ARIANT, PLLC
2021 N. MacArthur Blvd, Ste 225, Irving, TX 75061
5350 Independence Parkway, Ste 100, Frisco, TX 75035
Ph: (972) 253-4370 Fax: (855) 808-8622

Chart No._____DOB:_____

Name_____

Today's Date: _____

New Rheumatology Patient Consultation Request Form

First Name_____Middle_____Last _____

Social Security_____-___-_____Date of Birth_____/____/____Gender_____Male_____Female

Cell # _____ Other #_____ E-mail_____

Address_____City_____State_____Zip _____

Patient's Primary Care Physician_____Office # _____

Referring Physician_____Office # _____

Address_____City_____ State_____Zip _____

Additional Physicians participating in your care:
Physician:_____Phone: _____
Physician:_____ Phone:_____
Physician: _____ Phone: _____

Describe briefly your present symptoms:

_____

_____

Date symptoms began (approximate):_____Diagnosis given? _____

Previous treatment for this problem (include physical therapy, surgery and injections, medications to be listed separately)

_____

_____

Rheumatologic (Arthritis) History:

At any time have you or a blood relative had any of the following: (check if yes, list relative if known)

Arthritis (type unknown) _____ Lupus_____

Osteoarthritis_____ Ankylosing spondylitis _____

Rheumatoid Arthritis _____ Childhood arthritis _____

Gout_____ Osteoporosis _____

Other Rheumatologic Conditions:

_____

_____

_____

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Chart No._____DOB:_____

Name_____

Today's Date: _____

Past Personal History: Do you have or have you had -

☐ High Blood Pressure	☐ Jaundice	☐ Bad Headaches	☐ Diabetes
☐ Cancer	☐ Nervous Breakdown	☐ Pneumonia	☐ Thyroid Disease
☐ Stroke	☐ Psoriasis	☐ Heart problems	☐ Hepatitis
☐ Leukemia	☐ Asthma	☐ Stomach Ulcers	☐ Kidney Disease
☐ Epilepsy	☐ Cataracts	☐ Colitis	☐ Alcoholism
☐ Anemia	☐ Arthritis	☐ TB (Tuberculosis)	Blood Transfusions

Other significant illnesses (please list):

_____

_____

_____

Medication Allergies: _____

_____

Date of Last vaccine:

Flu Vaccine:_____Pneumonia vaccine:_____Prevnar Vaccine:_____Shingles Vaccine: _____

Previous Operations: N Y If yes, then please list type and approximate year.

Type	Year	Type	Year

Any previous fractures? N Y Describe: _____

Any other serious injuries? N Y Describe: _____

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Chart No._____DOB:_____

Name_____

Today's Date: _____

Social History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/widower

Menstrual:

Age when periods began _____
Periods regular? Y N
Last Pap smear (mo/yr):____/____

Beginning date of last period____/____/_____
How many days apart? _____
Bleeding after menopause? Y N

Obstetrical:

No. of pregnancies_____No. of miscarriages_____Please give approx. dates (mo/yr): _____
No. of living children _____

Education: Circle highest level attended

Grade School: 0-6 Junior high School 7 8 9 Senior high School 10 11 12
College Graduate School Degree: _____

Habits:

Please circle Y for "Yes" N for "No".

Do you drink coffee?	Y	N	Cups per day? _____
Do you smoke?	Y	N	Past?_____If so, when? _____
Cigarettes per day?			_____
Do you drink alcoholic beverages?	Y	N	Amount? _____
Recreational Drug use?	Y	N	

Current Occupation:_____**Former Occupation**: _____

Retired. Please give approximate month and year_____/_____

Disabled. Please give approximate month and year_____/_____

Family History

MEMBER	MEDICAL	HISTORY
FATHER		
MOTHER		
SISTER		
BROTHER		
GRANDPARENT		
GRANDPARENT		
CHILDREN		

Current ages of children: Males_____Females_____

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Chart No._____ DOB:_____

Name_____

Today's Date: _____

Medication List

Local Pharmacy: _____

Phone:_____

Address:_____

_____

_____

Mail order Pharmacy: _____

Phone:_____

Address:_____

_____

_____

Name of Medication	Dose (Mg/ml/etc.)	Amount taken per day/week/month
Example ES Tylenol	**500mg**	**2**

Multi-Dimensional Health Assessment Questionnaire (R808-NP2)

This questionnaire includes information not available from blood tests, X-rays, or any source other than you. Please try to answer each question, even if you do not think it is related to you at this time. Try to complete as much as you can yourself, but if you need help, please ask. <u>There are no right or wrong answers.</u> Please answer exactly as you think or feel. Thank you.

1. Please check (√) the ONE best answer for your abilities at this time:

OVER THE LAST WEEK, were you able to:	Without **ANY** Difficulty	With **SOME** Difficulty	With **MUCH** Difficulty	**UNABLE** To Do
a. Dress yourself, including tying shoelaces and doing buttons?	0	1	2	3
b. Get in and out of bed?	0	1	2	3
c. Lift a full cup or glass to your mouth?	0	1	2	3
d. Walk outdoors on flat ground?	0	1	2	3
e. Wash and dry your entire body?	0	1	2	3
f. Bend down to pick up clothing from the floor?	0	1	2	3
g. Turn regular faucets on and off?	0	1	2	3
h. Get in and out of a car, bus, train, or airplane?	0	1	2	3
i. Walk two miles or three kilometers, if you wish?	0	1	2	3
j. Participate in recreational activities and sports as you would like, if you wish?	0	1	2	3
k. Get a good night's sleep?	0	1.1	2.2	3.3
l. Deal with feelings of anxiety or being nervous?	0	1.1	2.2	3.3
m. Deal with feelings of depression or feeling blue?	0	1.1	2.2	3.3

2. How much pain have you had because of your condition OVER THE PAST WEEK? Please indicate below how severe your pain has been:

NO PAIN ✿ 0 ✿ 0.5 ✿ 1.0 ✿ 1.5 ✿ 2.0 ✿ 2.5 ✿ 3.0 ✿ 3.5 ✿ 4.0 ✿ 4.5 ✿ 5.0 ✿ 5.5 ✿ 6.0 ✿ 6.5 ✿ 7.0 ✿ 7.5 ✿ 8.0 ✿ 8.5 ✿ 9.0 ✿ 9.5 ✿ 10 PAIN AS BAD AS IT COULD BE

3. Please place a check (√) in the appropriate spot to indicate the amount of pain you are having today in each of the joint areas listed below:

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
a. LEFT FINGERS	☐ 0	☐ 1	☐ 2	☐ 3	i. RIGHT FINGERS	☐ 0	☐ 1	☐ 2	☐ 3
b. LEFT WRIST	☐ 0	☐ 1	☐ 2	☐ 3	j. RIGHT WRIST	☐ 0	☐ 1	☐ 2	☐ 3
c. LEFT ELBOW	☐ 0	☐ 1	☐ 2	☐ 3	k. RIGHT ELBOW	☐ 0	☐ 1	☐ 2	☐ 3
d. LEFT SHOULDER	⑥ 0	⑥ 1	⑥ 2	⑥ 3	l. RIGHT SHOULDER	⑥ 0	⑥ 1	⑥ 2	⑥ 3
e. LEFT HIP	☐ 0	☐ 1	☐ 2	☐ 3	m. RIGHT HIP	☐ 0	☐ 1	☐ 2	☐ 3
f. LEFT KNEE	☐ 0	☐ 1	☐ 2	☐ 3	n. RIGHT KNEE	☐ 0	☐ 1	☐ 2	☐ 3
g. LEFT ANKLE	☐ 0	☐ 1	☐ 2	☐ 3	o. RIGHT ANKLE	☐ 0	☐ 1	☐ 2	☐ 3
h. LEFT TOES	☐ 0	☐ 1	☐ 2	☐ 3	p. RIGHT TOES	☐ 0	☐ 1	☐ 2	☐ 3
q. NECK	☐ 0	☐ 1	☐ 2	☐ 3	r. BACK	☐ 0	☐ 1	☐ 2	☐ 3

4. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

VERY WELL ✿ 0 ✿ 0.5 ✿ 1.0 ✿ 1.5 ✿ 2.0 ✿ 2.5 ✿ 3.0 ✿ 3.5 ✿ 4.0 ✿ 4.5 ✿ 5.0 ✿ 5.5 ✿ 6.0 ✿ 6.5 ✿ 7.0 ✿ 7.5 ✿ 8.0 ✿ 8.5 ✿ 9.0 ✿ 9.5 ✿ 10 VERY POORLY

FOR OFFICE USE ONLY

1.a-j **FN** (0-10):

1=0.3 16=5.3
2=0.7 17=5.7
3=1.0 18=6.0
4=1.3 19=6.3
5=1.7 20=6.7
6=2.0 21=7.0
7=2.3 22=7.3
8=2.7 23=7.7
9=3.0 24=8.0
10=3.3 25=8.3
11=3.7 26=8.7
12=4.0 27=9.0
13=4.3 28=9.3
14=4.7 29=9.7
15=5.0 30=10

2.**PN** (0-10):

4.**PTGL** (0-10):

RAPID 3 (0-30)

Cat:
HS = >12
MS = 6.1-12
LS = 3.1-6
R = ≤3

Please turn to the other side

Allergy Rheumatology Immunology
Associates of North Texas – ARIANT, PLLC

NOTICE OF HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Allergy Rheumatology Immunology Associates of North Texas – ARIANT, PLLC, we are committed to treating and using protected health information about you responsibly. This ***Notice of Health Information Practices*** describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective 07/09/2018 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Allergy Rheumatology Immunology Associates of North Texas – ARIANT, PLLC, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Allergy Rheumatology Immunology Associates of North Texas – ARIANT, PLLC, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Request to amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Allergy Rheumatology Immunology Associates of North Texas – ARIANT, PLLC is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction (by law not required to accept restrictions as requested), and

- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the notice in our offices.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Walk-ins: Patients will be required to complete a short form identifying what healthcare issues they are presenting with at the time of the visits. All efforts will be made to speak to the patient in confidence.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the practice's Office Manager in writing to 2021 N. MacArthur Blvd., Suite 225, Irving, TX. 75061 or call (972) 253-4370.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Office Manager or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Office Manager or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services 200 Independence Avenue, S.W.
Room 509F, HHH Building Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.
For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you for continuity of care.

We will use your health information for payment.
For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

***We will use your health information for regular health* operations.**
For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

***We may share your information with Business* Associates.**
For example: There are some services provided in our organization through contacts with business associates. An example is a technical support company (or a business associate as deemed necessary) to help support our Practice Management System and/or Electronic Health Record application. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information.

***Notification*:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

***Communication with family*:** Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

***Research*:** If you elect to participate in a research study at the Allergy Rheumatology Immunology Associates of North Texas then we may disclose information to researchers as identified by your Clinic physician and as released by your authorization. At the time of review by the Research Team your medical record in its entirety will be made available. In the event that any request for release of your Medical Record is received all research information will also be released. We may disclose information to researchers when their research has been approved by an institutional review board (IRB) that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

***Funeral directors*:** We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

***Marketing*:** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

***Food and Drug Administration (FDA)*:** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

***Workers compensation*:** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

***Public health*:** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

***Law enforcement*:** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

HEALTH INFORMATION PRACTICES - ACKNOWLEDGMENT

Patient Name:_____Patient Identifier # : _____

ACKNOWLEDGMENT OF THE RECEIPT OF ARIANT, PLLC'S
NOTICE OF HEALTH INFORMATION PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

ARIANT is furnishing you with the attached notice, which provides information about how ARIANT and its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law.

By signing this form, you acknowledge that you have received a copy of ARIANT's *Notice of Health Information Practices.*

_____ _____
(Signature of Patient or Legal Representative) (Date)

Your name if not the patient: _____

Your relationship to patient: _____

July 9th, 2018

(Effective Date of *Notice*)

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle Initial

OTHERNAME(S) USED_____

DATE OF BIRTH: Month_____Day_____Yr_____

ADDRESS_____

CITY_____**STATE**_____**ZIP**_____

PHONE (____)_____**ALT. PHONE** (____)_____

EMAIL (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name_____
Address _____
City _ _____ State _ _____ Zip Code _____
Phone (_____) _____Fax (_____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?
Person/Organization Name: *Allergy Rheumatology Immunology Associates of North Texas - ARIANT, PLLC* Address: *5350 Independence Pkwy, Ste # 100*
City: *Frisco* State*: TX* Zip Code: *75035*

Phone (972) 253-4370 **Fax (855) 808-8622**

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☒ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☒ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

☐ **All health information**	☐ History/Physical Exam	☐ Past/Present Medications	☐ Lab Results
☐ Physician's Orders	☐ Patient Allergies	☐ Operation Reports	☐ Consultation Reports
☐ Progress Notes	☐ Discharge Summary	☐ Diagnostic Test Reports	☐ EKG/Cardiology Reports
☐ Pathology Reports	☐ Billing Information	☐ Radiology Reports & Images	☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month_____Day_____Year
RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.
SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____ If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **Date**

Patient Preference Regarding Communication of Health Information

Patient Name:_____ Patient Identifier #:_____

I. Who to Contact

I hereby give permission to ***Allergy Rheumatology Immunology Associated of North Texas (ARIANT)*** to disclose and discuss any information related to my medical condition(s) with the following family member(s), other relative(s) and/or close personal friend(s):

Name	Relationship	Phone number
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

II. How to Contact

I wish to be contacted in the following manner:

Home Telephone:	Work Telephone:	Cell Phone:
☐ OK to leave message with detailed information ☐ Leave message with call-back number only	☐ OK to leave message with detailed information ☐ Leave message with call-back number only	☐ OK to leave message with detailed information ☐ Leave message with call-back number only

☐ Written Communication

- ☐ OK to mail to my home address _____
- ☐ OK to mail to my work/office address _____
- ☐ OK to fax to this number _____

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

_____ _____

Signature of Patient or Legal Representative Date

ALLERGY
RHEUMATOLOGY
IMMUNOLOGY
ASSOCIATES OF
NORTH TEXAS -
ARIANT, PLLC

STANDARDIZED HEALTHCARE QUESTIONS

The Allergy Rheumatology Immunology Associates of North Texas - ARIANT, PLLC is required to gather the following information to comply with nationwide healthcare reform. You are not required to complete this form. Please keep in mind, however, that our physicians will only use this information to provide better service to you. As always, your information is and will remain completely confidential. Thank you for your cooperation.

PLEASE COMPLETE THE FOLLOWING QUESTIONS BY CHECKING YOUR SELECTION OR WRITING IN YOUR ANSWERS:

1) Date of Birth: _____/_____/_____
MM DD YYYY

2) Patient Gender: ☐ Male ☐ Female

3) Preferred Language: _____

4) Regardless of your answer to the prior question, please indicate how you identify yourself: (Check all that apply)

- ❑ Native American or Alaska Native (Includes all original peoples of the Americas)
- ❑ Asian (Includes Indian subcontinent and Philippines)
- ❑ Black or African American (including Africa and Caribbean)
- ❑ Native Hawaiian or other Pacific Islander (Original peoples)
- ❑ Caucasian (including Middle Eastern)

5) Are you Hispanic/Latino? ☐ Yes, Hispanic or Latino (including Spain)
❑ No

Print Patient Name:_____

Patient/Patient Guardian Signature:_____

Today's Date:_____/_____/_____

ALLERGY
RHEUMATOLOGY
IMMUNOLOGY
ASSOCIATES OF
NORTH TEXAS -
ARIANT, PLLC

Financial Policy

We appreciate your trust in us and the opportunity to serve you. As part of our practice, we try to offer efficient and helpful billing services. To this end, we ask you to read the following statement of our financial billing policy**.** Please sign it prior to seeing the physician for your exam and/or treatment**.**

Patient payment responsibilities

Please bear in mind that it is your responsibility to pay as a deposit any deductible amount, co-insurance, co-pay or any other balance not covered by your insurance company prior to receiving services. Even though we assist you in receiving reimbursement from your insurance company, please understand that you, the patient, ultimately have the final responsibility of your bill. Additionally, we cannot waive copays for our patients since this is an insurance plan requirement.

Self Pay

All self-pay patients are required to pay in full, before seeing the physician for your exam and/or treatment**.**

Cancellation of Scheduled patient Appointments and Procedures

Our office requires prior notification of minimum of 48 Hrs for rescheduling/cancelling of patient appointments. Any follow-up rescheduled/cancelled appointment with less than 48 hours notice will be billed a fee of $40.

Payments

Bills will be issued after the insurance company pays its portion of the bill. We do require all guarantors to provide their social security numbers during the patient registration. Balances are due in full 30 days of when the bill is issued to you. We do not have the ability to carry patient balances over any extended period. We accept cash, checks, and most credit cards as forms of payment.

Our practice is committed to providing the best care for our patients. Our charges are within the usual and customary range for the medical specialties and for this area.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read, understood, and agreed to this Financial Policy.

_____ _____

Patient Signature *Date*

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