

DALLAS ARTHRITIS CENTER, PA

Patient Information

Date: _____

Name: (First) _____ (MI) ____ (Last) _____

Address: _____

City: _____ States: _____ Zip Code: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Sex: __ Marital Status: _____ Date of Birth: _____ SSN: _____

Patient's Employer: _____

Address: _____

City: _____ States: _____ Zip Code: _____

Referred By: _____

Responsible Party or Spouse Information

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: (____) _____ Work #: (____) _____

Social Security Number: _____

Insurance Information

1st Insurance Company: _____

Policy Holder's Name: _____ Co-pay: _____

ID #: _____ Group #: _____ DOB: _____

2nd Insurance Company: _____

Policy Holder's Name: _____ Co-Pay: _____

ID #: _____ Group #: _____ DOB: _____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY:

This office does not accept responsibility for collecting your insurance proceeds or for the negotiating settlement of a disputed claim. If for whatever reason, your insurance company does not pay your claim in full, you are responsible for payment of the entire balance including any finance charge or collection fees that may be included.

Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS:

I hereby assign all medical benefits payable for services provided by _____, including, Medicare, private insurance and any other health plans to _____. I further authorize a release of any medical information necessary to process the claim and payment of benefits. A photocopy of this assignment is to be considered as valid as an original. This assignment remains in effect until revoked by me in writing.

Signature: _____ Date: _____

Dallas Arthritis Center, P.A.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name of Patient: _____ ("Patient")

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Date of Birth: _____ Age: _____ Sex: _____

Social Security Number: _____ Account Number: _____

Date of Last Visit: _____ Physician Seen: _____

1. I authorize the use or disclosure of the Patient's health information, as described below.

2. The following individual's or organizations are authorized to make the disclosure:

Name: _____

Address: _____

Phone: _____ Fax: _____

3. The type and amount of information to be used or disclosed is as follows: (Please Check)

Entire Health Record Operative Procedures Pathology Report

History & Physical X-ray/Imaging Reports X-ray Film

Echocardiogram Laboratory Reports

4. I understand that the information in the Patient's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual(s) or organization(s):

[] Dallas Arthritis Center, P.A.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

6. This information is being disclosed for the following purpose(s): _____

7. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Dallas Arthritis Center, P.A. at which authorization was originally submitted. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

If I fail to specify an expiration date, event, or condition, this authorization will expire six months from the date of signing.

9. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

10. I understand that I will be given a copy of this authorization form, after signing.

Signature of Patient/Responsible Party or Legal Representative

Date

If Signed by Legal Representative, Relation to Patient

Date

Signature of Witness

Date