RHEUMATOLOGY ASSOCIATES OF MAUI LLC

Patient Information

Last Name	First Name	Middle Name	Suffix	Social Security #

Gender (circle)	Date of Birth	Marital Status (circle)	Primary Care Physician
M / F		*Divorced - Married - Separated - Single - Widowed - Other*	

Preferred Language (circle)	Race (circle)	Ethnicity (circle)
English - Spanish - _____	*Asian - Black - White - Other: _____*	*Hispanic - Not Hispanic - Unknown*

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Email Address	How did you hear about us?	Referring Physician

Responsible Party *Check if same as: [ ] Patient*

Last Name	*First Name*	*Gender (circle)*	*Date of Birth*	What is Patient's Relationship to Responsible Party?
		M / F		

Mailing Address	*Apt / Lot*	*City / State*	*Zipcode*	Phone #s
				Home ( ) Mobile ( ) Work ( )

Employer Information

Employer	*Address*	*City / State*	*Zipcode*

Emergency Contact *Check if same as: [ ] Responsible Party*

Last Name	*First Name*	*Gender (circle)*	*Date of Birth*	What is Patient's Relationship to Emergency Contact?
		M / F		

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Guardian Contact Check if same as: [ ] Responsible Party [ ] Emergency Contact

Last Name	First Name	Gender (circle)	Date of Birth	What is Patient's Relationship to Guardian?
		M / F		

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Insurance Information **Check if: [ ] Self Pay**

Check if same as: [ ] Responsible Party		Check if same as: [ ] Responsible Party	
Subscriber / Member Name	Date of Birth	Subscriber / Member Name	Date of Birth
What is Patient's Relationship to Subscriber?	Gender (circle) *M / F*	What is Patient's Relationship to Subscriber?	Gender (circle) *M / F*
Primary Insurance Company	Begin Date	Secondary Insurance Company	Begin Date
Insurance Mailing Address	City / State / Zipcode	Insurance Mailing Address	City / State / Zipcode
Subscriber / Member #	Group #	Subscriber / Member #	Group #

RHEUMATOLOGY ASSOCIATES OF MAUI LLC

Financial and Treatment Consent By signing my name below:

I hereby promise to pay in full within thirty (30) days of all charges established by Rheumatology Associates of Maui, LLC for services rendered to me or my dependent unless other arrangements are satisfactory to Rheumatology Associates of Maui, LLC. This includes any charges a third-party payer may determine to exceed usual and customary limits. I understand and acknowledge that if any unpaid amounts owed by me are assigned to a third party for collection, I will be responsible for paying attorney fees, interest, court costs, and other collection costs, including but not limited to collection agency fees.

I authorize Medicare, Medicaid, and all relevant commercial payers to pay Rheumatology Associates of Maui, LLC, on my behalf for any services furnished to me or my dependent. I certify that I have read this assignment of benefits, that the information given by me is correct, and that I agree to all the provisions in it.

If I am facing financial difficulty, I can contact Rheumatology Associates of Maui, LLC to discuss my options. The insurance information I have provided is current and correct. If I sign this form and the insurance card is found later to be outdated or invalid, I understand that I am responsible for paying for the services in full and will need to file with the insurance carrier myself.

I hereby consent to treatment by Rheumatology Associates of Maui, LLC Provider(s). I understand that Rheumatology Associates of Maui, LLC will release to my referring or subsequent healthcare provider reports of my medical condition that will help him or her in my continuing care and as needed to process claims and for general healthcare operations.

I authorize Rheumatology Associates of Maui, LLC, to send text reminders for appointments and communicate via SMS/text messaging; _____ (**Initial)**

I understand that my insurance co-pay is due at the time of service, according to my insurance company policy.

I **ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES**: _____ (**Initial)**

I **AUTHORIZE** Rheumatology Associates of Maui, LLC to disclose and discuss my care and treatment, including labs results and imaging results, with: _____

Relationship: _____ Phone: _____

_____ _____

Patient/Legal Guardian Signature Date Patient/Legal Guardian Print