

**Patient Registration**

**(PLEASE PRINT CLEARLY!)**

Patient's Name: \_\_\_\_\_ SS #: \_\_\_\_\_  
First Name MI Last Name

Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Divorced \_\_\_ Separated

Street Address : \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_ Home Phone w/Area Code: \_\_\_\_\_

Cell Phone w/Area Code: \_\_\_\_\_ Fax w/Area Code: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Work Phone w/Area Code: \_\_\_\_\_ Ext \_\_\_\_\_

\*\*\*If you are not employed, are you retired? Yes \_\_\_ No \_\_\_ Year of retirement: \_\_\_\_\_ Full Time Student? Yes \_\_\_ No \_\_\_

\*\*\*Are you eligible for disability benefits through Social Security? Yes \_\_\_ No \_\_\_ \*\*\*

Spouse's Name: \_\_\_\_\_ Is your spouse employed? Yes \_\_\_ No \_\_\_

Does your spouse have health insurance through an employer? Yes \_\_\_ No \_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Work Phone #: \_\_\_\_\_

If patient is a dependent child: Are parents \_\_\_ Married \_\_\_ Divorced

Is child covered under a parent's insurance? Father's \_\_\_\_\_ Mother's \_\_\_\_\_ Both \_\_\_\_\_

If Divorced, who has custody: \_\_\_\_\_

Custodial Parent's Home Phone w/Area Code: \_\_\_\_\_ Work Phone w/Area Code: \_\_\_\_\_

Custodial Parent's SS #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

In case of emergency, contact (not living with you): \_\_\_\_\_

Phone Number w/Area Code: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Referring Physician's Name & Phone Number: \_\_\_\_\_

**PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION**

Insurance Company # 1: \_\_\_\_\_ Employer: \_\_\_\_\_

>> Policyholder Name: \_\_\_\_\_ >> Date of Birth: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Insurance Company # 2: \_\_\_\_\_ Employer: \_\_\_\_\_

>> Policyholder Name: \_\_\_\_\_ >> Date of Birth: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**If you are 65 years or older, or if you receive disability benefits through Social Security and do NOT have Medicare, check here \_\_\_\_\_**

- I hereby authorize the payment of insurance medical benefits directly to this practice for services rendered. I understand that I am financially responsible for all charges not paid by my insurance.
- I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.
- I hereby authorize this practice to release any medical information necessary to complete and process my insurance claims.

>> \_\_\_\_\_ Date \_\_\_\_\_

>> **Patient's OR Insured's Signature** (If patient is a Minor, must have Responsible Party Signature)

Date

# **CAROLINA ARTHRITIS ASSOCIATES, PA**

## **PATIENT RIGHTS AND RESPONSIBILITIES**

These are your rights and responsibilities as we partner with you to provide your health care:

### **You have the right to:**

- Health care regardless of race, gender, religion, disability, national origin, or sexual orientation
- Respect for personal dignity and privacy
- Confidentiality of your protected health information, as provided for by state and federal law.
- Know the identity of the health care professional providing your services.
- Information regarding services, hours of operation, and health insurance participation.
- Expect your diagnosis, prognosis, and method(s) of treatment to be explained clearly
- Be informed about any risk or mortality or serious side effects from your treatment
- Participate in decisions involving your health care
- Know what alternatives exist for health care and treatment
- Refuse medical care
- A second opinion or referral to another provider
- Know if treatment involves experimental or research methods and the right to refuse participation.

## **PATIENT RESPONSIBILITIES**

### **You have the responsibility to:**

- Provide accurate information relating to health history and current health status
- Provide accurate information regarding your health insurance coverage and inform us immediately of any changes in coverage that occur during your course of treatment
- Cooperate in the treatment plan recommended by those responsible for your care
- Consult your medical care provider if your condition worsens or does not improve
- Accept personal responsibility for refusing treatment
- Accept financial responsibility for paying your bill on time
- Abide by this practice's Policies and Procedures
- Respect the rights of Carolina Arthritis Associates' personnel and other patients
- Ask adequate questions to ensure understanding of your health condition and treatment
- Keep informed regarding our services, hours of operation, and status of our health insurance participation.

## CAROLINA ARTHRITIS ASSOCIATES, PA PAYMENT POLICY

Thank you for choosing us as your healthcare provider. We feel strongly that all patients deserve the best medical care we can provide. Everyone benefits when financial arrangements are agreed upon in advance of treatment, so we have prepared this material to inform you of our policies. If you have any questions, please ask us BEFORE you sign this document.

***Payment of all copays, deductibles, coinsurance, and any other amount not covered by insurance is due at the time of service. WE DO NOT EXTEND CREDIT FOR THESE AMOUNTS.***

### ***Patients with commercial insurance coverage***

IMPORTANT: Please understand that our services are rendered to you, not to your insurance company. Your insurance plan is a contract between you and the insurer, or between the employer who choose your group coverage and the insurer. We are NOT a party to that contract. Therefore, payment for treatment is ultimately YOUR responsibility, regardless of insurance coverage. **Please present your insurance card(s) at each visit.**

1. **We will collect the copay/deductible/coinsurance at the time of service.** Deductibles and coinsurance will be calculated on the **discounted fees** we have agreed to with your insurance carrier.
2. We will file a claim on your behalf for the services rendered, excluding any non-covered items or services.
3. Any amount denied or not paid by your insurance after 60 days becomes your responsibility.
4. Since we are not a party to your insurance contract, **you** are responsible for contacting your insurance carrier to settle any disputes regarding claim coverage denials/non-payment.
5. **It is your responsibility to inform our office of any changes to your insurance coverage BEFORE your next visit.** Any amounts not covered by your insurance because of a change in coverage will be your responsibility.

### ***Medicare Patients***

We are participating providers with Medicare. Therefore, your annual deductible and coinsurance amounts are calculated using the Medicare discounted fee. As stated above, payment of your deductible and coinsurance amounts are due at the time of service.

**PLEASE NOTE: We do not accept Medicare Advantage plans in this practice (Aetna Medicare, Humana Gold, etc.). If your Medicare coverage is through one of these plans, we will not be able to render your care in this practice.**

***Workers Compensation Claims***

1. We cannot treat work-related injuries/illnesses unless we have a prior agreement on file with your employer.
2. If your injury/illness is work-related, by law, we must bill your employer's worker's compensation carrier. We cannot bill any other insurance as the primary carrier.

***Patients with secondary insurance***

If you are covered by more than one insurance plan, **federal law determines which plan pays first. Neither you nor we can choose which plan pays first.** We will file a claim with the secondary insurance after the primary has paid their portion of the claim.

***Delinquent Accounts***

Once all or any portion of the amount due from you reaches **90** days past due, your account will be suspended and no further services will be rendered until payment arrangements are made. If reasonable payment arrangements are not made, delinquent accounts may be referred to an outside collection agency and they may report such accounts to the Credit Bureau. **You will be responsible for any additional charges or fees associated with attempts to collect this debt, including interest as allowed by North Carolina state law, and attorney's fees.**

***Missed Appointments***

If you are unable to keep your scheduled appointment, please notify us within 24 hours so we can make that time available to another patient. We reserve the right to charge a \$25.00 fee for all missed appointments for established patients, and a \$100 fee for new (first appointment) patients. These fees must be paid prior to your next appointment.

***Returned Checks***

There will be a \$25.00 charges for all checks returned by the bank for non-payment. We do not re-deposit unpaid checks.

I HAVE READ AND AGREE TO ABIDE BY THE TERMS OF THIS PAYMENT POLICY. I FURTHER UNDERSTAND THAT FAILURE TO DO SO MAY RESULT IN DISMISSAL FROM THIS PRACTICE.

\_\_\_\_\_  
Patient/Responsible party

\_\_\_\_\_  
Date

Payment Policy  
Carolina Arthritis Associates, PA

<b>Your Plan</b>	<b>What You Do</b>	<b>What We Do</b>
<b>Medicare</b>	Pay your deductible (\$155 for 2010) and co-insurance (20% of the allowable.)	We will file Medicare for you.
<b>Medicare and a secondary insurance</b>	No payment due at time of service.	We will file Medicare and your secondary insurance for you.
<b>Medicare and Medicaid</b>	No payment due at time of service.	We will file Medicare and Medicaid for you.
<b>Medicaid</b>	\$3.00 co-pay at every visit	We will check your Medicaid eligibility before every visit and will file Medicaid for you.
<b>Carolina Access Medicaid</b>	We must have authorization from your primary care provider. \$3.00 co-pay at each visit.	We will check your Medicaid eligibility before every visit and will file Medicaid for you.
<b>Blue Cross Blue Shield</b>	Pay your deductible, co-insurance or co-pay at time of service.	We will check your eligibility before every visit and will file your Blue Cross insurance for you.
<b>United HealthCare/Cigna/Aetna</b>	Pay your deductible, co-insurance or co-pay at time of service..	We will check your eligibility before every visit and will file your insurance for you.
<b>Insurance we are not contracted with</b>	Pay the visit in full at time of service.	We will file your insurance for you and assign benefits to you so you will receive payment from your insurance plan.
<b>Worker's Compensation</b>	We do not treat work-related illnesses/injuries unless prior arrangements have been made with your employer	We will file your Worker's Compensation insurance for you if we have an agreement with your employer.
<b>Automobile Accident</b>	You must have opened a claim with your insurance company to be seen. If your insurance will not pay in full, you will pay the balance at time of service.	We will call to find out the terms of and will file your automobile insurance for you. We do not file medical insurance if we know your automobile insurance is responsible.
<b>Self-pay</b>	Pay for the visit in full at time of service.	None.

**Other fees:**

- Returned check fee - \$25.00
- No-show fee - \$25.00

**AGREEMENT TO PAYMENT POLICY**

I acknowledge that I received a copy of Carolina Arthritis Associates, PA financial policy and agree to the terms of payment due.

**AUTHORIZATION TO RELEASE INFORMATION**

I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws.

**ASSIGNMENT OF BENEFITS**

I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to Carolina Arthritis Associates, PA for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

**CHANGES IN INSURANCE COVERAGE**

I agree to inform Carolina Arthritis Associates, PA when my insurance carrier/or plan benefits change. I understand that my insurance coverage is a contract between my employer (or myself if I have individual coverage) and the insurance company, and that Carolina Arthritis Associates, PA is not a party to that contract. Therefore, it is my responsibility to know and understand what my financial liability is for any services rendered by this practice.

**GUARANTEE OF PAYMENT**

I agree to pay all applicable charges, which are not paid in full by my insurance. If amounts due to Carolina Arthritis Associates, PA are not paid according to this financial policy, the account shall be deemed delinquent. In the event that I default on payment of my account, I understand I am responsible for any and all costs incurred on the collection of my account, including court cost and reasonable attorney’s fee. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

**WRITTEN ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practice of Carolina Arthritis Associates, PA.

\_\_\_\_\_  
Patient’s Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Responsible Party

\_\_\_\_\_  
Relationship to patient