Welcome to Carolina Rheumatology & Neurology (CRNA). Thank you for choosing our physicians for your rheumatology services. Our goal is to meet your individual needs and to provide quality medical care in a convenient, comfortable setting.

Our office is open four days a week, Monday through Thursday, from 7:00 am until 5:00 pm. To contact us during regular hours, just dial 843-692-0968 and follow the prompts for your Doctor's Medical Assistance, for appointments, for billing questions, etc.

Once you have completed your first visit with your doctor and you have an urgent medical need after regular hours of operation, your doctor is available to you. Just call 843-692-0968 and follow the prompts to leave a message for your doctor. This will page your doctor automatically. He/She will return your call within a short period of time.

Enclosed you will find a number of papers for you to read, complete, and sign. Please bring this packet with you to your appointment and ensure that it is completely filled out prior to your arrival. Check both front and back of each page for required documentation.

We ask that you arrive at our office 30 minutes prior to your scheduled appointment time. Please bring your insurance card(s), your copay, a photo ID, this packet entirely filled out, and any results from recent lab work or x-rays. If you do not arrive 30 minutes early with your entire packet completely filled out, your appointment may be rescheduled for a later available date.

We look forward to meeting you and providing you with high quality medical care.

Carolina Rheumatology and Neurology

Patient Registration

PATIENT INFORMATION- ***DO NOT MAIL BACK PLEASE BRING TO YOUR APPOINTMENT***

Last Name _____ First _____ MI _____

Street Address _____ City _____ State _____ Zip_____

Social Security #_____-_____ -_____ **(required)** Home Phone (_____) _____

Cell Phone (_____) _____ Work Phone (_____) _____

You have my permission to leave a detailed personal message on my: Home Y / N Cell Y / N Work Y / N

Age _____ Date of Birth _____/_____/_____ Gender _____ Marital Status _____

Preferred Language_____ Race_____ Ethnicity ____ Hispanic ____ Latino ____Other

Employer Name _____ Occupation _____

To Be Notified In Case of Emergency _____ Phone (_____) _____

Your e-mail address:_____

Referring Doctor_____ Phone (_____) _____

Referring Doctor Address_____ City_____State _____ Zip _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ Address _____

Policy # _____ Group # _____

Name of Policy Holder:_____ Date of Birth _____/_____/_____ Relationship to Patient __ _____

Policy Holder's Social Security #_____-_____-_____ **(required)**

Employer Name_____ Phone (_____) _____

Employer Address_____ City_____State _____ Zip _____

SECONDARY INSURANCE _____ Address _____

Policy # _____ Group # _____

Name of Policy Holder:_____ Date of Birth _____/_____/_____ Relationship to Patient __ _____

Policy Holder's Social Security #_____-_____-_____ **(required)**

Employer Name_____ Phone (_____) _____

Employer Address_____ City_____State _____ Zip _____

RX Insurance Policy # Phone (_____) _____

OTHER PHYSICIANS

Identification of other physicians involved with my medical care whom I authorize ongoing release of information for continuity of care:

Provider _____ Phone (_____) _____

Address _____ City _____ State _____ Zip_____

Type of physician / health care provided: _____

Provider _____ Phone (_____) _____

Address _____ City _____ State _____ Zip_____

Type of physician / health care provided: _____

Patient Name: _____ Date of Birth: ___/___/_____

Preliminary History Sheet

Where is most of your pain? Please check. Please circle right, left or both where appropriate

Ankles _____ R L B Hand _____ R L B Shoulders _____ R L B Fingers _____

Elbow _____ R L B Knees _____ R L B Wrist _____ R L B Toes _____

Foot _____ R L B Neck _____ Mid Back _____ Other _____

Low Back _____ Hip _____ R L B

Is your pain aggravated by any of the following? Please check

Bending _____ Lifting _____ Sitting _____

Climbing stairs _____ Movement _____ Standing _____

Descending stairs ___ Pusing _____ Walking _____

Other_____ Nothing _____

Is your pain relieved by any of the following? Please check.

Brace/splint _____ Ice _____ Activity _____ Streching _____

Elevation _____ Injection _____ OTC Medication _____ type?

Exercise _____ Massage _____ Physical Therapy _____

Heat _____ Pain/rx meds_____ Rest _____ Other _____

Nothing _____

Pain Frequency		Severity on a scale from 0 - 10 (10 being the worse) _____
Circle one		
Intermittent		Onset of pain _____ Months Years Days ago
Occasional		Specific date _____/_____/_____
Constant		
Rare		How long does your pain last? _____

When did your pain start? Please circle

1 2 3 4 5 6 7 8 9 10 Months Years Days ago

specific date _____/_____/_____

On a scale of 1-10, with ten being the highest, what is the level of your pain? Please circle

1 2 3 4 5 6 7 8 9 10

How often do you have pain? Please circle

Frequent Occasional Intermittent Persistent Rare

Preliminary History Sheet

Patient Name: _____ Date of Birth ____/____ Today's Date ____/____/_____

Medication	Dose	Instructions	Year started	Medication	Dose	Instructions	Year started

Allergies: **No Known Allergies** ☐

Medication	Reaction	Medication	Reaction

Social History: please circle answer

Tobacco Use: Yes No Former Year Quit_____

Type _____ Amount per day _____

Drinks Alcohol: Yes No Former Year Quit_____

Type _____ Freguency _____

Amount per day_____

Drinks Caffeine: Yes No

Vaccinations:

Vaccine:	**Dose#/Mfr**	**Date/Year**
Covid-19		
Hepatitis B		
Influenza		
Shingles		
BCG		
Pneumovac		
Test	**Results**	**Year**
TB skin test		
TB blood test		
Chest X-Ray		

Medical History Sheet

Name: _____ Date: _____/_____/_____

Are you taking or have you ever taken any of the following? If you answer yes, please list the stop date

Allopurinol (Zyloprim)		Bextra (Valdecoxib)	
Arava (Leflunomide)		Celebrex (Celecoxib)	
Auranotin (Gold tablets)		Clinorial (Sulindac)	
Azulfidine (Sulfasalazine)		Clinoril (Sulindac)	
Colchicine (Probenecid)		Daypro (Oxaprozin)	
Cuprimine, Depen (Penicillamine)		Feldene (Piroxicam)	
Cytoxan (Cyclophosphadmide)		Indocin (Indomethacin)	
Enbrel (Etanercept)		Lodine (Etodolac)	
Humira (Adalimumab)		Meclomen (Meclofenamote)	
Remicade (Infliximab)		Motrin / Nuprin / Advil (ibuprofen)	
Imuran (Azathioprine)		Mobix (Meloxicam)	
Methotrexate (Methotrexate Sodium)		Nalfon (Fenoprofen)	
Plaquenil (Hydroxychloroquine)		Naprosyn (Naproxen / Aleve)	
Opioid		Orudis / Oruvail (Ketaprofen)	
Cortisone, Prednisone, or Deltasone		Relafen (Nabumetone)	
a. Tablets		Tolectin (Tolmetion Sodium)	
b. injections in the joints		Voltaren (Diclofenac Sodium)	
c. IM injections		Actonel or Actonel w/ Calcium	
Hyalgan injections		Dironel (etidronate)	
Supartz injections		Fosamax or Fosamax plus D	
Synvisc injections		Evista (raloxifene)	
Oral Bonvia		Fareston (toremifene)	
Atelvia (risedronate)		Rinvoq (upadacitinib)	
Skelid (tiludronate)		Skyrizi (risankizumab-rzaa)	
Tamoxifen (nolvadex)		Tremfya (guselkumab)	
Femara (letrozole)		Orencia (abatacept)	
Ansaid (Flurbiprofen)		Cimzia (certolizumab pegol)	
Arthrotec (Diclofenac Sodium)		Simponi (Golimumab)	
Aspirin / Ecotrin / Trilisate / Disalcid			

Below, please list the medications stopped because of allergy, contraindication, failure or intolerance

_____ _____

_____ _____

_____ _____

Patient Name: _____ Date of Birth: _____/_____/_____

Family History

Please check if any member of your immediate family had or has had any of these conditions.

		Family Member	Cause of Death: Y/N
Alzheimer's disease	_____	_____	_____
Coronary Artery Disease	_____	_____	_____
Premature Coronary Artery Disease	_____	_____	
Cancer _____ Type _____			
Depression	_____	_____	_____
Diabetes	_____	_____	_____
Eczema	_____	_____	_____
Fibromyalgia	_____	_____	_____
Hypertension	_____	_____	_____
Irritable Bowel Syndrome	_____	_____	_____
Lupus	_____	_____	_____
Mental Illness	_____	_____	_____
Migraines	_____	_____	_____
Obesity	_____	_____	_____
Osteoarthritis	_____	_____	_____
Osteoporosis	_____	_____	_____
Peripheral Artery Disease	_____	_____	_____
Psoriasis	_____	_____	_____
Renal Disease	_____	_____	_____
Rheumatoid Arthritis	_____	_____	_____
Stroke	_____	_____	_____

Patient Name:_____ Date of Birth ___/____/_____

Preliminary History Sheet

Please circle any medical conditions you have been diagnosised with

Allergies	Cancer Type _____	Hepatitis	Renal Disease
Anemia	COPD	High Cholesterol	Peptic Ulcer
Anxiety	Coronary Disease	High Blood Pressure	Seizures
Arthritis	Crohn's Disease	IBS	Stroke
Asthma	Depression	Liver Disease	Thyroid Disease_
Atrial Fibrillation	Diabetes	MI	Shingles
BPH	Gall Bladder Disease	Osteoarthritis	Other _____
Blood Clots	GERD	Osteoporosis	Other _____

Please check if you have had any of these procedures and list the year of the procedure

Procedure	Year	Procedure	Year	Procedure	Year	Other
Angioplasty		Hernia Repair		Breast Biopsy		
Angioplasty w/ stent		Hip Replacement		Cesarean Section		
Appendectomy		Knee Replacement		D & C		
Back surgery		Knee Arthroscopy		Hysterectomy		
CABG		LASIK		Mastectomy		
Carpal tunnel release		Liver Biopsy		Prostate Biopsy		
Cataract Extraction		ORIF		Tubal Ligation		
Gall Bladder Removed		Pacemaker		Tubal Ligation		
Colectomy		Small Bowel Resection		TAH/BSO		
Colostomy		Thyroidectomy		TURP		
Gastric Bypass		Tonsilectomy		Vasectomy		

Dear Patient: Please only check the symptoms that you are experiencing at this time. If no symptoms apply please mark all negative, Thank you

Constitutional ○ all neg	
Neg	**Positive**
○	○ Chills
○	○ Fatigue
○	○ Fever
○	○ Night Sweats
○	○ Weight gain
○	○ Weight loss
○	○ Other:
HEENT ○ all neg	
○	○ Visual changes
○	○ Vision loss
○	○ Blurred vision
○	○ Dental cares
○	○ Double vision
○	○ Dry mouth
○	○ Dry eyes
○	○ Dysphagia
○	○ Epistaxis
○	○ Eye pain
○	○ Facial pain
○	○ Hearing loss
○	○ Hoarseness
○	○ Jaw pain
○	○ Nasal sores
○	○ Oral ulcers
○	○ Red eye
○	○ Sinusitis
○	○ Sore throat
○	○ Tinnitus
○	○ Other:
Respiratory	
○	○ Cough
○	○ Shortness of breath
○	○ Wheezing
○	○ Other:

Cardiovascular ○ all neg	
Neg	**Positive**
○	○ Chest pain
○	○ Claudication
○	○ Edema
○	○ Palpitations
○	○ Raynaud's
○	○ Substernal chest pain
○	○ Tachcardia
○	○ Thrombophiebitis
○	○ Varicose veins
○	○ Other:
Gastrointestinal ○ all neg	
○	○ Abdominal cramping
○	○ Abdominal pain
○	○ Bloating
○	○ Blood in stools
○	○ Constipation
○	○ Diarrhea
○	○ Dysphagia
○	○ Early satiety
○	○ Epigastric pain
○	○ Heartburn
○	○ Hemorrhoids
○	○ Loss of appetite
○	○ Nausea
○	○ Vomiting
○	○ Other:
Genitourinary ○ all neg	
○	○ Dribbling (male only)
○	○ Dysuria (painful urination)
○	○ Hematuria (blood in urine)
○	○ Polyuria (excessive urine)
○	○ Slow stream (male only)
○	○ Urinary frequency
○	○ Urinary incontinence
○	○ Urinary retention
○	○ Other:

Metabolic/Endocrine ○ all neg	
Neg	**Positive**
○	○ Cold intolerance
○	○ Gynecomastia
○	○ Hair loss
○	○ Heat intolerance
○	○ Hirsutism
○	○ Hot flashes
○	○ Polydipsia
○	○ Other:
Neurological ○ all neg	
○	○ Confusion/disorientation
○	○ Dizziness
○	○ Extremity numbness
○	○ Extremity weakness
○	○ Gait disturbance
○	○ Headache
○	○ Memory loss
○	○ Seizures
○	○ Syncope (fainting)
○	○ Tingling
○	○ Tremors
○	○ Other:
Psychiatric ○ all neg	
○	○ Anxiety
○	○ Depression
○	○ Emotionally labile
○	○ Hallucinations
○	○ Insomnia
○	○ Suicidal ideation
○	○ Other:
Immunologic ○ all neg	
○	○ Allergic rhinitis
○	○ Frequent infections
○	○ Food allergies
○	○ Other:

Integumentary ○ all neg	
Neg	**Positive**
○	○ Acne
○	○ Bruising
○	○ Discoid rash
○	○ Hives
○	○ Itching
○	○ Nail changes
○	○ Photosensitivity
○	○ Psoriasis
○	○ Rash
○	○ Scalp tenderness
○	○ Skin lesion
○	○ Other:
Musculoskeletal ○ all neg	
○	○ Back pain
○	○ Height loss
○	○ Joint pain
○	○ Joint swelling
○	○ Joint tenderness
○	○ Low back pain
○	○ Morning stiffness
○	○ Muscle cramping
○	○ Muscle weakness
○	○ Muscular atrophy
○	○ Myalgia
○	○ Neck pain
○	○ Neck stiffness
○	○ Other:
Hematologic/lymph ○ all neg	
○	○ Easy bleeding
○	○ Easy bruising
○	○ lymphadenopathy
○	○ Other:

Carolina Rheumatology and Neurology

Patient Disease Activity and Symptom Form

OVER THE PAST WEEK, were you able to **(Check only one)**:	*No Difficulty*	*Some Difficulty*	*Much Difficulty*	*Unable to do*
Dress yourself, including tying shoes and doing buttons?	☐	☐	☐	☐
Get in and out of bed?	☐	☐	☐	☐
Lift a full cup or glass to your mouth?	☐	☐	☐	☐
Walk outside on flat ground?	☐	☐	☐	☐
Wash and dry your entire body?	☐	☐	☐	☐
Bend down to pick clothing from the floor?	☐	☐	☐	☐
Turn regular faucets on and off?	☐	☐	☐	☐
Get in and out of the car, bus, train or plane?	☐	☐	☐	☐
Walk two miles, if you wish?	☐	☐	☐	☐
Participate in recreational activities and sports as you would like, if you wish?	☐	☐	☐	☐

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	1.5	2	2.5	3	3.5	4	4.5	5	5.5	6	6.5	7	7.5	8	8.5	9	9.5	10	PAIN AS BAD AS IT COULD BE
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Considering all the ways in which illness and health conditions may affect you **AT THIS TIME**. Please indicate how you are doing:

VERY WELL	0	0.5	1	1.5	2	2.5	3	3.5	4	4.5	5	5.5	6	6.5	7	7.5	8	8.5	9	9.5	10	VERY POORLY
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Please check **Yes** if you have any of the following symptoms/problems:

Yes		Yes		Yes		Yes		Yes		Yes	
○	Joint pain	○	Fatigue	○	Body rash	○	Weakness	○	Shortness of breath	○	Depression
○	Back pain	○	Persistent fever	○	Face rash	○	Chronic headaches	○	Chest pain	○	Anxiety
○	History of broken bones	○	Unexplained weight loss	○	Rash from the sun	○	Numbness or tingling	○	Abdominal pain	○	Dizziness
○	Dry mouth	○	Unexplained weight gain	○	Nose bleeds	○	Memory loss	○	Diarrhea	○	Double vision
○	Dry eyes	○	Night sweats	○	Mouth ulcers/sores	○	Muscle spasm	○	Constipation	○	Vision loss
○	Hair loss	○	Hives	○	Raynaud's (blue fingers)	○	Pleurisy or Pericarditis	○	Difficulty swallowing	○	Hearing loss
										○	History blood clots

○	**Joint swelling**	Location of swelling: _____
○	**Morning stiffness**	If yes, how long: _____

Assignment of Benefits

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MYHEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZEDREPRESENTATIVE

I hereby assign and convey directly to Carolina Rheumatology & Neurology, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the abovenamed health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named healthcare provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place alien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

This lifetime assignment will remain in effect until revoked by me in writing. It is valid for all administrative and judicial reviews under PPACA (healthcare reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it were the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT:

Name: _____ *Date:* _____

Signature: _____ *DOB:* _____

8220 NigelsDr.
Myrtle Beach, SC 29572
Phone: (843) 692-0968 Fax: (843) 692-2688

Carolina Rheumatology & Neurology
General Consent

Patient Name: _____

Date of Birth: _____/____/_____

Home Address:_____ _____ ____ _____
Street and Unit City State Zip Code

Primary Phone Number: _____

Provider: _____

I am requesting that health care services be provided to me (or the patient named above) at Carolina Rheumatology and Neurology ("CRNA"). I voluntarily consent to all medical treatment and health care related services that the caregivers at CRNA consider to be necessary for me (or the patient named above). These services may include diagnostic, therapeutic, imaging, and laboratory services. My blood may be used to perform routine quality assurance testing. I am aware that the practice of medicine and surgery is not an exact science; no guarantees have been made to me about the results of treatments or examinations.

I understand that I have the right to discuss any treatment plan with my physician about the purpose, potential risks and benefits of any test ordered for me. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I further understand that if I have any concerns regarding any test or treatment recommended by my health care provider contained in this section.

Financial Responsibility: Subject to applicable law and the terms and conditions of any applicable contract between CRNA and a third party payer, and in consideration of all health care services rendered or about to be rendered to me (or the above-named patient), I agree to be financially responsible and obligated to pay CRNA for any balance not paid under the "Assignment of Benefits/Third Party Payers" paragraph below; OR subject to applicable law and in consideration of all health care services rendered or about to be rendered to me (or the above patient), I agree to be financially responsible and obligated to pay CRNA for the patient balances due.

Assignment of Benefits/Third-Party Payers: In consideration of all health care services rendered or about to be rendered to me (or the above-named patient), I hereby assign to CRNA all right, title and interest in and to any third party benefits due from any and all insurance policies and/or responsible third party payers of an amount not exceeding CRNA's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carries, third party

payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third-party payer.

I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to CRNA on this form or updated at a later time, text message and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from CRNA and its affiliates, clinical providers, and business associates, along with any billing services, collection agencies, agents, or other third parties who may act on their behalf. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered. I understand this consent to communication is not required to receive services from CRNA or any of the other authorized callers and that data usage and other charges may apply. I may revoke this consent to these communication at any time.

I certify that I have read and fully understand the above states and consent fully and voluntarily to its contents.

_____ _____

Name of Signatory Relationship to Patient (if applicable)

_____ _____

Signature of Patient (18 years old or older) or Legal Guardian Date/Time

Acknowledgement of Receipt of Notice of Privacy Practices

HIPAA requires that CRNA give you a Notice of Privacy Practices that describes how CRNA will use and disclose your protected health information and explains your HIPAA Privacy Rights.

I have read the Notice of Privacy provided by CRNA.

_____ _____

Signature of Patient (18 years old or older) or Legal Guardian Date

TO OUR PATIENTS:

Carolina Rheumatology and Neurology shall comply with federal and state laws that require healthcare facilities to inform patients of their rights to execute advance directives, such as a Living Will, Health Care Power of Attorney, or Do-Not Resuscitate Directive.

If you have advance directives that you would like added to your medical record or if you would like more information about them please let us know.

Thank you!

Additional information may also be found on the internet at:
http://www.ohpco.org/aws/MCA/pt/sp/livingwills
http://www.caringinfo.org

Our office is participating in the Patient Portal. The Patient Portal. The Patient Portal is an easy way to send messages to our office, Request an Appointment, Refills and view results of your tests performed in our office.

If you please fill out the information below, we will be happy to send you an invite to register with us.

PLEASE PRINT CLEARLY:

*Patient name*_____

*Email Address*_____

*Date of Birth*_____

Limited Patient Authorization for Disclosure of Protected Health Information
Authorization to release information to friends/family

Please print all the information. Form must be signed and dated

Patient name: _____

SSN (last four digits): _____ Date of Birth: _____

Entity Requested to Release Information: _____

Address:_____

Purpose of request (who will be authorized to receive information) – I authorize the entity identified above to disclose or provide protected health information, about me to the individual/entity listed below.

Who will be authorized to receive information (The individual/entity who is to receive your PHI):

Individual/Entity Name: _____Carolina Rheumatology and Neurology_____

Address: ___8220 Nigels Dr Myrtle Beach, SC 29572_____

Phone/Fax: __843-692-0968/843-692-2688_____

Description of information to be disclosed – I authorize the practice to disclose the following protected health information about me to the entity, person or persons identified above:

☐ entire patient record; or, check only those items of the record to be disclosed:

☐ office notes ☐ nursing home, home health, hospice, and other physician records

☐ lab results, pathology reports ☐ record of HIV and communicable disease testing

☐ x-rays ☐ record of mental health or substance abuse treatment

☐ financial history report (previous 3 years only) ☐ Only send the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): _____

- This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protection health information. Therefore, your protection health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Act

_____ _____

Patient or authorized representative signature Date

You have the right to receive a copy of signed authorization upon request.

PATIENT FINANCIAL AGREEMENT

All services are provided to you with the understanding that YOU ARE ULTIMATELY responsible for the cost regardless of your insurance coverage. If you would like to know the cost of a service, please inquire prior to treatment. Please be aware that not all services are a covered benefit with all the insurance companies. **You are responsible for knowing what services are and are not covered with your insurance plan. EVERY INSURANCE PLAN IS DIFFERENT, PLEASE KNOW YOUR BENEFITS**.

Your insurance policy is a contract between you (your employer) and your insurance. We are NOT a party in that contract and CANNOT influence what services your insurance plan will not cover.

- **CHANGE OF INSURANCE: If your insurance changes, IT IS YOR RESPONSIVBILITY TO NOYIFY OUR OFFICE** and make sure your new insurance plan participates with Carolina Rheumatology and Neurology Assoc. (CRNA). You should bring your insurance cards to all doctors' visits. If you are receiving IV infusion please let us know of any changes 1 week prior to your infusion appointment, if we are not notified in time this could cause a delay in your treatment.
- **BILLING AND CODING:** Billing and coding are performed based on medical record documentation. We cannot comply with any request to improperly alter coding, as this is considered healthcare fraud.
- **REFERRAL AND AUTHORIZATOINS**: If your insurance company requires a referral or authorization, it is your responsibility to obtain this from your primary care provider prior to your appointment. If your insurance company denies payment because there is a no referral or authorization on file, the balance will be your responsibility.
- **CANCELLATION/NO SHOWS**: We do realize that the wait to be seen in our office can be quite lengthy. We try to accommodate each person as best as we can. If for any reason you cannot make your appointment, please contact our office a minimum of **24 hours** before your scheduled appointment as a courtesy to us and others waiting to be seen. If you cancel or no show three consecutive times you will no longer be allowed to schedule with CRNA.
- **COMPLETION OF FORMS**: If you require forms to be completed for school, work, or legal purposes there is a fee. This fee pays for the physician's time to perform a chart review and fill out the appropriate paperwork. Please see the front desk for pricing.
- **MEDICAL RECORDS**: As a patient CRNA, you have a right to a copy of your medical records. A fee may apply if you require a large volume of copies and notes. Please see the front desk for pricing.
- **CHECK-IN**: We will collect your deductible, co-pay and payment for uncovered services as well as patients' portion as determinate by insurance. We accept cash, check, and credit cards.
- **OFFICE LABS**: Quest is our in-office lab. They draw and process all the labs from this office. You may also receive a bill from Quest for the blood draw you have in our office. We do not participate in any of the billing process for Quest and therefore are not able to communicate on any of the bills received from them. If your insurance has restrictions on where you are allowed to have your blood drawn, it is your responsibility to know these restrictions. Please inform your

doctor and they will provide you with a lab order to have your blood work done elsewhere.

- **COLLECTION POLICY:** Full payment or payment arrangements are expected upon receipt of your first billing statement. If your account balance is not paid in full or payment arrangements confirmed after 60 days or two billing statements, your account will be in default and auto referred to a collection agency. The outside collection agency has the right to report all past due balances to the credit bureau.
- **WORKMANS COMPENSATION/AUTO COMP:** Our office will not participate in Workman's Comp/Auto Insurance claims.
- **UNINSURED PATIENTS**: As a courtesy to our patients who do not have health insurance coverage, we offer a discount only if services are paid for in full at the time of service. We will not offer a discount on accounts that already carry a balance.
- **RETURNED CHECKS:** All returned checks are subject to a $35.00 return check fee and will require that future payments are made by cash or credit card.
- **OUT OF NETWORK PLANS:**

UHC Mid-Atlantic	UHC Gated HMO
UHC National Ancillary	UHC NHP Direct Access, Gated L1, L2 & L3
Veterans Affair CCN	UHC Compass EPO/HMO/HMO Plus & POS
VA	UHC Heritage EPO/primary advantage/HMO/POS
UHC Heritage Select Advantage HMO & POS HMO	
UHC Medicare Plans (till 12-1-24)	Tricare West
Workers Comp	Blue Choice Medicaid
First Choice Medicaid	North Carolina Medicaid
Molina Medicaid	SC Connect (as primary)

- **NOT CONTRACTED WITH***: you may self-pay with these plans*

PHCS	Multiplan
GHI (as a primary)	BCBS starting with PEZ

Patient Financial Policy Acknowledgement

By signing below, I acknowledge that I have been provided a copy of the CNRA Patient Financial Policy and agree to the specified terms; I agree to pay all charges due to CRAN for patient care and treatment, including co-payments, coinsurance, and deductibles, as required or provided pursuant to my insurance plan; regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered; if I fail to make any payment for which I am responsible to pay, my credit report may be affected.

ONCE I HAVE SIGNED THIS AGREEMENT, I AGREE TO ALL THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN EFFECT FOR 1 YEAR.

_____ _____

Patient Name Printed Date of Birth

_____

Patient/Guardian Signature Date