Advanced Rheumatology Solutions

New Patient Registration Form

General Information (please print)

Name DOB Sex (please circle) M ☐ F ☐

Social Sec # _____ Marital Status (please check) Single ☐ Married ☐ Divorced ☐ Widowed ☐

Primary Address

City State Zip Code

Home Phone _____ Work Phone _____ Cell Phone _____

Secondary Address

City State Zip Code

Email Address Authorize Email? (please check) Yes ☐ No ☐

Pharmacy Name Phone Fax

Employment Status (please circle) Employed ☐ Not Employed ☐ Retired ☐ Student ☐

Occupation

Emergency Contact Relationship Phone

Primary Insurance

Insurance Name Subscribers Name

Social Sec # DOB Relationship to insured

Secondary Insurance

Insurance Name Subscribers Name

Social Sec # DOB Relationship to insured

Accident Information

Is visit related to an auto accident? (please check) Y☐ N☐ If you answered yes, please complete the following information

Accident claim #_____ Accident Date Insurance co.

Adjuster's name Adjuster's phone

Attorney name Attorney phone

Patient Authorization for MEDICARE PATIENTS

I authorize Dr. Margaret Gradzka and her staff to release to the Social Security Administration, Health Care Financing Administration or its intermediaries or carriers and/or the above named Medigap any information needed for this or any Medicare and or Medigap claim. I permit a copy of the Authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who may cause Medicare payment information to cross over automatically to my supplemental insurer. I understand that I am financially responsible for any services deemed non-covered by Medicare.

Patient signature Date

Patient Authorization for PPO and HMO Patients

I authorize Dr. Margaret Gradzka and her staff to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above named insurance company to pay directly to Margaret Gradzka, M.D. the amount due for medical or surgical services. I understand that I am financially responsible for any services deemed non-covered by my insurance company.

Patient signature Date

Patient Authorization for ALL PATIENTS

I understand that I am financially responsible for services in the office and that refunds from services charged on a credit card will be returned to the same credit card. Furthermore, I also understand that any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all cost and fees relating to the collection of my debt. I also authorize Dr. Margaret Gradzka and staff to photograph me for medially related documentation purposes.

Patient Signature Date

Patient Phone Message Consent

It is our policy to notify you to confirm appointments. This is to acknowledge that you authorize us to:

Leave a detailed message on voicemail/answering machine (Please check AND initial) Yes☐ _____ No☐ _____

Leave a detailed message with individual answering the phone (Please check AND initial) Yes☐ No☐

ACKNOWLEDGEMENT OF RECEIPT OF PRIVATE PRACTICES

Notice to patients: We are required to provide you with a copy of our Notice of Privacy Practices which states how we may us and/or disclose our health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign the acknowledgement, if you wish. I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Printed Name: Signature: Date