Patient Consent Form

Consent- In April of 2003, a new federal requirement regarding privacy of information for health care patients took effect. H.I.P.A.A., the Health Insurance Portability and Accountability Act requires that all medical providers, insurance companies, and others put in place controls to ensure that your personal medical information is safe.
Arthritis Consultants (A.C., P.A.) request that each patient sign this consent form which allows us to share protected health information with other physician's offices, your hospital, and insurance company(s). By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.
Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. A copy of this policy is posted in our waiting area and is available online at www.arthritisconsultantstx.com.

Authorization to Release Information to Family Members- Many of our patients allow family members such as their spouse, parents, or others to call and request results of tests and procedures or general information regarding your care. Also, you may require this individual to pick up samples or prescriptions on your behalf. Under the requirements for H.I.P.A.A., we are not allowed to provide this information to anyone without the patient's consent. If you wish to have this information released to others you must sign this form. Signing this form will only give consent to the individuals indicated below. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

1. Relationship:

2. Relationship:

Authorization of Leave Messages with Household Members/Answering Machine- From time to time it is necessary for a representative of Arthritis Consultants, P.A., to leave messages for patients. The purpose of these messages are to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss lab or procedure results, or to ask a patient to call A.C.P.A., regarding an issue to concern. At no time will a representative of A.C.P.A., discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household and/or on your answering machine. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Policy regarding Children in the Office- Please be advised there are no children allowed in the office unless they are scheduled for an appointment.

By signing below, you acknowledge that you have read and fully understand all above mentioned policies.

Patient Name/Signature of Patient &/or Legal Guardian:
Date:

Financial Policy

1. We will collect your co-pay, annual deductibles, and uncovered service fees PRIOR TO SEEING THE PHYSICIAN. Payment methods are: cash, check, money order, Visa, MasterCard, American Express, and Discover.
2. There is a $25 charge on all returned checks. This is to be paid by cash, money order, or credit card ONLY.
3. There is a $25 charge for failure to show for a scheduled appointment for established patients and a $50 charge for new patients. We ask that your appointment is cancelled 24 hours prior to your scheduled appointment time.
4. If you have no health insurance, we require payment in full at the time of the visit.
5. Please update any information changes you might have with our staff to include address and phone numbers. Please be thorough with your insurance information. Have your current insurance card with you at each appointment. You will be responsible for any unpaid balance due to lack of information.
6. As a courtesy, we will file a claim with your insurance. It is your responsibility to make sure that we receive prompt payment from them. It is use to maintain frequent contact with your insurance carrier to make sure they are paying, as they should. If your insurance does not pay or respond to your claim within 60 days, from date of service, you will be responsible for payment.
7. Your insurance will send you an explanation of benefits that explain what they have paid to our office. This is a record that you should keep on file. If you do not agree with their payment, please contact the insurance company directly.
8. If your insurance denies payment on your account, you will be asked to pay by cash, check, money order, or credit card as soon as you are notified of the denial.
9. If you are sent outside of the office for additional testing such as lab work or imaging, that facility will file your insurance for you. If you have questions regarding billing or claim payment, call the facility directly. We DO NOT have information regarding billing from outside of this office.
10. There is a fee to have forms completed by your physician. These fees will not be billed to your insurance, but are due at the time the forms are filled out. The fees are as follows:
    1. Attending Physician Statement $25.00
    2. DMV Forms $10.00
    3. Family Medical Leave Act $25.00
    4. Social Security Forms $25.00
    5. State Disability Forms $25.00
    6. Jury Duty Excuses $10.00
    7. Letter of Medical Condition $25.00
    8. Power Mobility Device Forms $25.00
    9. Miscellaneous Forms/Additional Forms $25.00
11. There are also other miscellaneous administration fees that are assessed at our office. The fees are as follows.
    1. Mailing RX $5.00
    2. RX re-write $5.00
    3. Medical Record (First 25 pages) $25.00
        a. Extra page fee $0.50/per page thereafter

Patient Name/Signature of Patient &/or Legal Guardian:

Date: