The Arthritis Clinic LLC

Appointment Date:_____ **Appointment time:**_____

Thank you for selecting The Arthritis Clinic for your health care needs. We look forward to meeting you and getting you on the road to recovery.

To aid the doctor in your diagnosis and treatment plan, we ask that you complete the enclosed paperwork. Please print all information and bring your completed forms to the office with you for your visit.

Please arrive 15 minutes prior to your appointment. Forms must be completed before you can be seen. Allow a minimum of 2 hours for your first visit.

You are required to confirm this appointment.
Call 330-262-1500 to confirm 24-48 hours before your scheduled appointment. If you do not speak to someone, leave a message with your name, appointment date and time with a confirmation that you will be at your appointment. If scheduled on Friday, please call on Wednesday. (Our office is closed on Thursdays.)

If you need to reschedule your appointment, we request 24 hours notice to accommodate someone waiting for care.

**** Please note: If you do not confirm this appointment, your appointment time will be given to someone on our waiting list who is in need of care.**

Please bring the following items with you for your appointment:

- Completed Forms
- Current insurance card(s)
- Photo ID
- Shorts or loose-fitting pants that can be pulled above the knee
- Detailed list of all medications/supplements you are currently taking with dosages
- Notes from your last visit to your family doctor; ** last 2 office visit notes, recent labs and radiology should be faxed to 330-262-2294 BEFORE your appointment

The time you spend with the doctor is very important to you and the doctor. So that you may both focus on the reason for your visit, we ask that you please:

- Do not bring small children with you to your initial appointment
- Refrain from using your cell phone while in the office

All copays, unmet deductibles and self pay amounts are due at the time of service. If you cannot pay, you will be rescheduled. For questions, call the insurance/billing office at 330-262-1500, option 3.

If you have questions, do not hesitate to call our office at 330-262-1500

Your health is important to us! We look forward to meeting you.

**We are located in the HealthPoint Building. It is the second building from the corner of Friendsville Road and Milltown Road between the Milltown Building and the Akron General Children's Building.

3727 Friendsville Rd., Ste. 3 Wooster, OH 44691 Phone 330-262-1500 Fax 330-262-2294

AMERICAN COLLEGE of RHEUMATOLOGY
Empowering Rheumatology Professionals

Patient History Form

Date of first appointment: ____/____/____ (MONTH / DAY / YEAR) Time of appointment: _____ Birthplace: _____

Name: _____ (LAST / FIRST / MIDDLE INITIAL / MAIDEN) Birthdate: ____/____/____ (MONTH / DAY / YEAR)

Address: _____ (STREET / APT#) Age _____ Sex: ☐ F ☐ M

_____ (CITY / STATE / ZIP) Telephone: Home: (____) _____ Work: (____) _____

MARITAL STATUS: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse/Significant Other: ☐ Alive/Age _____ ☐ Deceased/Age _____ Major Illnesses: _____

EDUCATION *(circle highest level attended):*

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of hours worked/Average per work: _____

Referred here by: *(check one)* ☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Describe briefly your present symptoms: _____

_____

_____

_____

_____

Date symptoms began *(approximate)*: _____

Diagnosis: _____

Previous treatment for this problem *(include physical therapy, surgery and injections; medications to be listed later)*:

_____

_____

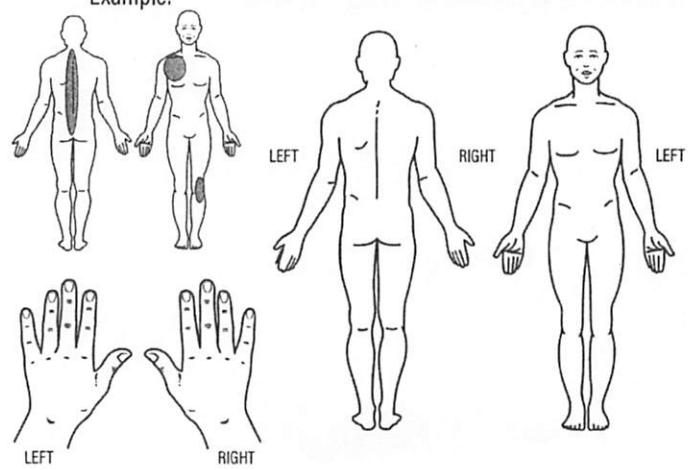
_____

Please list the names of other practitioners you have seen for this problem:

_____

_____

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands.**



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9): 1797-808. Used by permission.

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? *(check if "yes")*

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood Arthritis			Osteoporosis	

Other arthritis conditions: _____

Patient's Name: _____ Date: _____ Physician Initials: _____

SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day? _____

Do you smoke? ☐ Yes ☐ No ☐ Past – How long ago? _____

Do you drink alcohol? ☐ Yes ☐ No Number per week _____

Has anyone ever told you to cut down on your drinking?

☐ Yes ☐ No

Do you use drugs for reasons that are not medical? ☐ Yes ☐ No

If yes, please list: _____

_____

Do you exercise regularly? ☐ Yes ☐ No

Type _____

Amount per week _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ☐ Yes ☐ No

Do you wake up feeling rested? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Do you now have or have you ever had: *(check if "yes)*

☐ Cancer	☐ Heart problems	☐ Asthma
☐ Goiter	☐ Leukemia	☐ Stroke
☐ Cataracts	☐ Diabetes	☐ Epilepsy
☐ Nervous breakdown	☐ Stomach ulcers	☐ Rheumatic fever
☐ Bad headaches	☐ Jaundice	☐ Colitis
☐ Kidney disease	☐ Pneumonia	☐ Psoriasis
☐ Anemia	☐ HIV/AIDS	☐ High Blood Pressure
☐ Emphysema	☐ Glaucoma	☐ Tuberculosis

Other significant illness *(please list)* _____

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

PREVIOUS SURGERIES

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ☐ No ☐ Yes *Describe:* _____

Any other serious injuries? ☐ No ☐ Yes *Describe:* _____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number deceased _____

Number of children _____ Number living _____ Number deceased _____ List ages of each _____

Health of children _____

_____

Do you know any blood relative who has or had: (check and give relationship)

☐ Cancer _____	☐ Heart disease _____	☐ Rheumatic fever _____	☐ Tuberculosis _____
☐ Leukemia _____	☐ High blood pressure _____	☐ Epilepsy _____	☐ Diabetes _____
☐ Stroke _____	☐ Bleeding tendency _____	☐ Asthma _____	☐ Goiter _____
☐ Colitis _____	☐ Alcoholism _____	☐ Psoriasis _____	

Patient's Name: _____ Date: _____ Physician Initials: _____

MEDICATIONS

Drug allergies: ☐ No ☐ Yes If yes, please list: _____

_____

Type of reaction: _____

PRESENT MEDICATIONS *(List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)*

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped?		
			A Lot	Some	Not At All
1.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐

PAST MEDICATIONS: Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the results of taking the medication and list any reactions you may have had. *Record your comments in the spaces provided.*

Drug names/Dose	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not At All	
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		☐	☐	☐	
Circle any you have taken in the past Flurbiprofen Diclofenac + misoprostil Aspirin (including coated aspirin) Celecoxib Sulindac Oxaprozin Salsalate Diflunisal Piroxicam Indomethacin Etodolac Meclofenamate Ibuprofen Fenoprofen Naproxen Ketoprofen Tolmetin Choline magnesium trisalcylate Diclofenac					
Pain Relievers					
Acetaminophen		☐	☐	☐	
Codeine		☐	☐	☐	
Propoxyphene		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Disease Modifying Antirheumatic Drugs (DMArDS)					
Certolizumab		☐	☐	☐	
Golimumab		☐	☐	☐	
Hydroxychloroquine		☐	☐	☐	
Penicillamine		☐	☐	☐	
Methotrexate		☐	☐	☐	
Azathioprine		☐	☐	☐	
Sulfasalazine		☐	☐	☐	
Quinacrine		☐	☐	☐	
Cyclophosphamide		☐	☐	☐	
Cyclosporine A		☐	☐	☐	
Etanercept		☐	☐	☐	
Infliximab		☐	☐	☐	
Tocilizumab		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	

Patient's Name: _____ Date: _____ Physician Initials: _____

PAST MEDICATIONS *Continued*

Drug names/Dose	Length of time	Please check: Helped? A Lot	Some	Not At All	Reactions
Osteoporosis Medications					
Estrogen		☐	☐	☐	
Alendronate		☐	☐	☐	
Etidronate		☐	☐	☐	
Raloxifene		☐	☐	☐	
Fluoride		☐	☐	☐	
Calcitonin injection or nasal		☐	☐	☐	
Risedronate		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Gout Medications					
Probenecid		☐	☐	☐	
Colchicine		☐	☐	☐	
Allopurinol		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Others					
Tamoxifen		☐	☐	☐	
Tiludronate		☐	☐	☐	
Cortisone/Prednisone		☐	☐	☐	
Hyaluronan		☐	☐	☐	
Herbal or Nutritional Supplements		☐	☐	☐	

Please list supplements:

Have you participated in any clinical trials for new medications? ☐ Yes ☐ No

If yes, list:

Patient's Name: _____ Date: _____ Physician Initials: _____

SYSTEMS REVIEW

As you review the following list, please check any problems, which have significantly affected you:

Date of last mammogram: ____/____/____ Date of last eye exam: ____/____/____ Date of last chest x-ray: ____/____/____

Date of last Tuberculosis Test ____/____/____ Date of last bone densitometry ____/____/____

Constitutional
- ☐ Recent weight gain amount _____
- ☐ Recent weight loss amount _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever

Eyes
- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye
- ☐ Itching eyes

Ears-Nose-Mouth-Throat
- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Dryness in nose
- ☐ Runny nose
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness of mouth
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty swallowing

Cardiovascular
- ☐ Chest Pain
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat
- ☐ High blood pressure
- ☐ Heart murmurs

Respiratory
- ☐ Shortness of breath
- ☐ Difficulty breathing at night
- ☐ Swollen legs or feet
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing (asthma)

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting of blood or coffee ground material
- ☐ Stomach pain relieved by food or milk
- ☐ Jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools
- ☐ Heartburn

Genitourinary
- ☐ Difficult urination
- ☐ Pain or burning on urination
- ☐ Blood in urine
- ☐ Cloudy, "smoky" urine
- ☐ Pus in urine
- ☐ Discharge from penis/vagina
- ☐ Getting up at night to pass urine
- ☐ Vaginal dryness
- ☐ Rash/ulcers
- ☐ Sexual difficulties
- ☐ Prostate trouble

For Women Only:

Age when periods began: _____

Periods regular? ☐ Yes ☐ No

How many days apart? _____

Date of last period? ____/____/____

Date of last pap? ____/____/____

Bleeding after menopause? ☐ Yes ☐ No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal
- ☐ Morning stiffness

  Lasting how long?

  _____Minutes _____ Hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint swelling

  List joints affected in the last 6 mos.

_____

_____

_____

_____

_____

Integumentary (skin and/or breast)
- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive (sun allergy)
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet in the cold

Neurological System
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle spasm
- ☐ Loss of consciousness
- ☐ Sensitivity or pain of hands and/or feet
- ☐ Memory loss
- ☐ Night sweats

Psychiatric
- ☐ Excessive worries
- ☐ Anxiety
- ☐ Easily losing temper
- ☐ Depression
- ☐ Agitation
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

Endocrine
- ☐ Excessive thirst

Hematologic/Lymphatic
- ☐ Swollen glands
- ☐ Tender glands
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Transfusion/when_____

Allergic/Immunologic
- ☐ Frequent sneezing
- ☐ Increased susceptibility to infection

Patient's Name: _____ Date: _____ Physician Initials: _____

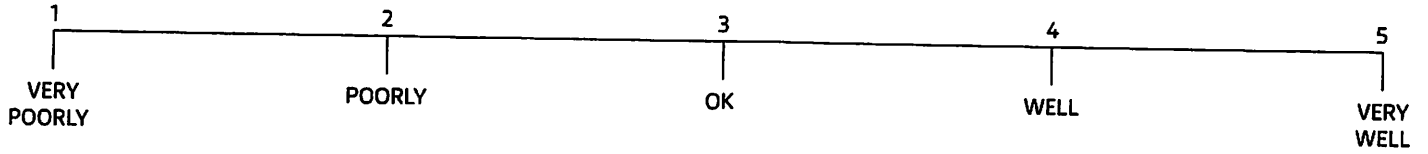
ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ☐ Yes ☐ No *If yes, how many?*

How many people in household? _____ Relationship and age of each _____

Who does most of the housework? _____ Who does most of the shopping? _____ Who does most of the yard work? _____

On the scale below, circle a number which best describes your situation; *Most of the time, I function...*



Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)	☐	☐	☐
Walking?	☐	☐	☐
Climbing stairs?	☐	☐	☐
Descending stairs?	☐	☐	☐
Sitting down?	☐	☐	☐
Getting up from chair?	☐	☐	☐
Touching your feet while seated?	☐	☐	☐
Reaching behind your back?	☐	☐	☐
Reaching behind your head?	☐	☐	☐
Dressing yourself?	☐	☐	☐
Going to sleep?	☐	☐	☐
Staying asleep due to pain?	☐	☐	☐
Obtaining restful sleep?	☐	☐	☐
Bathing?	☐	☐	☐
Eating?	☐	☐	☐
Working?	☐	☐	☐
Getting along with family members?	☐	☐	☐
In your sexual relationship?	☐	☐	☐
Engaging in leisure time activities?	☐	☐	☐
With morning stiffness	☐	☐	☐
Do you use a cane, crutches, walker or wheelchair? *(circle one)*	☐	☐	☐

What is the hardest thing for you to do? _____

Are you receiving disability? ..... Yes ☐ No ☐

Are you applying for disability? ..... Yes ☐ No ☐

Do you have a medically related lawsuit pending? ..... Yes ☐ No ☐

Patient's Name: _____ Date: _____ Physician Initials: _____

SPECIALIST LIST
AUTHORIZATION TO PROVIDE HEALTH INFORMATION

Patient Name: _____ **Date of birth:** _____

Patient Signature: _____ **Date:** _____

I request and authorize the following physicians/specialists to release healthcare information of the patient named above to:

Padma Vellanki, M.D. The Arthritis Clinic, LLC

Optometrist/Ophthalmologist

Name: _____ Phone: _____
Location: _____

Dermatologist

Name: _____ Phone: _____
Location: _____

Orthopedist

Name: _____ Phone: _____
Location: _____

Cardiologist

Name: _____ Phone: _____
Location: _____

Neurologist

Name: _____ Phone: _____
Location: _____

Pulmonologist

Name: _____ Phone: _____
Location: _____

Gastroenterologist

Name: _____ Phone: _____
Location: _____

Endocrinologist

Name: _____ Phone: _____
Location: _____

****Please list all other specialists on the reverse.**

PATIENT PROFILE

Please Print

Name_____ SS# _____
Last First Middle initial

Address_____ Date of birth_____

City_____ State_____ Zip_____ Sex: [ ] Male [ ] Female

Phone:_____ Home _____ Cell Marital Status:[ ] M [ ] S [ ] D [ ] Widowed

Employer _____ Phone: _____ [ ] Work [ ] Other

Email Address:_____

Pharmacy_____Location:_____ Pharmacy Phone:_____

Referring Physician:_____Phone_____ Primary Care Physician:_____

EMERGENCY CONTACTS Name: _____Phone other than patient:_____
Relationship: _____Spouse Name: _____ DOB_____

PRIMARY INSURANCE
Insurance Company _____ ID #_____Group #_____

SECONDARY INSURANCE
Insurance Company_____ ID#_____ Group#_____
Insured Person (if other than patient) _____ Relationship to Patient _____
Date of Birth _____ SS #_____
Employer_____

**The Arthritis Clinic, LLC will file Primary and Secondary insurance only. Claims to all other policies are the responsibility of the patient. No MEDICAID is accepted by The Arthritis Clinic, LLC. You are required to divulge any Medicaid policy upon the start of your plan. All patients found with a Medicaid policy will be released from care. All insurance policy changes must be disclosed when policy takes effect.

Guarantor (responsible party) [ ] Patient [ ] Other than Patient
Name_____DOB_____Relationship to patient: _____

Payment Policy – Patients are required to pay co-payments or outstanding balances at the time of service. If The Arthritis Clinic is out of network with your insurance company, all charges will be the responsibility of the patient. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Treatment Authorization - By signing below, I am authorizing treatment with Dr. Padma Vellanki of The Arthritis Clinic, LLC.

By signing below, I authorize disclosure of information necessary for treatment and the assignment of payments, including Medicare to The Arthritis Clinic LLC. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I authorize assignee to release all information necessary to secure payment.

I understand that appointments not cancelled within 24 hrs are subject to a $45 late-cancellation/no show fee.

Signature_____ Date_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

The Arthritis Clinic LLC
3727 Friendsville Rd. Ste 3
Wooster OH 44691

I understand that, under the Health Insurance Portability and Accountability act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct my treatment and follow among the multiple health-care providers who may be involved in that treatment directly
- Obtain payment from third party payers
- Conduct normal health-care operations such as quality assessment and physician certifications.
- Notify me of upcoming appointments

I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization 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 above to obtain the current copy of the notice of privacy practices

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health-care operations. I understand you are not required to agree to my requested restrictions but if you do then you are bound to abide by such restrictions.

Patient Name _____

Relation to Patient (self) _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

2016

The Arthritis Clinic LLC

3727 Friendsville Road, Suite 3
Wooster, Ohio 44691

Phone: 330.262.1500
Fax: 330.262.2294

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Maiden Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: The Arthritis Clinic

Address: Dr. Padma Vellanki MD
3727 Friendsville Road Suite 3
Wooster, Ohio 44691

City: _____ Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

The Arthritis Clinic LLC

AUTHORIZATION TO PROVIDE HEALTH INFORMATION

From the U.S. Department of Health & Human Services

"Do I have to give my health care provider written permission to share or discuss my health information with my family members, friends, or others involved in my care or payment for my care?

Answer:

HIPAA does not require that you give your health care provider written permission. However, your provider may prefer or require that you give written permission. You may want to ask about your provider's requirements"

It is the policy of The Arthritis Clinic that patients treated in this office list family members in whom the patient willingly gives permission to discuss his/her health information.

The following are given my permission to discuss my health information:

1._____relationship_____

2._____relationship_____

3._____relationship_____

If at any time I wish to revoke the permission given to the above person or persons, I understand that I am solely responsible for making such changes in writing to the Arthritis Clinic.

I understand and agree that unless there is a written document signed by me stating this revocation, I will not and cannot hold the staff of the Arthritis Clinic or Dr. Vellanki responsible for any disclosed information.

Patient signature:_____Date:_____

3727 Friendsville Rd. Ste 3 • Wooster, Ohio 44691 • Phone (330) 262-1500 • Fax (330) 262-2294

FINANCIAL POLICY AGREEMENT
The Arthritis Clinic, LLC

In becoming a patient at The Arthritis Clinic, LLC, I understand and agree to abide by the following financial policies of same. The following policies apply to all patients seen in our clinic.

NOTE: If a balance exists at your next scheduled visit, balances are due in full before being seen.

Charges for services provided at The Arthritis Clinic (known hereafter as TAC) are due as follows:

Patients with Medicaid coverage:
TAC does not accept Medicaid insurances. This includes Medicare with Medicaid (QMB), Buckeye, United HealthCare Community Plan, Medicaid, Molina, CareSource, Paramount, MyCare Ohio etc.

Patients with Medicare
Medicare Part B deductible begins each year on January 1st. If your supplement does not cover this deductible or you have no supplement, the deductible will be due at your visit upon verification of the remaining unmet deductible.

Patients with Medicare Advantage Plans
Copays or deductibles for Medicare advantage plans are due before seeing the doctor. All patients with a Medicare Advantage Plan are required to present their Medicare Beneficiary Identification or Social Security number to allow the confirmation of not having Medicaid with their Medicare.

Patients with insurance coverage: Commercial Carriers, Indemnity Plans
Copays, unmet insurance deductibles, and required co-insurance for services are due on the date of service.
PLEASE NOTE: Because copays may not cover all services at TAC, your insurance carrier may expect you to pay an amount above the copay for care. This balance will be due as your carrier designates.

Patients with no insurance coverage: Self pay
Services rendered to patients with no insurance coverage must be paid in full at the time of service. TAC provides a time-of-service discount for self-pay patients. All printouts of visits for reimbursement have a fee of $8.00.

Patients leaving TAC:
All balances must be paid in full upon your decision to discontinue care or upon your release from TAC.

Patients with delinquent accounts:
Patients are given 2 billing cycles to resolve the balance due on their account. At the 3rd billing cycle, accounts will be sent to collections at the discretion of the billing office. If collections are notified, you will be released from care from The Arthritis Clinic.

The patient understands it is his/her sole responsibility to present accurate insurance information to The Arthritis Clinic. As a patient, I must immediately inform the clinic of changes to my coverage. Should I not bring these updated changes causing claims to be rejected or unprocessed, I will be responsible for all charges in full.

I agree and understand that TAC does not guarantee payment from my insurance carrier for services rendered whether primary or secondary/supplemental carriers. I am aware that TAC will not enter into dispute over the processing or payment with said carrier(s) regarding payment, lack of payment or rejection of services. It is my responsibility as the insured to contact my insurance company in a timely manner to assure payment to TAC for my care.

By signing below, I agree that I am personally responsible for any and all covered and non-covered treatment costs rendered to me at The Arthritis Clinic. I agree that all deductibles, coinsurances, copays, and non-covered services are due as stated above. I am aware that TAC is not responsible for guaranteeing payment from any carrier.

***Checks returned for non-sufficient funds will incur a $40 returned check charge.**
***Patients not canceling appointments 24 hours prior to scheduled date/time will incur a $45 charge.**
***Reprinted lab/radiology orders will require a $5 reprint fee due at the time of reprint.**
***Credit card fees are added to all payments made with a credit card. Debit cards have no credit card fees.**

Patient signature:: _____ Date:: _____