PATIENT REGISTRATION

GULF COAST RHEUMATOLOGY

Patient Full Name: _____ SS #: _____

Date of Birth: _____ Male ___ Female ___ Other ___ Single __ Married __ Widowed __ Divorced____

Home Address: _____

City/State/Zip _____

Alternate Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Language Preference: English ___ Spanish ___ Other ___ Hearing Impaired ___ Translator ___

Employer/Company Name: _____ Work Phone: _____

Primary Care Physician's Name & Phone Number: _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

How Did You Hear About Us? Physician Referral (Provide Name) _____

Website _____ Provider Directory _____ Other _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone Number: _____

Alternate Phone Number: _____ Relationship: _____

INSURANCE AND FINANCIAL INFORMATION

IS THE PATIENT THE FINANCIALLY RESPONSIBLE PARTY? **YES or NO IF NO, PLEASE SPECIFY**

Relationship: _____ Phone Number: _____

Address: _____

Primary Insurance Carrier: _____ Policy #_____

Policyholder Name:_____ Relationship: _____

Secondary Insurance Carrier: _____ Policy #_____

Policyholder Name: _____ Relationship: _____

1. **Consent for Treatment.** I understand that medical treatment of an immediate nature may be necessary for the patient and that such medical care, treatment and procedures will be performed by licensed physicians and/or employees of Gulf Coast Rheumatology during operating hours. I understand that treatment is only being provided and I hereby grant my authorization and consent to such treatment and procedures, and recognize that Gulf Coast Rheumatology is also a teaching facility.
2. **Do you have an Advance Directive? YES or NO**
3. **Consent to Review Prescriptions Via E-FORCSE Database**
4. **Financial Responsibility.** In consideration of the care and treatment provided to the patient, I promise to pay Gulf Coast Rheumatology all charges for services rendered to or on behalf of the patient. Any services that are not covered by insurance are the patients' responsibility and will be due and payable at the time services are rendered unless other arrangements are made in advance. Patient is also responsible for the costs of collection of any amounts due Gulf Coast Rheumatology, to include reasonable attorney's fees and court costs.
5. **Release of Medical Information.** I hereby authorize Gulf Coast Rheumatology to release any medical information, in connection with these services, requested with regard to processing my claim or to my personal physician, insurance carrier and/or attorney of record with appropriate release.
6. **Diagnostic Testing.** Please be aware of your insurance policy exclusions with regard to diagnostic testing. Insurance companies have specific facilities you must go to for certain tests (for example: laboratory, X-ray procedures, etc.). It is your responsibility to verify this information before scheduling and/or receiving any recommended diagnostic tests. Non-emergent results received before visits will not be discussed over the phone prior to follow-up visits. Patients will be called for any results that require any change in treatment.
7. **Medicare/Medigap, Blue Cross/Blue Shield or Other Health Insurances.** I hereby authorize Gulf Coast Rheumatology to apply for Medicare/Medigap, and other health insurance benefits on my behalf. I hereby request reimbursements from any applicable insurance to be made directly to Gulf Coast Rheumatology. I certify that the information I have provided with regard to my insurance carrier is correct. I authorize the release of medical information about me to my health insurance carrier and HCFA (Health Care and Finance Administration) agents, as well as any and all other information needed to determine the benefits payable for related services. I hereby authorize payment of Medigap benefits be made on my behalf to Gulf Coast Rheumatology. I release any holder of Medicare information about me to my insurance carriers, necessary to determine benefits payable to related services.
8. **Attorney of Record.** I authorize my attorney to release to Gulf Coast Rheumatology any information detailing my case, case status, or case settlement in connection with date of accident and medical services rendered.
9. **Authorization to Appeal Determination.** I authorize the Billing Department of Gulf Coast Rheumatology to act on my behalf, as a designated representative, to appeal my insurance carrier's determination, if necessary. I understand that communications may contain confidential medical and financial information, including, but not limited to, treatment of venereal disease, alcoholism and drug abuse, abortion, mental health disorders, domestic violence, HIV status relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed. I understand the confidential information will only be released as specified in the authorization, or as permitted by law. This authorization is valid for a period of one year.
10. **Consent to Photograph.** I understand that services conducted by Gulf Coast Rheumatology may be photographed. These photographs will be used to assist with training and is also an important tool of the services provided. I understand my information and identity will remain confidential and protected.
11. **Consent to Receive Phone Calls / emails.** I consent to receive calls from Gulf Coast Rheumatology to any of the information provided. These calls may include patient appointment reminders, responses to after-hours emergency calls, nursing call backs, etc. Unless otherwise specified, Gulf Coast Rheumatology has the right to leave voicemails.
12. **The policy of this facility is to call 911 for all emergencies within Gulf Coast Rheumatology.**

The undersigned hereby makes the following acknowledgements and agreements regarding the medical treatment to be provided by Gulf Coast Rheumatology and any of its duly authorized agents to the patient whose name appears on this form.

I have read and fully understand the above. I also understand that it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Signature: _____ Date: _____

GULF COAST RHEUMATOLOGY

Policies and Procedures

It is our policy to inform you of our patient payment procedure. Please review and check the section(s) that are applicable.

____ 1. Commercial Insurance

You are responsible for deductibles, copays, non-covered services, coinsurance and items considered "not medically necessary" by your insurance company. Co-payments are to be made at time of service. You will receive a statement for any balance not covered by your insurance company.

____ 2. Worker's Compensation Patient

As a worker's compensation patient, you may be covered by insurance if your injury is reported at work and verified with your employer. Be sure to inform the office personnel that your injury resulted during employment. Patient is ultimately responsible for balance.

____ 3. Personal Injury (accident)

If you are a personal-injury patient, our office will bill the appropriate insurance companies. If we are unable to obtain payment, the charges for the services rendered will be your responsibility. Please give all information needed for billing. If an attorney is involved and asks you not to submit insurance claims, a doctor's lien must be signed by you and your attorney.

____ 4. Medicare

Our office will submit your Medicare charges to Medicare and your secondary insurance. You are responsible for deductibles, copays, and any non-covered services.

ASSIGNMENT

____ I request that payment of authorized Medicare benefits be made either to me or on my behalf to Gulf Coast Rheumatology for any service furnished me by that provider. Medicare #_____

____ The signature below authorizes payment of mandated supplemental benefits to Gulf Coast Rheumatology.
Supplement _____ Policy # _____ Group # _____

____ I assign the benefits from my insurance carrier(s) to this office for the medical benefits I am entitled to.

RELEASE OF INFORMATION

____ I authorize Gulf Coast Rheumatology to release my insurance carrier(s) and/or Medicare and its agents and/or my supplemental insurer any information needed to determine benefits or benefits payable for related services.

I have read and agree to the Financial Policy, Assignment, and Release of Information paragraphs above that apply.

_____

Patient or responsible party signature Date

_____

Person signing of behalf of patient (print name) Relationship to patient

GULF COAST RHEUMATOLOGY

MEDICAL RELEASE OF INFORMATION

(including minors)

Patient Name: _____ DOB: _____

I hereby authorize Gulf Coast Rheumatology P.L.L.C. to furnish information and/or discuss information contained in my medical record, including appointment information, with the following person(s):

Please list all names of all family members and/or other persons we may speak with regarding your medical care.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

Printed Name: _____

Witness: _____ Date: _____

GULF COAST RHEUMATOLOGY

Privacy Practices and Consent for Use of Patient Health Information

Patient Name: _____ Date: _____

Date of Birth: _____ Phone Number:_____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Gulf Coast Rheumatology may use or disclose my protected health information for treatment, payment or health care operations, which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Gulf Coast Rheumatology has a detailed document called ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the '*Notice*' before signing this agreement. If I ask, Gulf Coast Rheumatology will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Gulf Coast Rheumatology to use and disclose my protected health care information to carry out treatment, payment and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Gulf Coast Rheumatology has taken action relying on this consent.

Do you reside in a Skilled Nursing Facility? **YES or NO** Facility Name: _____

Do we have permission to release medical information to this facility? **YES or NO**

Do we have permission to leave a voicemail message? **YES or NO**

I consent to receive calls from Gulf Coast Rheumatology for my protected healthcare and other services at the phone number(s) provided.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____