Rheumatology Associates, P.A.

Last Name: _____ ☐ Mr. ☐Mrs. ☐ Miss ☐ Other _____ Sex: Male _____ Female _____

First Name: _____ Date of Birth: ____/____/_____ Age _____ SSN: _____-_____-_____

Middle Name: _____ Preferred Name: _____

Address: _____City: _____County_____ State: _____ Zip: _____

Email Address: _____

Phone: Home ( ) _____ Work ( ) _____ Cell: ( ) _____

Marital Status: ☐Married ☐Single ☐Separated ☐Divorced ☐Widowed

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Other: _____

Primary Language: ☐English ☐Spanish ☐Other: _____

Race: ☐ Caucasian ☐ African American ☐Asian ☐ Hispanic ☐Other: _____

Student Status: ☐Full ☐Part ☐N/A School:_____ Employment: ☐Full ☐Part ☐N/A Employer: _____

May we leave a voice message to remind you about appointments at your home and/or cell phone number? Yes ____ No ____

May we leave a voice message for normal test results at your home or cell phone number? Yes ____ No ____

Pharmacy Name and Address: _____

Emergency Contact Name _____Relationship_____

Home Phone ( )_____ Work Phone ( )_____ Cell Phone ( )_____

(Complete only if you want this Practice to contact you at an alternate address or telephone number.)

Other Address: _____City: _____ State:_____ Zip: _____ Other Phone ( ) _____

Referring Physician_____ **Primary Care Physician**_____

Guarantor/Financially Responsible Person (if different from patient)

Last Name: _____ ☐ Mr. ☐Mrs. ☐ Miss ☐ Other _____ Sex: Male _____ Female _____

First Name: _____ Date of Birth: ____/____/____ Age _____ SSN: _____-_____-_____

Middle: _____ Relationship to Patient: _____

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

Phone: Home ( ) _____ Work ( ) _____ Cell: ( ) _____

Guarantor/Financially Responsible Person's Email Address: _____

Primary Insurance

Insurance Company: _____

Policyholder Name: _____

Member or Policyholder ID#: _____

Policy Holder Date of Birth:_____

Insurance Co. Phone Number: (_____)_____

Group #_____

Insurance Co. Address: _____

City:_____ State:_____ Zip:_____

Secondary Insurance

Insurance Company: _____

Policyholder Name: _____

Member or Policyholder ID#: _____

Policy Holder Date of Birth: _____

Insurance Co. Phone Number:(_____)_____

Group #_____

Insurance Co. Address: _____

City:_____ State:_____ Zip:_____

Ongoing Communication Regarding Your Healthcare

You must complete this section to authorize this Practice to release/discuss your health information with the following people or organizations for the following dates of service, range of time, or event(s):

From (MM/DD/YY) _____ To (MM/DD/YY) _____

Name (Physician, family, etc)	Address	Phone/Fax	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

A separate Authorization to Release Information Form must be completed if the information being released is different than the people or organizations listed above.

Authorization, Assignment of Benefits, and Referral Medical Release

I give permission to Rheumatology Associates, P.A. to provide me with medical treatment, including prescription medications, intra-articular joint injections, infusion therapy and any other treatment recommended.

I allow this Practice to use and release my protected health information for treatment, payment, and healthcare operations as allowed by HIPAA and as described in the Rheumatology Associates, P.A. Notice of Privacy Practices, which I have been provided a copy.

I allow the release of medical information including complete medical records, test results, and billing information to my insurance company and to other medical professionals and medical care institutions that I may be referred to for treatment.

I allow payment to be made directly to Rheumatology Associates, P.A. for all medical or surgical benefits otherwise payable to me under terms of my insurance.

I understand that I am financially responsible for paying all co-payments, co-insurance, deductibles, and non-covered services.

A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep this Practice and my Physician informed of changes to any of my contact information; a failure to do so may interfere with the ability to contact me concerning my healthcare.

Print Patient's Name: _____

Patient's Signature: _____ Date _____/_____/_____

To request restrictions of the use of your information, you must complete a separate Request For Restrictions Form.

Authorization to Release and/or Obtain Medical Records

I hereby authorize all physicians participating in my health care, and Rheumatology Associates, P.A. to release use, and disclosure of my entire medical record by mail, phone, and fax, to carry out my treatment, payment and healthcare operations.

Patient Signature Required_____ Date _____/_____/_____

Acknowledgement of Notice of Privacy Practices

I have received a copy of the summary of the Notice of Privacy Practices (NPP) for Rheumatology Associates, P.A.. I have had the opportunity to ask questions and discuss its content with the Contact Person and to request a copy of the full Notice that explains in more detail, how my information may be used or disclosed by Rheumatology Associates P.A.

Patient's Signature _____ Date____/_____/_____