



ARTHRITIS & RHEUMATOLOGY ASSOCIATES
of Palm Beach

1411 N Flagler Dr, Suite 5600
West Palm Beach, FL 33401
Ph(561) 659-4242 F(561) 659-5816

7108 Fairway Dr, Suite 300
Palm Beach Gardens, FL 33418
Ph(561)626-9696 F(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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MICHAEL SCHWEITZ, M.D. • JONATHAN GREER, M.D. • AMIEL TOKAYER, M.D. • RUI CEREJO, D.O.
MARICARMEN QUINTERO, M.D. • PAUL MENDOZA, M.D. • CATHERINE GARCIA, M.D. • ANDREW VASCONCELLOS, M.D.

Specializing In Arthritis & Rheumatic Diseases

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 ALL 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

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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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