Center for Arthritis and Rheumatic Diseases

INFORMATION SHEET

Name: Last_____First_____MI_____ SS#:_____
Address:_____City:_-_____State:_____Zip:_____
Date of Birth:_____ Sex: M / F Marital Status:_____
Race:_____ Ethnicity:_____Preferred Language: _____
Home Phone#: (__)_____ Cell#:(__)_____E-mail:_____
Employer/Job Title & Address_____
Notification Preference **(Circle One)**: Phone Mail E-mail Text
Emergency Contact: _____Relationship:_____Phone#:_____
Primary Physician:_____ City:_____ Phone#:_____
Referring Physician:_____ City:_____Phone#:_____
Preferred Pharmacy:_____ Address:_____
Pharmacy Phone#:_____
How did you hear about us? (Check One) __Google __Zoc Doc __Facebook __Family __Friend
__Referring Provider __Drive By __Other:_____

SUBSCRIBER/POLICYHOLDER INFORMATION-(PLEASE COMPLETE-NECESSARY FOR CLAIMS FILING)

Check one: ○Self ○Spouse ○Mother ○Father ○Other_____(relationship to patient)

Policyholders Name:_____Date of Birth:_____ SS#:_____

Primary Insurance:_____ID#:_____Group#:_____

Secondary Insurance:_____ID#:_____ Group#:_____

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any medical information necessary to process this claim. I authorize Center for Arthritis and Rheumatic Diseases, Huma Shujaat D.O., to apply for benefits on my behalf covered services rendered by the physician's order. I request the payment from my insurance company be made directly to Huma Shujaat D.O.

Signature:_____ **Date**:_____

Patient or Guardian Signature:_____Date:_____

LAST NAME:_____ FIRST NAME:_____

PRIVACY POLICIES

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any medical information necessary to process this claim. I authorize Center for Arthritis and Rheumatic Diseases, Huma Shujaat D.O., to apply for benefits on my behalf covered services rendered by the physician's order. I request the payment from my insurance company be made directly to Huma Shujaat D.O.

Patient or Guardian Signature:_____ **Date:**_____

LAST NAME:_____ **FIRST NAME:**_____

CONSENT FOR MEDICAL TREATMENT

I hereby authorize and request Huma Shujaat D.O. and Associates Center for Arthritis and Rheumatic Diseases to provide such medical care and administer such diagnostic and/or therapeutic procedures and treatments as in the judgement of the physician in attendance are deemed necessary and advisable.

_____ _____ _____

Signature of Patient or Responsible Party Relationship Date

CONSENT TO OBTAIN PHARMACY RECORDS

I give consent for Center for Arthritis and Rheumatic Diseases, Dr. Huma Shujaat D.O., to obtain prescription history information for the purpose of providing direct health care services to me. Center for Arthritis and Rheumatic Diseases will treat this information as required by any and all applicable federal, state, local, common law, rules, regulations, directives and guidelines, including but not limited to HIPAA and related regulations.

_____ _____ _____

Signature of Patient or Responsible Party Relationship Date

LAST NAME:_____ **FIRST NAME:**_____

FINANCIAL POLICY

Prior to your visit, we will do our best to determine your insurance eligibility and benefits. This is **only an estimation** based on the information given by you and your insurance company. You are responsible for your deductible, co-payments, coinsurance, and any payments that your insurance company does not cover. All fees are due at the time of service, including unpaid balances.

Your medical benefits are determined by your insurance policy and we will not be involved should there be disputes about your benefits, including covered and uncovered charges.

If your insurance company does not pay within 30 days of claim submission, you should call your insurance company to determine the reason. Otherwise, you are responsible for the balance. Balances older than 90 days are subject to collection and an additional collection fee of $50. Accounts sent to collections may incur an additional fee for legal services.

If you have no insurance coverage, we ask that you coordinate your care with our business office prior to your visit. We require an advance payment for professional services.

After-hour care or care on days the clinic is closed including prescription refills or telephone assessment and treatments will be charged an urgent care or after-hours fee of $50 or a holiday fee of $75.

OTHER FEES:

The fee for a returned check is $75.

If you cannot keep your appointment, we ask that you kindly call to cancel or reschedule within 24 hours prior to your appointment time. The fee for not doing so is $50. Two "no-show" occasions will lead to dismissal as our patient.

We are happy to provide you with a copy of your medical records. In accordance with the Texas Medical Board guidelines, a fee of $25.00 (non-payable by your insurance company) for the first 20 pages and $0.50 per page for every copy thereafter. In addition, fees may include the actual cost for mailing, shipping, or delivery of records.

I have read and understand the financial policy of the Center for Arthritis and Rheumatic Diseases, Huma Shujaat D.O.

_____ _____

Signature of Patient or Responsible Party Date

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

I, _____(name) authorize Center for Arthritis and Rheumatic Diseases to release all/any information regarding my medical care or treatment, including clinic visit notes, reports, labs, imaging, appointment, and billing information to the following person (s):

Primary care physician: _____ phone number: _____

Referring physician: _____ specialty: _____ phone number: _____

Other physicians: _____ specialty: _____ phone number: _____

OTHERS:

Name:	Relationship to Patient
_____	_____
_____	_____

PATIENT RIGHTS:
I have the right to revoke this authorization at any time.
I may inspect or copy the protected health information to be disclosed as described in this document.
Revocation is no effective in cases where the information has already been disclosed but will be effective going forward.
Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may longer be protected by federal or state law.
I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

_____	_____	_____
PATIENT SIGNATURE	DATE OF BIRTH	DATE

PATIENT COMMUNICATION CONSENT FORM

I authorize the Center for Arthritis and Rheumatic Diseases, Huma Shujaat D.O., to send text message appointment reminders to me on my provided cell phone number. I may be contacted via email and/or text messaging to remind of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receive appointment reminders and other healthcare communications/information at that email or text address from Center for Arthritis and Rheumatic Diseases, Huma Shujaat D.O.

_____ (Patient initials) I consent to receive text messages from the Center for Arthritis and Rheumatic Diseases, Huma Shujaat D.O at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information to the following Cell Phone number:

Cell Phone Number: ( )
I authorize to receive email/text messages for appointment reminders and general health reminders/feedback/ information in the Patient Portal to the following **Email Address**: _____ Center for Arthritis and Rheumatic Diseases, Huma Shujaat D.O., does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan contact your carrier for pricing plans and details.

Signature:_____ **Date**:_____