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INSURANCE INFORMATION:

As the patient, it is your responsibility to know your individual coverage. Failing to comply could result in you being responsible for all costs incurred. You will be responsible for all costs that are not a covered benefit by your insurance company, or if you do not follow your insurance guidelines. Also if we are unable to verify your insurance and/or you do not provide us with the most current insurance information and updated patient information, you will be responsible for any charges incurred. Please remember, the insurance policy is ultimately between you and your insurance company, not with the insurance company and the doctor.

As the patient, you authorize your physician to release any medical or incidental information that may be necessary for either medical care or in processing payment for medical services.

HIPAA:

The office has a Notice of Privacy Practices (HIPAA) form and if inclined, you may request a copy.

IDENTITY THEFT:

If you, the patient, are a victim of identity theft, the office will act accordingly and thoroughly in helping resolve the false claims in your name. The office will compare records to confirm whether documents/records have been released to any ancillary service providers and are linked to said records. If records have resulted in inaccurate information regarding the patient it will be removed and appropriate action taken.

LEGAL GUARDIAN:

I, _____, as legal guardian of, _____
give my permission for the above named physicians to examine and treat said patient.

Guardian _____
Please print _____ Sign _____
Patient Signature: _____ Date: _____