REGISTRATION/CONSENT FORM

❑ *Please check this box if you are a winter visitor. If so, please provide both addresses*

(Please Print)

PATIENT INFORMATION

Patient's Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Preferred Name:	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:	Social Security #:	Home phone #: ( )	Cell phone #: ( )		
P.O. Box:	City:	State:	ZIP Code:		
Summer address (if applicable):	City:	State:	ZIP Code:		
Occupation:	Employer:	Work phone #: ( )			
Chose clinic because/Referred to clinic by (please check one box):	❑ Dr. ______________________	❑ Insurance Plan	❑ Hospital		
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other________________________________	
Your Email Address:					
Primary Care Physician:					
Preferred Pharmacy:	Phone No. ( )				
Spouse's last name:	First:	Date of Birth:			
Primary Language: ❑English ❑Spanish ❑Other_______	Ethnicity: ❑ White ❑American Indian or Alaska Native ❑Asian ❑Black or African American ❑ Hispanic or Latino ❑Native Hawaiian or Other Pacific Islander ❑Unknown ❑Refuse				

INSURANCE INFORMATION

Please give your insurance card and photo ID to the receptionist. You must notify us if this is an accident or work-related visit.

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )
Name of primary insurance:	Subscriber's name:		
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other Insurance ID Number:	Co-payment: $ Group Number:		
Name of secondary insurance (if applicable):	Subscriber's name:		
Insurance ID Number:	Group Number:		

EMERGENCY CONTACT INFORMATION

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Patient Name: ________________________________ Date of Birth: ________________

ASSIGNMENT AND RELEASE:

- I hereby assign my insurance benefits to be paid directly to the physician.
- I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan. I understand any balance over 90 days due will be submitted to a collection agency and I agree to pay all costs charged by the collection company and/ or attorney fees.
- I authorize the physician to release any medical information required to process this claim.
- I authorize my provider's office to contact me by telephone to remind me of my appointments.
- I understand a fee for no shows may apply.

FINANCIAL POLICY:

It is our office policy, to require payment of all office charges at the time they are given, unless prior arrangements have specifically arranged. All accounts over 60 days will be charged an interest rate of 1.5% per month (18% per annum). In the event any balance due here under is not paid as agreed, the undersigned agrees to pay all costs charged by the collection company, which costs will not exceed 20% of said unpaid balance including reasonable attorney fees.

MEDICARE PATIENTS:

I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to RHEUMATOLOGY & ARTHRITIS CONSULTANTS

PATIENT CONSENT TO TREAT:

I, the undersigned, hereby consent to the following treatment: (1) administration and performance of all treatments (2) administration of any needed anesthetics, (3) performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, (4) use of prescribed medication, (5) performance of diagnostic procedures/tests, cultures, biopsies and surgery, performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees. I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. I understand that RHEUMATOLOGY & ARTHRITIS CONSULTANTS may include consent at satellite offices under common ownership.

MEDICATION HISTORY AUTHORITY:

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your medication history. A medication history is a list of prescription medicines that we or other physicians have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions. By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose, information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record. This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history.

I give permission for RHEUMATOLOGY & ARTHRITIS CONSULTANTS to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNTAIRLY TO ITS CONTENT. ALSO, THAT ALL INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT TO MY KNOWLEDGE.

✖ ________________________________ ________________

Patient/Guardian signature *Date*

Patient Name: ________________________________ Date

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

To better assist with your medical care, Rheumatology & Arthritis Consultants, request your consent for a photograph to be used in your medical record. I consent for a medical photograph to be made of me. I understand that the information will be used in my medical record. By consenting to these medical photographs I understand I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact the office directly at (928) 680-4255.

✖ ________________________________ ________________

Patient/Guardian signature *Date*