to you.

Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. You are required to pay a percentage or a copay at the time of service. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or authorization may result in lower or non-payment from the insurance company.

SELF PAYMENT: You are required to pay for services rendered in full at the time of service, unless other payment arrangements have been made before the appointment.

PAST DUE AMOUNT: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs.

WAIVER OF CONFIDENTIALITY: You understand that if this account is submitted to an attorney or collection agency, the fact that you received treatment in our office may become a matter of public record.

RETURNED CHECKS: There is a fee (currently \$30.00) for any checks returned to the bank.

We ask all patients to show their driver's license and insurance membership card so that we may make copies of them.

I, _____ hereby authorize Joseph A. Rutz, Jr. M.D. to furnish information concerning my present illness necessary for processing claims on my behalf. I direct the insurer to pay, directly to the physician, all benefits due for services rendered. I am aware that I am personally responsible for all charges for services rendered me regardless of insurance.

Patient's Name: _____
(Please Print)

Signature: _____ Date: _____



Request for Confidential Communication

Joseph A. Rutz, Jr., MD, PC
77 Weaver Road, Suite B
Blairsville, GA 30512

Please contact me in the manner(s) below; (check all that apply)

- Home Phone** _____
- Ok to leave message with detailed information
- Leave message with call back only
- Ok to leave message with another person _____

- Work Phone** _____
- Ok to leave message with call back name and number only

- Mail**
- Ok to mail to my home address
- Ok to mail to my work/office address _____
- Ok to fax to my office number _____

Do you give us your consent to disclose your health information to physicians we refer you to for additional medical care?

- Consent for Referral:**
- Yes, I give my consent
- No, I do not give my consent
- Yes, I give my consent, but with the following restrictions: _____

 Request for other confidential communications, please specify:

 I agree to reimburse Dr. Rutz for costs associated with this request, which will be explained prior to billing me. yes no

By signing this form, I acknowledge that the above information is accurate and that I have received information from the office regarding HIPAA Notice of Privacy Practices.

Signature: _____ Date: _____

Printed Name: _____

The HIPAA privacy rules provide you with the right to request a restriction of uses and disclosures of your protected health information (PHI). You also have the right to request that confidential communications regarding PHI be made by alternative means, such as sending correspondence to your office instead of your home.