Patient Name: ____ Date of Birth: ____________________

Home Address: ____

City:_____________________________________ State: ______________ Zip Code:____________________

Gender at Birth: ☐ Male ☐ Female Gender Identity: ____________________________Pronouns:__________________

Email Address:____

Mobile Phone:____________________ Home Phone: ____________________ Work Phone: ____________________

Occupation: ____

Employer:____Employer Phone:________________________

Preferred Language: ______________________________

Ethnicity: ☐ Hispanic ☐ Not Hispanic Race: ☐ Asian ☐ Black ☐ American Indian / Alaska Native ☐ Pacific Islander ☐ White ☐ Mixed

Preferred And Emergency Contacts:

Spouse or Domestic Partner: ____________________________________ Phone: ________________________

Party to Notify in Case of Emergency: (if other than spouse) __________________________ Phone: ____________________

Relationship to patient: ____

Referring Provider Information:

PRIMARY CARE PHYSICIAN: ____________________________ REFERRING PHYSICIAN: __________________________

ADDRESS: ______________________________________ ______________________________________

CITY/STATE/ZIP: __________________________________ CITY/STATE/ZIP: ______________________________

Primary Insurance: ____________________________________ ID: ______________________________________

Subscriber name: ________________________________ DOB: ______________ Relationship to Insured: ______________

Secondary Insurance: __________________________________ ID: ______________________________________

Subscriber name: ________________________________ DOB: ______________ Relationship to Insured: ______________

Pharmacy Information:

Pharmacy: ______________________________ City: ______________________________

Mail Order: ____________________________ Phone: ______________ City: ______________________________

- I consent to the downloading of my E-prescribing history.
- I give permission for Arthritis & Rheumatic Care to submit claims to my insurance carrier and receive payment for services rendered.
- I understand that I am ultimately responsible for the bills for services rendered.
- I have completed these forms to the best of my knowledge and ability. If there are any changes to my information, I will report them to the office.

Patient Signature: ____ **Date:** ________________________________

Acknowledgment of Receipt of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1006 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment, directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand the Notice of Privacy Practices document containing a more complete description of the uses and disclosures of my health information. I understand that Arthritis & Rheumatic Care, LLC has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below for a current copy of the Notice of Privacy Practices document.

Do we have your permission to: check off yes or no

- Leave a message on your answering device (cellular or otherwise)? ☐ yes ☐ no
- Confirm appointments by leaving messages or speaking with family? ☐ yes ☐ no
- Leave pre-medication reminders (if applicable)? ☐ yes ☐ no
- Communicate with me via Text, patient portal or secure email? ☐ yes ☐ no

I give my permission for Arthritis & Rheumatic Care, LLC and its assigns to release information regarding my health, my results, my appointments to the following individuals:

Name: ____ Relationship: ________________________________ Phone: ____________________________

Name: ____ Relationship: ________________________________ Phone: ____________________________

Name: ____ Relationship: ________________________________ Phone: ____________________________

Patient Name: ________________________________ Signature: ____________________________ Date: _________________

<u>FOR OFFICE USE ONLY</u>

The Practice provided the above referenced patient with the Practice's Notice of Privacy Practices and this Acknowledgement of Receipt of Notice of Privacy Practices, but could not obtain a signed acknowledgement from them because:

☐ Patient or Guardian refused to sign

☐ Emergency Situation

☐ Other: ____

____

Permission for Telehealth Visits

What is telehealth?

Telemedicine, also referred to as telehealth medicine, is the real-time, audio-visual visit between a provider and patient. It can be used as an alternative to traditional in-person care delivery and, in certain circumstances, can be used to deliver care including the diagnosis, consultation, treatment, education, care management and patient self-management.

How do I use Telehealth?

You talk to your provider with a phone, computer or tablet. Sometimes, you use video so you and your provider can see each other.

How does Telehealth help me?

You don't have to go to the clinic or hospital to see your providers. It also reduces your risk of getting sick from other people.

What are some of the benefits of Telehealth?

No transportation time or costs, reduce wait time, and more detailed and personalized care compared to telephone calls.

What are some of the challenges of Telehealth Visits?

You and your provider will not be in the same room, so it may fee different from an office visit. Your provider cannot examine you as closely as they might at an in-office visit. Your provider may decide that you still need an office visit. Technical problems may interrupt or stope your visit before you are done.

Will my telehealth visit be private?

We will not record visits with your provider. If people are close to you, they may hear something you do not want them to know. You should be in a private place so other people cannot hear you. Your provider will tell you if someone else from their office can hear or see you. We use HIPAA compliant, encrypted telehealth technology that is designed to protect your privacy. If you use the internet for telehealth, use a network that is private and secure. There is a very small chance that someone could use technology to hear or see your telehealth visit.

What types of visits can telehealth be used for?

Telehealth is best suited for interactions with established patients who do not require a physical exam or lab work.

What types of visits are not appropriate for telehealth visit?

Telehealth is not suited for a physical exam or lab testing.

What if I want an office visit and not a telehealth visit?

The decision is up to you and your provider. Find out what options are available to you by calling the practice.

What if I try telehealth and I don't like it?

You can stop using telehealth any time, even during a telehealth visit. You can still get an office visit if you no longer want a telehealth visit. If you decide you do not want to use telehealth again, call 201-975-2400 and say you want to stop.

How much does a telehealth visit cost?

What you pay depends on your insurance. If you providers decides you do need an office visit in addition to your telehealth visit, you may have to pay for both visits.

Do I have to sign this document?

Only if you want to use telehealth.

What does it mean if I sign this document?

If you sign this document you agree that: We talked about the information in this document. We answered all your questions. You want a telehealth visit.

PRINT YOUR NAME:____

SIGNATURE: X ____ DATE: __________________

ARTHRITIS &
RHEUMATIC
CARE

PATIENT NAME:_________________________________ **DATE OF BIRTH:** _________________

MEDICATIONS:
LIST ALL OF YOUR CURRENT MEDICATIONS INCLUDING PRESCRIPTIONS, HERBALS, VITAMINS, SUPPLEMENTS AND OVER THE COUNTER MEDICATIONS

MEDICATION NAME	DOSE	HOW OFTEN DO YOU TAKE IT?	WHO ORDERED THIS DRUG?

IF MORE SPACE IS NEEDED, PLEASE ATTACH AN ADDITIONAL SHEET.

ALLERGIES: PLEASE LIST ALL ALLERGIES

ALLERGEN	SEVERITY OF REACTION	WHAT TYPE OF REACTION?	TREATMENT IN THE PAST

PREFERRED PHARMACY:

PHARMACY NAME		LOCATION	ADDRESS	PHONE NUMBER	FAX NUMBER

Signature: ____ Date: _________________________________

197 Cedar Lane, Suite 2 (Rear)
Teaneck, NJ 07666

Phone: 201-975-2400 www.njarthritiscare.com Fax: 940-301-3919

REQUEST FOR MEDICAL RECORDS

Referring Provider Name: ____

Address: ____

City: _________________________________ **State:**__________ **Zip:** _____________

Fax: ________________________________

Thank you for referring your patient to Arthritis & Rheumatic Care, LLC.

In preparation for their upcoming appointment, we are requesting the following records:

- **Clinical Notes**
- **Labs**
- **Imaging reports**
- **Pathology**

PLEASE FAX REQUESTED RECORDS AS SOON AS POSSIBLE TO 940-301-3919.

I, (PT NAME)____________________________________, DOB _________________ request that my medical records outlined above be sent to Arthritis & Rheumatic Care, LLC in preparation for my upcoming appointment.

Patient Name: _____________________________ **Date of Birth:** _________________

Patient Signature: __________________________ **Date of Request:** _______________