

Patient Center Medical Home Brochure Received Initial_____

Patient Information

Last Name_____ First _____ M.I _____

Date of Birth_____ SS# _____

Address_____ City _____

State_____ Zip _____

P.O. Box_____ City _____

State_____ Zip _____

Home _____ Cell _____ Work _____

- **Please circle the preferred contact number**
- **May we leave a message at the preferred number? Y or N**

Email for Patient Portal: _____

Local Pharmacy: _____

Mail Order Pharmacy: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Authorization for release of Information and Assignment of Benefits

I authorized Dr. Ruoff to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. Ruoff's Notice of Privacy Practices prior to signing this consent. Dr. Ruoff reserves the right to revise the Notice of Privacy Practice at any time. With my consent, Dr. Ruoff may call my home or other designated number and leave a message that assists the practice to carry out TPO such as appointment reminders and patient statements. I have the right to request that Dr. Ruoff restricts how it uses and discloses my PHI to carry out TPO. However the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement. I hereby authorize insurance benefits to be paid directly to Dr. Ruoff, realizing that I am responsible to pay the non-covered services.

I agree that these provisions will remain in effect until I provide written revocation to the provider

Signature of Patient/legal guardian: _____ Date: _____