ARTHRITIS & RHEUMATOLOGY ASSOCIATES

of Palm Beach

Palm Beach Gardens: 7108 Fairway Dr, Suite 300, Palm Beach Gardens, FL 33418

Phone (561) 626-9696 Fax (561) 626-2264

Date: _____ Acct: _____

Patient Name: Last First MI

Street Address City State Zip

Home Phone # Work Number Mobile Phone # Northern Phone #

Date of Birth Age Sex M/F Social Security # Marital Status S/M/D/W

Northern Address, If Applicable City State Zip

Spouse's Name Spouse's Date of Birth Spouse's Social Security #

Parent's Name (if minor) Daytime Phone # Mobile Phone #

Primary Care Physician Occupation

Referred by: Emergency Contact (Name & Phone #)

Yes No

Insurance Name (e.g. Medicare, BCBS of FLA, United) HMO

INSURANCE - A COPY OF YOUR CARD WILL BE ATTACHED TO THIS FORM

Please read and sign the following:

1. Payment for services is expected at time of visit.
2. If insurance is filed, I authorize benefits to be paid directly to Arthritis & Rheumatology Associates of Palm Beach.
3. I am responsible for the balance on my account, regardless of insurance coverage.
4. _____initial I authorize Arthritis & Rheumatology Associates of Palm Beach, to release information requested with regard to the processing of my claims.
5. _____initial I authorize laboratory / test information results / appointments to be left on my home phone answering machine.
6. _____initial I authorize Laboratory / test information to be discussed with my spouse, or another family member.

Patient or Legal Guardian Signature Today's Date

Please Print Name of signature above.

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CHIEF COMPLAINT: Please indicate the main reason for your visit

CURRENT MEDICATIONS: Please write the medications and vitamins that you are currently taking and the dosage

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To our patients,

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to an address other than your home address.

The physicians and staff of the Arthritis & Rheumatology Associates of Palm Beach respect your privacy and wish to make all reasonable attempts to respect your wishes regarding your confidential information. With that in mind, please indicate your preferences for the areas noted below.

I wish to be contacted in the following manner (check <u>ALL</u> that apply):

- ❑ Home/Cell Telephone _____
  - ❑ Leave message with ***detailed*** information
  - ❑ Leave message **ONLY** with call back number
- ❑ Work Telephone _____
  - ❑ Leave message with ***detailed*** information
  - ❑ Leave message **ONLY** with call back number
- ❑ Written Communications
  - ❑ Mail to my home address
  - ❑ Mail to my work/office address
  - ❑ Fax to this number:_____

You may speak with the following individuals (spouse, family, caretakers, etc.) regarding:

- ❑ My care or treatment (blood results, etc.)
- ❑ My bills
- ❑ My appointments
- ❑ Prescriptions (**giving permission to pick up medicine scripts as well*)

Name	Relationship
_____	_____
_____	_____
_____	_____

I understand that I may revoke this authorization at any time with written notification to Arthritis & Rheumatology Associates of Palm Beach.

_____	_____
Print Patient Name	Date of birth
_____	_____
Patient Signature	Date

1411 North Flagler Drive, #5600
West Palm Beach, Florida 33401
(561) 659-4242 * FAX: 659-5816

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Patient Name:_____

Date of Birth: _____Social Security #:_____

By signing this form, you acknowledge that we have provided you with our Notice of Privacy Practices, which explains how your health information may be handled in various situations including your treatment, payment of your bill, and our healthcare operations. If your first date of service with us was due to an emergency, we must try to provide you with our Notice and get your written acknowledgement for the Notice as soon as we can once the emergency has passed.

[ ] I have received the Notice of Privacy Practices (effective date September 23, 2013)

_____ _____
Patient's (or Legal Representative's Signature) Date

_____
Relationship of Legal Representative

For office use only

To be completed only if Acknowledgment is not signed.

1) Was the patient given a copy of the Notice of Privacy Practices?
[ ] Yes [ ] No

2) Please explain why the patient was unable to sign this Acknowledgment and our efforts to try to obtain the patient's signature:

_____
_____
_____
_____
_____

_____ _____
Name/Title Date

Place completed Acknowledgment in patient's medical record.

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NO SHOW POLICY

In an effort to address this concern and continue to meet the needs of our patients, we have developed the following No Show Policy.

1. To cancel an appointment, we require advance notice of **24 hours**.
2. For appointments **canceled the same day**, or for **missing an appointment**, a **fee of $50** will be levied to cover administrative expenses.
3. Patients who do not reschedule within 30 days or have a history of repeatedly not showing may be subject to dismissal for "non-compliance."
4. Patients who **arrive 15 minutes or so late must reschedule** their appointments.

_____ _____
Patient Signature Date

INSURANCE HOLDER, CO-PAY & REFERRAL POLICY

It is the patient's responsibility to be aware of their insurance co-pay amount and referral requirements. All co-payments are to be made at the time of visit. The patient is responsible to bring or confirm with the office that a referral is on file prior to scheduled appointment, if it is required. Failure to cooperate may result in the appointment being rescheduled.

_____ _____
Patient Signature Date

Insurance Holder: ☐ Self (Patient) ☐ Other (Please fill out the following)
Name of Insurance Holder:_____
Relationship to Patient:_____
Date of Birth:_____
Social Security Number:_____
Insurance Company: _____
Policy #: _____

RETURN CHECK POLICY

If a patient's check is returned by the bank, the patient will be charged a fee of $25.00 and will no longer be allowed to make payments with checks.

_____ _____
Patient Signature Date

PHARMACY INFORMATION

Name of your pharmacy: _____

Pharmacy phone #: _____

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Attention All Patients

Our practice has converted to Electronic Health Records (EHR). You will be able to access some of your electronic chart and contact medical staff *via* an online patient portal, **NextMD**. By giving us your e-mail address, an account will be created. An e-mail will then be sent to you containing a link to the patient portal and a "token" code to complete your account set-up.

Please do ***not*** reply to the e-mail; all messages for the staff and/or doctor must be sent through the patient portal, after you have completed your account set-up.

Signing this form and releasing your e-mail address gives our Practice authorization to create your personal online account. You will be able to view your demographic information on file, allergies, problems/diagnoses, medications, vital signs recorded during your appointments, lab results (once signed off by the physician), and any educational literature given by the doctor(s). You will also be able to send a message to the staff, request medication refills and follow-up appointments.

☐ I authorize Arthritis and Rheumatology Associates of Palm Beach to create an online account and to email me the account information for me to have limited access to my Electronic Health Record. I understand that the patient portal is not for emergencies and that I will not receive immediate responses. I acknowledge that Arthritis and Rheumatology Associates of Palm Beach is not responsible for any illness or injury from my choice not to seek emergency treatment.

Email: _____

☐ I decline this service and understand I may contact the office at any time if I change my decision.

_____ _____

Signature Date

_____ _____

Patient's Name (Print) Date of Birth

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