Carolina Arthritis

Arthritis
Rheumatic Diseases
Osteoporosis
Infusion Therapy

Dr. / Miss /Mrs. / Mr. / Ms. Patient Name ______________________ ______________________
(Please Circle One) First Name MI Last Name

DOB:____________ Sex: M/F SS# ___-___-_____ Age:_____ Marital Status: S/M/D/W

Patient Street Address______ __________ ______________City_________ __________ST______Zip________

Home Phone( )_____-______ Cell Phone ( ) _____-_______ Work Phone ( ) _____-_______

Best number to contact you: Home /Cell/Work Email address______________________________

Patient's employer name and address:____

Emergency contact:____
Name Phone Relationship

Responsible Party for Account/Billing: Self / Spouse / Parent / Legal Guardian(Please circle one)

____
Name DOB Relationship

____
Phone Employer Name and Address Employer Phone

Who is your Primary Care Physician?____
Name of Physician/Provider Practice name

____
Address Phone Fax

Who referred you to our office?__________ ______________ ______________
Name of Physician/Provider Practice Name

__________ ______ ______________ ______________
Address Phone Fax

Primary Insurance:______________________ Secondary Insurance:______________________

Policy Holder: Self /Spouse/Parent/Legal Guardian Policy Holder: Self/Spouse/Parent/Legal Guardian

Policy Holder Name:____________________ Policy Holder Name:____________________

Policy Holder DOB:_____________________ Policy Holder DOB:_____________________

I consent to treatment necessary for the care of the above named person for whom I am legally responsible. I authorize the release of all medical records to the referring or primary care physician, or to other physicians as required for treatment and to my health insurance company, if applicable. I authorize transmission of medical information by fax. To promote better patient care, I give Carolina Arthritis Associates permission to retrieve my medication history. I authorize any health insurance company to utilize the medical information as reasonably necessary for the proper administration of the health plan. I acknowledge full financial responsibility for services rendered by Carolina Arthritis Associates. I understand that payment of charges incurred is due at time of service unless other defined financial arrangements have been made prior to treatment. I further authorize and request that insurance payments be made directly to Carolina Arthritis Associates. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Signature:_________________________ Date ___/___/____

PAYMENT POLICY of Carolina Arthritis Associates, PA

All copays, coinsurance and/or deductibles must be paid at check-in. We accept cash, checks, MasterCard, Visa and Discover. We do not accept post-dated checks. Should you owe additional monies after your insurance has processed your claim, the balance should be paid within 30 days of our receiving our statement. If necessary, we will try to reach an agreeable payment plan with you; it is important for you to call to set up this payment plan shortly after you receive your first statement.
There will be a $25.00 charge for all checks returned by the bank for non-payment. We will only try to deposit your check once.

Please understand that your insurance plan is a contract between you and your insurance company. If we are contracted with your insurance company, we will always file your claim for office visit, laboratory and x-ray charges on your behalf; however, **we cannot guarantee that all services will be paid.** If all or part of your claim is denied by your insurance, we will assist you if we can; the remaining balance after insurance has processed your claim, is your responsibility.

It is imperative that you keep us informed of any change in your insurance. Each time you receive a new insurance card, you should bring it with you to your appointment; if you are changing insurance, it is critical to call us PRIOR to your appointment to ensure that we are contracted with your new insurance company and verify your benefits if necessary.

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.

____

Printed name of patient or responsible party

________________________________ ____________________

Signature of person above Date

CONSENT TO RELEASE INFORMATION

I authorize Carolina Arthritis Associates, PA to release my medical records, pursuant to applicable federal and state laws, rules and regulations for the purposes of:

1. Payment (i.e. insurance companies)
2. Continued treatment (i.e. other treating physicians)
3. Healthcare Operations (i.e. laboratories, transcriptionists)

______________________________ ______________________________

Printed name of patient or responsible party   Signature of Patient or responsible party

____

Date

AUTHORIZATION TO RELEASE INFORMATION

I authorize release of my medical records by Carolina Arthritis Associates, PA to the following person(s):

______________________________ __________________________

Name of person   Relation to patient

______________________________ __________________________

Name of person   Relation to patient

This authorization if valid one year from the date signed below, unless revoked prior to that date.

You may revoke this Authorization at any time, except to the extent that Carolina Arthritis Associates has already acted based on this Authorization. To revoke this Authorization, you must write to: Carolina Arthritis Associates, PA, 1710 South 17th Street, Wilmington, NC 28401.

Once Carolina Arthritis Associates, PA releases our Protected Health Information to the above person(s), it may be re-disclosed by the person(s) and no longer protected by the HIPAA laws.

______________________________ ______________________________

Printed name of patient   Signature of patient

____

Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

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

______________________________ Printed name of patient or responsible party

______________________________ Signature of Patient or responsible party

____________________ Date

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 or my dependents.

______________________________ Printed name of patient or responsible party

______________________________ Signature of Patient or responsible party

____________________ Date