Wrightington Rheumatology, LLC
6413 Waters Ave.; Suite 101, Savannah, GA 31406

PATIENT INFORMATION

Last Name _____ Middle Initial ____ Home Phone ( ) _____
First Name _____ Cell Phone ( ) _____
Address _____ Date of Birth: _____
City, State _____ Zip _____ (Check One) □Employed___ □Retired _____
Email address:_____ □Full Time Student __Other _____
Employer:_____ Advance Directive? Y_____ N_____
Race: _____ Ethnicity: _____
Marital Status: □Single □Married □Divorced □Widowed Sex: □Male □Female

SPOUSE/RESPONSIBLE PARTY

Name _____ Relationship _____
Address _____ Employer _____
Work/Day Phone _____ Social Security # _____

EMERGENCY CONTACT

Name _____ Relationship _____
Address _____ Phone ( ) _____

PRIMARY INSURANCE INFORMATION

Please provide your insurance card to the receptionist.

Carrier Name _____
Policy Holder's Name _____ Relationship to Policy Holder _____
Policy Holder's Social Security # _____
Policy # _____ Group # _____ Phone ( ) _____

SECONDARY INSURANCE INFORMATION

Carrier Name _____
Policy Holder's Name _____ Relationship to Policy Holder _____
Policy Holder's Social Security # _____
Policy # _____ Group # _____ Phone ( ) _____

PHARMACY INFORMATION

Pharmacy Name: _____ Phone: _____

Address:_____

PLEASE COMPLETE REVERSE SIDE

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Financial Policy

1. All professional services rendered are charged to the patient and are due at the time of service. Any co-payments and/or co-insurance must be paid on the day service is rendered. A fee of $25 will be charged to your account if the co-pay is not paid on the date of service. We may also require pre-payment of any unmet deductible on the date services are provided. It is your responsibility to contact our office 24 to 48 hours in advance to obtain an estimate of patient liability.
2. As a courtesy to our patients, we will automatically file all claims with your insurance carrier. Please understand that health insurance is a contract between you and your carrier. Ultimately, the patient or responsible party is responsible for any non-covered charges or rejected claims. In the event that the insurance company disputes Or rejects the claim, it is your responsibility to pay the charges and pursue reimbursement from your carrier.
3. We accept payment in the form of cash, check, Visa, Mastercard, and Discover cards. There will be a $45.00 charge for returned checks. You will be expected to pay the amount of the check, in addition to the returned check charge in the form of cash or a money order within 7 days of notification.
4. When you receive a statement from Wrightington Rheumatology, LLC, you are required to pay the balance upon receipt. If your account is not paid in full within 60 days, it will be considered past-due. A finance charge may be assessed to your account to personal balances beyond 60 days. If you have difficulty paying your account, please contact our office manager to make payment arrangements.
5. If your account is turned over to a collection agency, you will be subject to collection fees. If legal action is taken to collect your debt, you are responsible for all attorney's fees and court costs. If your account is in collection status, you will be discharged from the practice.
6. We request 24 hours' notice (excluding weekends and holidays) to cancel or change appointments. Patients who fail to give advance notification or to show for an appointment will be charged $75.

I have read, understood and agreed to the above financial policy. I understand my responsibility regarding charges incurred at this office. I also understand that these terms may be amended by the practice at any given time.

Patient Name (please print) _____

_____

Signature of Patient or Responsible Party Date

Consent to Treatment/Assignment of Benefits

My signature below serves as consent for medical treatment by the physician and physician's assistant for the named patient.

My signature below also assigns and authorizes my insurance benefits to be paid directly to Wrightington Rheumatology. I understand that I am financially responsible to Wrightington Rheumatology for any balance not covered by my insurance carrier.

Patient Name (please print) _____

_____

Signature of Patient or Responsible Party Date

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Name: _____ **Date: _____**

Primary Care Physician

Name _____
Address _____
_____
_____
Phone ( ) _____

Referring Physician (if different)

Name _____
Address _____
_____
_____
Phone ( ) _____

Reason for visit _____
_____
_____

_____

Past Medical History (diagnosed history)

_____
_____
_____
_____
_____
_____

Surgeries

_____
_____
_____
_____
_____
_____

Family Medical History

Mother: Living: Y/N Deceased: Y/N Age: _____ Medical History: _____
_____
Father: Living: Y/N Deceased: Y/N Age: _____ Medical History:_____
_____
Significant history with siblings: _____
Biological Children: # M: ____ # F: _____ Significant Medical History:_____
_____

Social History

Have you ever smoked? □ Yes □ No; If yes, age of onset _____ # pack/day _____
Do you smoke now? □ Yes □ No; If no, age when stopped smoking _____
Do you drink alcohol? □ Yes □ No; If yes: □ Beer □ Wine □ Liquor
Number of alcoholic beverages per week _____
Are you sexually active? □ Yes □ No
Occupation _____
Hobbies _____

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Name: _____ Date: _____

Prescription Medicines

MEDICATION	DOSAGE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Non-prescription Medicines

MEDICATION	DOSAGE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications to which you are allergic (please list the medicines and describe reactions)

_____ _____
_____ _____
_____ _____
_____ _____

I certify by my signature that the foregoing information is accurate and truthful to the best of my knowledge.

_____ _____

Patient Signature Date

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AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS

This authorization serves as permission to obtain a copy of my complete medical record from other physician practices or medical facilities. It also provides authorization for Wrightington Rheumatology to furnish and/or release any information necessary to insurance carriers, third party administrators, self-insured plan administrators, and/or health benefit payor representatives in order to process health care claims incurred at this office or for utilization review or quality assurance. I understand that I may withdraw this authorization to release medical information at any time, communicated to the practice either in writing or verbally, followed by a written withdrawal.

Patient Name (Please Print) _____

Patient Date of Birth: _____

Signature: _____

Date: _____

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MEDICATION REFILL POLICY

1. **Prescription refills require a minimum notification of 72-hours**. Approval of your refill may take longer than three business days if prior authorization is required, so please be courteous and do not wait to call. If you use a **mail order pharmacy**, please contact us fourteen **(14) days** before your medication is due to run out. We request that you call your pharmacy first and contact us only if there is a problem getting the refill.

2. Prescription refills **will only be addressed during regular office hours (Monday-Thursday 9 am-5 pm and Friday 9 am - 12 noon.)** We will not return your phone call regarding refills after hours. Please notify the office on the next business day if you find yourself out of medication after hours. **No prescription will be refilled on Saturdays, Sundays or holidays.**

3. It is important to keep your scheduled appointment to ensure that you receive timely refills. **If you have missed appointment(s), cancelled, or are a no-show to your appointment, we will not refill any medications** and you may be sent back to your primary care or referring physician for further care.

I acknowledge receipt of this notice of medication refill policy.

PATIENT NAME (PLEASE PRINT)_____

PATIENT DATE OF BIRTH _____

PATIENT SIGNATURE_____

DATE_____

PLEASE COMPLETE REVERSE SIDE