Arthritis and Osteoporosis Associates, P.L.L.C

Patient Registration Form

Appointment date: ______/______/______ Time: ________ Physician: Dr. Goddard _, Dr. Golden _, Dr. Gutierrez _

Last name: ______________________________ First name: _______________________________ MI: _____

DOB: ______/______/______ Age: ______ Sex: M _ F _ SS# ______-______-______

Marital Status: Single _ Married _ Divorced _ Widowed _

Address: ____ Apt# __________

City: ______________________________________ State: _________________ Zip: _______________

Home#: _________________________________ Mobile/Pager#: ________________________________

Employed _ Student _ Employer / School name: ____

Employment / School#: ________________________ Ex#: _______

Referring Physician's Information

Referring Doctor: _____________________________________ Tel# ____________________________

Referring Dr.'s Address: ____

Reason for visit: ____

Primary Insurance Information

Primary Insurance: __________________________________ ID#: _________________________

Insured name (if not patient): ___________________________________ DOB: _____/_____/_____

SS# ______-______-______ Relationship to insured: Spouse _ Child _ Other _ Tel# ____________________

Secondary Insurance Information

Secondary Insurance:): ___________________________________ ID#: _________________________

Insured name (if not patient): ______________________________________ DOB: _____/_____/_____

SS# ______-______-______ Relationship to insured: Spouse _ Child _ Other _ Tel# ____________________

Payment authorization

Name of beneficiary: ____ Health insurance Claim Number (HICN): __________________
I request the payment of authorized Medicare/Other insurance company benefits to be made either to me or on my behalf to The Arthritis & Osteoporosis Center, LLC for services rendered to me by that party who accepts assignment/Physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to any social security Administration & Health Care Financing Administration or its intermediaries or any other insurance company any information needed for this or a related Medicare/Other Insurance company claim.

I understand my signature request be made & authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes release of the information to the insurer or agency shown. In Medicare/Other insurance company assignment cases, the physician or supplier agrees to accept the charge determination of the Medicare/Other insurance company as a full charge, & the patient is responsible only for the deductible, coinsurance & non covered services coinsurance & the deductible are based upon the charge determination of the Medicare/Other insurance company. If my account is placed in collection, I understand that I will be responsible for all collection fees.

Signature of insured/Payer: ____ Date: ______________________

HIPPA Patient Consent form

The Department of Health & Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for users and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or discloser of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent.
If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Authorization to release Medical record information

I hereby authorize ______________________________________ (the Practice) to obtain any & all medical records concerning my care from any physician, hospital or other health care professional that has provided medical care to me in the past.

I also authorize the Practice to release any & all medical records concerning my care to any physician, hospital or other health care professional providing care to me at any time. Additionally, I authorize the Practice to release any and all medical records concerning my care to Medicare, Medicaid, any insurance company, third administrator or managed-care company.

Patient signature: ____ Date: _______________________

Printed name: ____ Date of birth: ___________________

Authorization to release Medical record information to individuals / Family members

In accordance with the federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your physician or staff of the Practice to discuss your condition with members of your family or other individuals that you designate , we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

__________ I do not authorize the Practice to release any or all information concerning my medical care to any individual except as set forth above.

__________ I authorize the Practice to verbally release any or all information concerning my medical care to the following individuals:

Name: ____ Relationship to patient: _________________________

Name: ____ Relationship to patient: _________________________

Name: ____ Relationship to patient: _________________________

Patient signature: ____ Date: ________________________

Witness signature: ____ Date: _______________________