RA RHEUMATOLOGY ASSOCIATES

Cancellation/No Show Policy

A “no-show” is someone who misses an appointment without notifying the office a minimum of one business day prior. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a “no-show”. A total of 2 “no-show” appointments within the past 12 months, may result in being discharged from the practice.

Patients are expected to keep their scheduled appointments. In order to be respectful of the medical needs of other patients, please be courteous and call the office promptly if you are unable to show up for a scheduled appointment. If you need to cancel or reschedule your appointment, please contact our office at 214-540-0700 no later than 24 hours prior to your appointment time. (Exception: Notification for Monday appointments should be given no later than 12:00 pm on the Friday before your appointment).

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Name _____ **Cell #** _____
E-Mail _____ **DOB** _____

Receipt of Notice of Privacy Practices

I, _____, have received a copy of Rheumatology Associates' Notice of Privacy Practices.

_____
Patient Signature

Patient Request Regarding Health Information Release

(Friends/Family only – Not physicians)

Who to Contact

By completing and signing this document I hereby give permission to Rheumatology Associates to disclose as well as discuss any Protected Health Information related to my medical condition(s) with the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ **I do not wish to give access to my Protected Health Information to anyone besides myself regarding my medical condition**

How to Contact
Note that you are responsible for any charges incurred in receiving our communications.

Alternate Form of Communication:

_____

_____
Patient Signature Date

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Legal Representative

If the patient has a legal representative who will be signing these forms for them please fill out the information below.

Legal Representative Name	**Legal Representative Signature**
Legal Representative E-Mail	**Legal Representative Cellphone #**

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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: _____