ARTHRITIS & RHEUMATOLOGY ASSOCIATES

of Palm Beach

Boynton Beach location: 6056 Boynton Beach Blvd Suite 145, Boynton Beach FL 33437
Phone (561) 439-1800 Fax (561) 439-4874

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.

Office Use Only:
B/P: ____/____ Wt: _____

T: ____. ___ P: _____

Ht: _____"

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MICHAEL SCHWEITZ, M.D. • JONATHAN GREER, M.D. • AMIEL TOKAYER, M.D. • RUI CEREJO, D.O.

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Specializing In Arthritis & Rheumatic Diseases

PLEASE PRINT ☺
AND FILL OUT COMPLETELY

NAME: _____ DATE: _____
LAST FIRST MIDDLE INITIAL

MAIN REASON FOR TODAY'S VISIT? _____

ANY SERIOUS ILLNESSES OR MEDICAL CONDITIONS THAT THE DOCTOR SHOULD BE AWARE OF?

_____

_____

_____

_____

_____

_____

LIST **ALL** CURRENT PRESCRIPTIONS/VITAMINS/OVER-THE-COUNTER MEDS.

NAME	HOW MANY MGS?	TAKEN HOW OFTEN?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES TO MEDS? YES _____ NO _____

IF YES, LIST MEDICATIONS WITH TYPE OF REACTION: _____

_____

LATEX ALLERGY? YES _____ NO _____

DR. TOKAYER
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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 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 48 hours.
2. For appointments canceled in 24 hours or less, or for missing an appointment, a fee of $25 will be levied to cover administrative expenses.
3. Patients who do not schedule within 30 days or have a history of repeatedly not showing may be subject to dismissal for "non-compliance."

_____ _____
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 is using www.NextMD.com Patient Portal. You will be able to access some of your electronic chart as well communicate with your doctor's staff. By giving us your e-mail address, an account will be created and you will be given an **enrollment token**. An e-mail will then be sent to you containing a link to the patient portal 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, and any educational literature given by the doctor(s). You will also have the ability to request appointments and contact the staff.

You should **not** use your Patient Portal for emergencies. If your condition is serious, a visit to the Emergency Room may be your best choice for treatment, dial 911 if you need immediate assistance. By utilizing Arthritis and Rheumatology Associates of Palm Beach's Patient Portal you acknowledge that you will not receive immediate responses to questions, medical requests, medication requests, or appointment requests. Arthritis And Rheumatology Associates of Palm Beach is not responsible for illness or injury from your choice to not seek emergency treatment.

□ I authorize Arthritis and Rheumatology Associates of Palm Beach to create a patient portal account.

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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