PATIENT REGISTRATION FORM

Last Name:_____ First Name:_____ Date of Birth: _____

Home Address: _____

City:_____ State: _____ Zip Code:_____

Gender at Birth: _____ Gender Identity: _____Pronouns:_____

Email Address:_____ Drivers License # _____

Mobile Phone:_____ Home Phone: _____ Work Phone: _____

Occupation: _____

Employer:_____Employer Phone:_____

Employer Address:_____

City:_____ State: _____ Zip Code:_____

Preferred Language: _____Do you Require an Interpreter? _____

Ethnicity: ____ Hispanic ____ Not Hispanic Race: _____

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:

Who may we thank for referring you to our Practice? _____

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____

ADDRESS: _____ _____

CITY/STATE/ZIP: _____ CITY/STATE/ZIP: _____

Other Providers you wish us to communicate with

SPECIALTY PHYSICIAN: _____ SPECIALTY PHYSICIAN: _____

ADDRESS: _____ _____

CITY/STATE/ZIP: _____ CITY/STATE/ZIP: _____

INSURANCE INFORMATION:

Primary Insurance: _____ ID: _____

Subscriber name: _____ DOB: _____ Relationship to Insured: _____

Secondary Insurance: _____ ID: _____

Subscriber name: _____ DOB: _____ Relationship to Insured: _____

Patient Signature: _____ **Date:** _____

Guardian Signature: _____ **Date:** _____

Arthritis & Rheumatic Care, LLC
197 Cedar Lane, Suite 2 (Rear)
Teaneck, NJ 07666

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: _____

FOR OFFICE USE ONLY

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: _____

_____

Notice of Privacy Practices

Arthritis and Rheumatic Care, LLC
197 Cedar Lane, Suite #2 (Rear)
Teaneck, NJ 07666

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCES THIS INFORMATION PURSUANT TO FEDERAL REGULATIONS. PLEASE REVIEW IT CAREFULLY.

At Arthritis & Rheumatic Care, we understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of care and services you receive directly from one of our providers. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice of Privacy Practices ("Notice") applies to all the records of your care generated by the Practice.

This notice will tell you about the ways in which the Practice may use and disclose your Protected Health Information (PHI). This Notice also describes your rights and certain obligations the Practice has regarding the use and disclosure of PHI.

REGULATORY REQUIREMENTS:

Practice is required by law to maintain the privacy of your PHI, to provide individuals with notice of Practice's legal duties and privacy practices with respect to PHI, and to abide by the terms described in the Notice currently in effect.

RIGHTS: You have the following rights regarding your PHI:

Restriction: You may request that Practice restrict the use and disclosure of your PHI. To request restrictions, you must make your request in writing to our Privacy Officer using the applicable Practice form. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the restrictions to apply, for example, disclosures to your spouse.

Alternative Communications: You have the right to request that communications of PHI to you from Practice be made by particular means or at particular locations. For instance, you might request that communications be made at your work address, instead of your home address. Your requests must be made in writing using Practice's form and sent to the Privacy Officer. Practice will accommodate your reasonable requests.

Inspect and Copy: Generally, you have the right to inspect and copy your PHI that the Practice maintains, provided you make your request in writing to the Practice's Privacy Officer. If you request copies of your PHI, we may impose a reasonable fee to cover copying and postage. If we deny access to your PHI, we will explain the basis for denial and your opportunity to have your request and denial reviewed by a licensed health care professional (who was not involved in the initial denial decision) designated as a reviewing official. If Practice does not maintain the PHI you request and if we know where that PHI is located, we will tell you how to redirect your request.

Amendment: If you believe that your PHI maintained by the Practice is incorrect or incomplete, you may ask us to correct your PHI. Your request must be made in writing, and it must explain why you are requesting an amendment to your PHI Your request must be made in writing, and it must explain why you are requesting an amendment to your PHI We can deny your request if your request relates to PHI: (i) not created by Practice; (ii) not part of the records Practice maintains; (iii) not subject to being inspected by you/ or (iv) that is accurate and complete. If your request is denied, we will provide you a written denial that explains the reason for the denial and your rights to: (i) file a statement disagreeing with the denial; (ii) if you do not file a statement of disagreement, submit a request that any future disclosures of the relevant PHI be made with a copy of your request and Practice's denial attached; and (iii) complain about the denial.

Accounting of Disclosures: You generally have the right to request and receive a list of the disclosures of your PHI we have made at any time during the six (6) years prior to the date of your request (provided that such a list would not include disclosures made prior to April 14, 2003). The list will not include disclosures made at your request, with your authorization, and does not include certain uses and disclosures to which this Notice already applies, such as those: (i) for treatment, payment and health care operations; (ii) made to you; (iii) for Practice's patient list; (iv) for national security or intelligence purposes; or (v) to law enforcement officials. You should submit any such requests to the Practice's Privacy Officer. Practice will provide the list to you at no charge, but if you make more than one request in a year, you will be charged a fee of the cost of providing the list.

Right to Copy Notice: You have the right to receive a paper copy of this notice upon request. To obtain a paper copy of this notice, please contact the Privacy Officer at the address and contact information stated at the end of this notice.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The Practice may use or disclosure your PHI for the purposes described below without obtaining written authorization from you. In addition, Practice and the members of its medical and allied health professional staff who participate in the organized health care arrangement described below may share your PHI with each other as necessary to carry out their treatment, payment and health care operations related to the organized health care arrangement.

FOR TREATMENT: Practice may use and disclose PHI while providing, coordinating or managing your medical treatment, including the disclosure of PHI for treatment activities of another health care provider.

FOR PAYMENT: Practice may use and disclose PHI to bill and collect payment for the health care services provided to you. For example, Practice may need to give PHI to your health plan to be reimbursed for the services provided to you. Practice may also disclose PHI to its business associates, such as billing companies, claims processing companies and others that assist in processing health claims. Practice may also disclose PHI to other health care providers and health plans for the payment activities of such providers or health plans.

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FOR HEALTH CARE OPERATIONS: Practice may use and disclose PHI as part of its operations, including for quality assessment and improvements, such as evaluating the treatment and services you receive and the performance of staff and physicians in caring for you, patient surveys, provider training, underwriting activities, compliance and risk management activities, planning and development, credentialing and peer review activities, and health care fraud and abuse detection or compliance, and management and administration. Practice may disclose PHI to doctors, nurses, technicians, students, attorneys, consultants, accountants and others for review and learning purposes, to help make sure Practice is complying with all applicable laws, and to help Practice continue to provide quality health care to its patients.

AS REQUIRED BY LAW AND LAW ENFORCEMENT: Practice may use or disclose PHI when required to do so in a judicial or administrative proceeding. Practice may also use or disclose PHI upon a properly documented and limited request from law enforcement agencies.

FOR PUBLIC HEALTH ACTIVITIES AND PUBLIC HEALTH RISKS: Practice may disclose PHI to government officials in charge of collecting information about births and deaths, preventing and controlling disease, or notifying a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition.

FOR HEALTH OVERSIGHT ACTIVITIES: Practice may disclose PHI to the government for oversight activities authorized by law, such as audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, actions or activities necessary for monitoring the health care system, government programs and compliance with civil rights laws.

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS: Practice may disclose PHI to coroners, medical examiners and funeral directors for the purpose of identifying a decedent, determining a cause of death or otherwise as necessary to enable these parties to carry out their duties consistent with applicable law.

RESEARCH: Under certain circumstances, Practice may use and disclose PHI for medical research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication with those who received another, for the same condition.

TO AVOID A SERIOUS THREAT TO HEALTH OR SAFETY: Practice may use and disclose PHI to law enforcement personnel or other appropriate persons to prevent or lessen a serious threat to the health or safety of a person or the public.

SPECIALIZED GOVERNMENT FUNCTIONS: Practice may use and disclose PHI of military personnel and veterans under certain circumstances. Practice may also disclose PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities, and for the provision of protective services to the President or other authorized personal or foreign heads of state or to conduct special investigations.

DISCLOSURES TO YOU OR FOR HIPAA COMPLIANCE INVESTIGATIONS: Practice may disclose your PHI to you or to your personal representative and is required to do so in certain circumstances described below in connection with your rights to access your PHI and to an accounting of certain disclosures of your PHI. Practice must disclose your PHI to the secretary of the United States Department of Health and Human Services (The Secretary) when requested b the Secretary in order to investigate Practice's compliance with privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996.

PATIENT LIST; MARKETING: Unless you object, Practice may use some of your PHI to maintain a list of patients it has served. This information may include your name, treatment facility, and the services the Practice provided to you. This patient list and the information on it may be used for marketing purposes.

DISCLOSURES TO INDIVIDUALS INVOLVED IN OUR HEALTH CARE OR PAYMENT FOR YOUR HEALTH CARE: Unless you object, Practice may disclose your PHI to a family member, other relative, friend, or other personal you identify as involved in your health care or payment for your healthcare.

OTHER USES AND DISCLOSURES: Other types of uses and disclosures of your PHI not described above will be made only with your written authorization, which with some limitations; you have the right to revoke your authorization in writing. If you revoke your authorization, Practice will no longer use or disclose PHI about you for the reasons covered in your authorization. Please understand that Practice is unable to recover any disclosures already made with your authorization, and that Practice is required to retain records of the care provided to you.

RIGHT TO FILE A COMPLAINT: At Practice, we value the relationships we develop with our patients, our patients' privacy, and the trust our patients have in us. As such, we make every effort to remedy any issues or concerns you may have. You may submit any complaint regarding your privacy right to:

Terri Newhouse, Privacy Officer

Arthritis & Rheumatic Care, LLC
197 Cedar Lane, Suite 2 (rear)
Teaneck, NJ 07666

You also have the right to file a complaint with the secretary of the Department of Health and Human Services, Office for Civil Rights. You will not be penalized for filing a complaint. You may contact the Office for Civil Rights.

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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: _____

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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

Name: _____ Signature: _____ Date: _____

Arthritis & Rheumatic Care, LLC
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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: _____