RHEUMATOLOGY & DERMATOLOGY Associates, PC

Patient Information

Legal Name: (First, Middle, Last)			Preferred Name:	
Address:	City:		State:	Zip:
Phone Number:	E-mail:		Would you like to receive our newsletter? ☐ Y ☐ N	
Date of Birth:	Social Security Number:	Marital Status: ☐ Married ☐ Single ☐ Other		Sex:

Employment/School Information

Employed: ☐ Full Time ☐ Part Time Student: ☐ Full Time ☐ Part Time	Employer/School:			Position:
Employer/School Address:	City:	State:	Zip:	Phone Number:

Emergency Information

Person to Contact in Case of Emergency:				Relationship to Patient:
Address:	City:	State:	Zip:	Phone Number:

Responsible Party for Minors

If Patient is a Minor, Responsible Party Name PRESENT WITH CHILD:				Relationship to Patient:
Address:	City:	State:	Zip:	Phone Number:
Date of Birth:		Social Security Number:		

Referral Information

How were you referred?
☐ Our Website ☐ Family ☐ Friend ☐ Google ☐ Other (please list):

Primary Insurance

Policy Holder's Name: (As Appears on Card)	Patient's Relationship to Policy Holder:		Policy Holder's DOB:	Policy Holder's Sex:
Policy Holder's Address:	City:	State:	Zip:	Phone Number:
Work Phone:	Employer's Name:	Policy Holder's SS#:	Individual ID Number:	Group Number:
Insurance Company Name & Address:				

Secondary Insurance (if Applicable)

Policy Holder's Name: (As Appears on Card)	Patient's Relationship to Policy Holder:		Policy Holder's DOB:	Policy Holder's Sex:
Policy Holder's Address:	City:	State:	Zip:	Phone Number:
Work Phone:	Employer's Name:	Policy Holder's SS#:	Individual ID Number:	Group Number:
Insurance Company Name & Address:				

Signature

***By signing this, I agree that the information above is true to the best of my knowledge.**

Patient/Guardian Signature:	Date:

RHEUMATOLOGY & DERMATOLOGY Associates, PC

AUTHORIZATION TO DISCUSS MY CARE AND/OR ACCOUNT STATUS WITH ANOTHER PERSON

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits the office from discussing a patient's care and/or account information with any other person than the patient or the guardian of a minor and in some cases the legal guardian of an adult under such care. For this reason, your permission is needed if you want your medical and/or account information to be disclosed to another party. Once such permission is given, this permission will remain in effect until revoked in writing by the patient or by the guardian of a minor patient.

I give Rheumatology & Dermatology Associates, PC permission to discuss my medical care and/or account information with the following person(s):

Name	Relationship	Medical Info	Account Info
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No

OFFICE FEES DISCLOSURE

A fee of $25.00 will be charged by Rheumatology & Dermatology Associates for any physician appointment that is missed without notice and for physician appointments that are cancelled with less than 24 business hours' notice.

Payment is expected when services are rendered. You as the patient or guardian or guarantor are ultimately responsible for any charges, with or without insurance. By signing this agreement, you authorize the release of medical information to process any and all insurance claims and authorize all such payments to the physician for services rendered.

Should our office need to take any actions to collect an amount due, you agree to pay, in addition to the services, a collection fee of up to 33.3% of the outstanding balance and any incurred bank fees (such as return item fees charged on our office accounts), or $25.00, whichever is greater, which will be added to your account and shall become part of the Total Amount Due. In addition, you shall be responsible for any other reasonable collection fees, including, but not limited to, attorney fees and court and filing fees required to collect the outstanding amount. You also agree should there be any refunds due to you while an outstanding balance is owed to us by you, our office may take such amount and apply it to the outstanding balance.

You agree, that in order for us to service your account or to collect any amounts you may owe, we and any entity our office may use to collect such amount owed, may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We and our collection agencies or attorneys used to collect any amounts owed may also contact you via phone, text message, or e-mail, using any information you have provided. You agree to accept any service of process that may be available pursuant to applicable court rules. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I acknowledge that I have been informed of the Office Fees of Rheumatology & Dermatology Associates, P.C. disclosed above.

I acknowledge that I have had the opportunity to read Rheumatology & Dermatology Associate's Privacy Practices if I choose to do so.

Patient Name (Print): ______________________________

Patient/Guardian Signature: ______________________________

Date: ____________________