PATIENT INFORMATION SHEET

Patient Name:	DOB:	Age:
Gender: M / F	SSN:	Language:
Address:	City: State:	Zip:
Home Phone:	Cell/Work Phone:	
Marital Status: Single/ Mar / Div. / Wid.	Race: White / Black / Asian / Hispanic	
In Case of Emergency, contact:	Relationship:	
Home Phone:	Cell/ Work Phone:	
Patient's Employer:	Occupation:	Employment Status: FT / PT
Referred by:		
Preferred Pharmacy	Pharmacy's Phone:	
Insurance Company:	Subscriber's Name:	
Subscriber's SSN:	Subscriber's DOB:	
Insurance Card ID #:	Subscriber's Relationship to Patient:	

Assignment of Insurance Benefits: I hereby authorize and request my insurance company to pay directly to the doctor the amount due on my claim for services to my dependent or me. I further agree that should the amount be insufficient to cover the entire medical and surgical expense, I will be responsible for payment of the difference; and if the nature of the disability be such that it is not covered by the policy, I will be responsible to the doctor for payment of the entire bill.

Authorization to Release Information: I hereby authorize the above signed physician to release any medical information acquired in the course of my examination or treatment as may be necessary for the completion of my insurance claims to any insurance carrier, health or hospital plan.

Notice Concerning Complaints: Assistance in filing a complaint about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, may be reported for investigation by calling the following telephone number 1-800-201-9353.

Privacy Practices: I have read the notice of privacy practices and the patient rights information posted in the waiting room of this office.

X ______________________________ ______________________________

Signature of Patient (or Guardian if Patient is a Minor) Date

CONSENT TO TREATMENT

Patient Name: ______________________________ DOB: _________________ SSN: _______________________

I, _________________________________ (the ______________________ of ___________________________)
if applicable, Relationship to MINOR'S NAME

Hereby voluntarily consent to outpatient care at Houston Comprehensive Rheumatology, P.A., encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), taking of x-rays, heart tracing and administration of medications prescribed by the physician.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including nurse practitioners, physician's assistants, medical assistants, or their designees as is necessary in the medical staff's judgment.

Release of Information: (a) I authorize Houston Comprehensive Rheumatology, P.A., to release medical information to third party insurance carriers for the purpose of filing insurance claims related to my medical care. (b) I further authorize the release of medical information about treatment here to my doctor or anyone designated by me.

I understand that this consent form will be valid and remain in effect as long as I receive medical care at Houston Comprehensive Rheumatology, P.A.

This form has been explained to me and I fully understand this Consent to Treatment and agree to its contents.

Comments:

X____

Signature of Patient or Person Authorized to consent for patient

____

Signature of Witness who explained the contents of this "Consent to Treatment" form

OFFICE POLICY AND FINANCIAL AGREEMENT

Houston Comprehensive Rheumatology will bill all contracted commercial insurance plans. It is the responsibility of the patients (or patient's legal guardian) to ensure that their individual doctor is a contracted physician under their individual health plan.

We do not bill secondary insurance (the ONLY exception is for Medicare cross-over insurance). We will be happy to supply you with all the necessary information to receive reimbursement personally from your secondary if you have one.

All services performed are the complete responsibility of the patient (or patient's legal guardian). We will work diligently with your insurance company to ensure that payment is received prior to 60 days after the service was performed. When the 60-day point is reached, the balance will then become your responsibility. It is rare that a claim will go more than 60 days without being paid. If it does, it is usually due to information being requested by the insurance company from you. We ask that you work with us and contact your insurance company should your claim not be paid in a timely manner.

In the event that your insurance company finalizes your claim but a partial responsibility is still yours through outstanding deductible or coinsurance, you will have 30 days from the date that we receive the explanation of benefits (EOB) to pay your balance. Should you not pay your balance within 60 days, further collection activity may be taken on your account.

Should any service be performed that is viewed as non-covered by your insurance plan, all payment for that service is your responsibility. Any service that is verified as non-covered by our staff will be brought to your attention prior to being performed. However, it is ultimately your responsibility to know the limitations of you plan.

If you should break an appointment without 24-hour notice, your account may incur a $30 "NO-SHOW" fee, which will be your responsibility. PLEASE BE COURTEOUS and notify the office if you need to cancel or reschedule your appointment, so that other patients may see the doctor.

By signing below, I acknowledge that I have read and understand the preceding financial terms and agree to abide by it. I authorize the release of medical information as necessary to process claims and I authorize benefits to be paid directly to my provider.

X ____ ________________________

Signature of Patient (or Guardian if Patient is a Minor) Date

PATIENT AUTHORIZATION FOR ACCESS TO PROTECTED HEALTH INFORMATION

I give permission for the following people to have access to my protected health information and reserve the right to revoke this at any time by notifying the office in writing.

____ Any Family Member

____ Specific Family Member: Name(s) / Relationship: 1) ______________________________

2)______________________________

____ Other: Name (s) / Relationship: 1) ______________________________

2)______________________________

X ____ ______________________

Signature of Patient (or Guardian if Patient is a Minor) Date

Medical Record Release Consent

I, ________________________________ hereby request and authorize my medical records be released to:

Houston Comprehensive Rheumatology, P.A.

11240 FM 1960 Rd West, Suite 401

Houston, Texas 77065

Phone: 832-521-8088

Fax: 832-688-9186

From: ____

____

Phone: ______________________ Fax: ______________________

To release the complete medical records in your possession concerning my illness and/or treatment from__________________ to ______________________

This authorization applies to all of the reports checked:

_____ My complete health record

_____Laboratory test reports

_____X-Ray reports

Purpose of Disclosure

______Attorney/Legal

______Insurance Claim Processing

______Personal use

______Continued Patient Care

______Referral

______Other ____

PLEASE FAX RECORDS TO OUR SECURE FAX: 832-688-9186

I understand this consent can be REVOKED at any time except to the extent that disclosure made in good faith has already occurred in the reliance on this account.

Signed ________________________ Date of Birth ____________________

Witness ____________________________ Date Signed____________________