Patient Registration Information

Title (circle one) Mr. Mrs. Ms. Miss

Name _____ (First / M. / Last)

Primary Care Doctor _____ **Referring Doctor** _____

Date of Birth _____ **Last 4 digits SS#** _____

Gender (circle one) M F

Right or Left Hand Dominant (Circle One)

Marital Status

Single ☐
Married ☐
Widowed ☐
Divorced ☐
Other ☐

Ethnicity

African American ☐
Asian ☐
Caucasian ☐
Native American ☐
Native Hawaiian ☐

Hispanic ☐
Decline to state ☐

Address _____

_____ (City / State / Zip)

Phone(s) Home _____ Cell _____

Work _____ Email _____

Pharmacy Name _____ Address _____

Primary Insurance

Plan Name _____

Relationship to Insured (Circle One) Self Spouse Child Other

ID # _____

Group # _____

Insured Name _____

Insured DOB _____

Secondary Insurance

Plan Name _____

Relationship to Insured (Circle One) Self Spouse Child Other

ID# _____

Group # _____

Insured Name _____

Insured DOB _____

Permission To Bill Insurance

By my signature below, I authorize Rheumatology Associates, PC to act as my agent in helping obtain payment from my insurance company. I authorize payment directly to my doctor and I permit this form to be used as my "Signature on File" for all my insurance submissions. I authorize release of any information that is required to obtain payment to my doctor. I understand THAT I AM RESPONSIBLE for payments to Rheumatology Associates, PC for charges for the above patient regardless of my insurance coverage. I also understand that in the event my insurance company denies payment, I am responsible for the balance in full. I am aware that I am responsible for any copayments and/or deductibles as is specified under my insurance contract.

_____ Signature

_____ Date

Print Name: _____

Date of Birth: _____

HIPAA - Notice of Privacy Practice

HIPAA is a federal law developed to provide a standard to protect your health information. The purpose of the Notice of Privacy Practice is to explain how Rheumatology Associates, PC may use or disclose your healthcare information. The Notice also explains the rights that you are guarenteed under HIPAA regulations.

Though we take great care to protect the integrity and confidentiality of your health care information, we are required by HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgement that you have been provided access to the Notice. If you would like to review the notice it is available in our waiting room.

I hereby acknowledge that I have read and understand the paragraphs above.

_____

Please sign here.

Permission To Share Medical Information

My medical information may be obtained and exchanged verbally to:

_____ ***Phone #:*** _____

Name/Relationship

ePrescribing

ePrescribing gives our practice information about which drugs are covered by insurance, what medications you are already taking or have tried, and allows your doctor to prescribe and renew prescriptions electronically. This will ensure your prescriptions are filled in a more timely manner, reduce errors and prevent adverse drug reactions to help your doctor treat you more efficiently.

By signing you are aware that Rheumatology Associates, PC can request and use your prescription medication history for treatment purposes.

_____

Please sign here.

I understand that there are insurance plans (i.e. Medicaid) that Rheumatology Associates, PC does not accept, and that it is my responsibility to verify your participation with my insurance before I am seen. I also understand that it is my responsibilty to obtain any referrals required by my insurance.

I am responsible for paying my full copayment at the time of each visit. If I cannot pay at time of service I understand that my appointment will be rescheduled.

Notice of 24 hours or more is required for any appointment cancellation.

_____

Please sign here.