ARTHRITIS RHEUMATOLOGY CONSULTANTS
SUGAR LAND & HOUSTON, TX

Arthritis Rheumatology Consultants
7102 Tarrington Avenue unit 703 Sugar Land,
TX 77479

Insurance Information Form

Patient Name: _____ Date of Service: _____
First Name Last Name MI

PRIMARY INSURANCE CARRIER

Insurance Name: _____

Member ID #: _____ Group #: _____

Insured's Name: _____ Insured's SS #: _____

Insured's DOB: _____ Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent

SECONDARY INSURANCE CARRIER

Insurance Name: _____

Member ID #: _____ Group #: _____

Insured's Name: _____ Insured's SS #: _____

Insured's DOB: _____ Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent

- I understand that I am required to give current insurance card, photo ID, and other billing information for claims to be filed to any contracted carriers on my behalf. I agree to notify Arthritis Rheumatology Consultants of any changes in my insurance coverage or statement address and contact information as soon as possible.
- I authorize payment of medical benefits to be made directly to Arthritis Rheumatology Consultants for services rendered. This assignment covers any and all benefits under Medicare, private insurance, other government sponsored programs, and any other health plans.
- In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Arthritis Rheumatology Consultants.
- I understand that I am financially responsible for all charges, whether or not paid by insurance, for all services rendered on my behalf.
- I authorize Arthritis Rheumatology Consultants to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that my insurance coverage is a contract between myself and my insurance company and I take full responsibility for financial obligations incurred.
- I understand that I have the right to request and receive a Notice of Privacy Practices from Arthritis RheumatologyConsultants.

THIS AGREEMENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

Patient Signature: _____ Date: _____

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Patient Agreement Form

CONSENT TO TREAT: I hereby authorize Arthritis Rheumatology Consultants to examine me/the patient named below and to furnish such diagnostic and therapeutic services as they deem necessary and appropriate. If I am authorizing on behalf of someone other than myself such examination and services may be provided in my absence.

FINANCIAL RESPONSIBILITY: I understand that I am responsible for all services rendered at the doctor's regular rates. If, however, insurance benefits are assigned to the doctor and billed to the insurer, I agree to pay all charges which are not covered by insurance or which are not promptly paid by the insurer. I understand and agree that it is my responsibility to obtain any prior approval required by my insurer, and to take all other steps to qualify for insurance coverage. I agree that all charges are due upon billing. I agree that if referred to a collection agency or legal action is necessary to collect my balance; I will pay the doctors' reasonable attorney fees and costs of collection. No extension or forbearance, and no attempt to obtain payment from insurance or other sources, shall waive or release my financial obligations under this agreement.

ASSIGNMENT OF BENEFITS: I hereby allow Arthritis Rheumatology Consultants to receive payment of insurance benefits for services provided by the doctor, their employees or others working under contract. Any credit balance resulting from benefit payments or other sources may be applied to any other account owed by the patient of the undersigned.

RELEASE OF INFORMATION: I authorize the release and disclosure of all or any part of my medical records to any person or entity (or representative thereof) which may be responsible to pay for any portion of the charge incurred, including but not further authorize release to any physicians, hospitals, or others who may require such records in connection with my current or subsequent health care. I also authorize Arthritis Rheumatology Consultants to obtain medical records from other sources I needed for my medical care. A photocopy of this release shall be considered valid. No person or entity shall be liable for disclosing records in the good faith belief that disclosure is authorized by this release. This release may or may not be revoked as to any records relating to services provided during this course of treatment.

BY SIGNING BELOW, I obligate the patient, and personally obligate myself if I am the patient or the patient's spouse or parent, to all of the terms set forth herein. This Agreement shall remain valid for all subsequent visits and all services after this date unless expressly revoked. **I HAVE READ THIS DOCUMENT OR IT HAS BEEN READ TO ME. I UNDERSTAND AND VOLUNTARILY ACCEPT ITS TERMS, IF I AM SIGNING FOR SOMEONE ELSE, I CERTIFY THAT I HAVE LEGAL AUTHORITY TO DO SO.**

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

IF RESPONSIBLE PERSON IS SOMEONE OTHER THAN THE PATIENT, SPOUSE, OR PARENT:
The undersigned, who is a person other than the patient, patient's spouse, or patient' s parent, individually agrees to be personally responsible for the financial obligations set forth above, and personally guarantees payment of all charges.

Signature of Responsible Party: _____ Relationship to Patient: _____

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Patient Acknowledgement Form

PATIENT ACKNOWLEDGEMENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing the consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this acknowledgement in writing at any time, except to the extent that you have taken action relying on this acknowledgement.

Patient (or Authorized Representative) Signature: _____Date: _____

AUTHORIZATION DISCLOSURE FORM (OPTIONAL)

In general, the HIPAA privacy rule gives individuals the right to request uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home or discussing PHI with family members.

*****PLEASE NOTE THAT YOU RETAIN THE RIGHT TO REVOKE OR CHANGE THIS CONSENT. REFOCATIONS AND CHANGES MUST BE SUBMITTED IN WRITING. THE REVOCATION AND/OR ITS CHANGES SHALL BE EFFECTIVE EXCEPT TO THE EXTENT THAT DHG HAS ALREADY TAKEN ACTION BASED ON THE PRIOR CONSENT.***

Individuals you authorize HIPAA to disclose specific PHI:
*****BY LAW WE DO NOT DISCLOSE ANY INFORMATION CONTAINING DRUG, ALCOHOL, MENTAL HEALTH STATUS, OR SEXUALLY TRANSMITTED DISEASES, INCLUDING HIV/AIDS RELATED INFORMATION BY PHONE TO ANYONE.***

Name/Relationship/Phone # _____

Name/Relationship/Phone # _____

Patient (or Authorized Representative) Signature: _____Date: _____

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Fee Form/Financial Obligation Form

Our goal is to provide quality rheumatogial care in a comfortable, safe, and convenient environment.

You may incur separate charges related to your procedure: (if applicable).

Procedure/In-office Procedure fee (joint injections, IV infusions, Nutrition therapy, Supplements, Durable Medical Equipment

Physician Fee - if insurance does not cover appointment fee or your referral (HMO plans) is not active from your primary care, you maybe subject to financial responsibility.

If you have HMO insurance we leave the responsiblity up to the referring provider and the patient to obtain the referral in time for the appointment. Failure to do so may result in financial responsibility to the patient or responsible party.

Administration fee (admin for drugs) - At times the insurance may cover only a portion of the procedure and procedures maybe subject to a deductible.

By signing below, I acknowledge that I understand and agree to the Terms and Conditions listed above:

Patient Name (Please Print):

Patient Signature: Date:

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Cancellation Policy Form

Patient Name: _____ Date of Birth: _____ MRN: _____

Dear Valued Patient,

We are reserving time for your office visit appointment and/or procedure. If you are scheduled for a procedure/ infusion, it is important that you arrive on time and be prepared to have your procedure/infusion done on the day and time of your reservation.

Since we have a limited number of appointment times to reserve for our patients to have their procedures performed, we need to assure that your appointment is kept. Should you find you are unable to keep your office visit/procedure appointment, please let us know at least 48 hours in advance so another patient may be scheduled in your place.

If you are note able to keep your appointment and do no tlet us know in advance of 48 hours (2 days) of your reservation, then effective immeiately, there will be a fee of $75 billed to your account as a missed office visit/procedure fee. This will be your responsibility and will not be beilled to your insurance.

Thank you for your understanding and assistance in assuring your care is provided timely and as scheduled. I appreciate the opportunity to be a part of your medical care team.

Sincerely,

Arthritis Rheumatology Consultants

I acknowledge that I will be responsible for payment of the missed appointment/procedure fee that will be charged in the event I do not keep my appointment and do not notify the office at least 48 hours in advance. I understand this is a missed appointment fee and as it is my financial responsibility, it will not be billed to my insurance on my behalf.

Patient Signature: _____ Date: _____

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Medicare Lifetime Claim Authorization and Information Release

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Arthritis Rheumatology Consultants for any services furnished to me by its providers.
I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.
I understand that this authorization/signature is valid for the duration of my Medicare coverage unless I revoke it in writing.
A photocopy or scanned copy of this authorization is considered as valid as the original.
I understand that I am financially responsible for any deductible, coinsurance, or non-covered services under Medicare guidelines.
If other health insurance is indicated in item 9 of the HCFA- 1500 claim form or elsewhere on the other approved claims form or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient Signature_____ Date_____

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Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive telephone and/or videoconferencing equipment and devices that enable healthcare providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applied to a telemedicine visit as applies to an in-person visit.

2. I understand that I will not be physically in the same room as my health care provider. I will be notified of, and my consent will be obtained for anyone else other than my healthcare provider present in the room.

3. I understand that there are potential risks to using technology including service interruptions, interception, and technical difficulties. a. If it is determined that the telephone/videoconferencing equipment and/or connection is not adequate, I understand that my health care provider may discontinue the telemedicine visit and make other arrangements to continue the visit.

4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care of treatment. a. I may revoke my right at any time by contacting Arthritis Rheumatology Consultants, 832-742-4131.

5. I understand that the laws that protect my privacy and the confidentiality of health care information apply to telemedicine services.

6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes. a. I understand that my insurance carrier will have access to my medical records for quality review/audit. b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit. I understand that my health plan payment policies for telemedicine visits may be different from policies for in-person visits.

7. I understand that this document will become a part of my medical record. By signing this form, I attest that (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit.

Patient Name _____ Date: _____

Signature (Patient/Parent/Guardian) _____