RA RHEUMATOLOGY ASSOCIATES

No Show/Cancellation Policy

Policy

Patients are expected to keep scheduled appointments. If they wish to cancel their appointment, they should contact our office no later than 24 hours prior to their appointment time. (Exception: Notification for cancellation of Monday appointment should be given no later than 12:00 pm on the Friday before the appointment)

Definition of a No-Show

A scheduled appointment for which a patient did not show up at the appropriate office prior to the appointment time and 24 hour advanced notice was not given.

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Receipt of Cancellation Policy

I have received and understand the Rheumatology Associates policy and definitions regarding cancellations. _____ (*initials*)

Insurance Authorization

I hereby authorize any and all insurance benefits be paid directly to the physician and acknowledge that I am financially responsible for any unpaid balance. I understand that if my account should be turned over to a collection agency that I will be responsible for any fees incurred, up to and including 35% of the unpaid balance. I also authorize the physician to release any information required by my insurance company. _____ (*initials*)

Consent to Obtain External Prescription History

I authorize Rheumatology Associates and its providers to view my external prescription history via the RxHub service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit manager may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. _____ (*initials*)

General Authorization for Treatment

I authorize physicians, nurse practitioners and/or physician assistants of **Rheumatology Associates** who attend to me, their assistants, including those employed by **Rheumatology Associates** to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my provider. These services may include pathology, radiology, emergency services and other special services ordered by my provider. In consenting to treatment, I have not relied on any statements as to results. I further authorize my provider to examine, use, store, and/or dispose of in any manner any tissue, fluids or parts removed from my body. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C and HIV. _____ (*initials*)

Additional Treatment Opportunities

The doctors at Rheumatology Associates are involved in research that is designed to lead to better treatments for the types of medical problems experienced by the people who come to this clinic. As such, if they feel there is an opportunity that would be medically appropriate for you, you may be contacted by a qualified professional on their staff.

Patient Signature: _____ Date: _____