PATIENT'S INFORMATION

Title____ First Name_____ Middle Initial_____ Last Name_____

Social Security # _____ _____Birthdate ____/____/____ Gender M__ F__

Home Address_____

City_____ State_____ Zip_____Home Phone_____ Cell

phone_____ Work Phone_____ Email address_____

Primary Language: _____ Marital Status: Married/Separated/Widowed/Single

Referring Physician: _____How did you learn about our practice_____

Race (Circle one): American Indian or Alaska Native/Asian/Native Hawaiian or Pacific Islander/

Black or African American/ White/ Hispanic/Other Race/Other Pacific Islander/Refuse to report

Ethnicity (Please circle one): Hispanic or Latino/ Non-Hispanic or Latino/ Refuse to report

EMERGENCY CONTACT INFORMATION

First Name: _____Middle Initial___ Last Name_____ Relation to patient_____

Home Address (if different from yours) _____

City_____ State_____ Zip_____ Contact phone _____

EMPLOYMENT

Occupation_____ Employer's Name _____

Work Address _____

City_____ State_____ Zip Code_____ Contact Phone_____

INSURANCE INFORMATION

Primary Insurance company_____ Policy # _____ Group #_____

Secondary Insurance company_____ Policy # _____ Group # _____

Primary Insured's Last Name_____ First Name_____ Middle Initial_____

Primary Insured's Home Address_____

City_____ State_____ Zip Code_____ Contact phone_____

SSN_____ Birthdate_____ Age_____ Gender____

PHARMACY INFORMATION

Name of the pharmacy: _____ Phone _____ Fax: _____

Address: _____

North Fulton Rheumatology

Arthritis, Bone and Connective Tissue Diseases

Ciela Lopez-Armstrong, M.D

770-619-0004/ 770-619-0252 (fax)

B. INSURANCE INFORMATION (Provide copies of all insurance cards & Driver's license to office)

1. Name of Insured_____ Policy #_____ Group #_____
2. Name of Insured_____ Policy #_____ Group #_____

C. PRIMARY INSURED'S INFORMATION--PERSON RESPONSIBLE FOR PAYMENT

Title_____ First Name_____ Middle Initial ____ Last Name_____

Home Address_____

City_____ State _____ Zip code_____ Work Phone_____

Mobile Phone_____ Home Phone_____

Social Security # _____-_____-_____ Birthdate ____/____/____ Age_____ Gender: M ___ F____

Employment

Occupation_____ Employer's Name _____

Work Address_____

City_____ State_____ ZipCode_____Work Phone ( ) _____

NFR

North Fulton Rheumatology

Arthritis, Bone and Connective Tissue Diseases

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A. CONSENT TO RECEIVE MEDICAL TREATMENT:

I hereby authorize North Fulton Rheumatology, PC and Dr. Ciela Lopez- Armstrong, and/ or her designee to examine me and to provide medical services.

Signature of Patient or Responsible _____ Date _____

B. AUTHORIZATION FOR PAYMENT FOR MEDICAL SERVICES:

I. I hereby authorize North Fulton Rheumatology, PC to release any and all information about my medical treatment to my insurance company as required or requested for purposes of processing claims to obtain payment for medical services rendered.

II. I hereby authorize my insurance company to make direct payment to North Fulton Rheumatology PC for any and all covered medical services rendered to me and payable to me and/or in accordance with contractual agreements and/or Medicare/Medicaid regulations in effect. I understand that I am personally responsible to pay North Fulton Rheumatology PC directly for co-pay, co-insurance and deductible amounts, if any, in accordance with contractual agreements and/ or Medicare/Medicaid regulations in effect and agree to do so.

III. I understand that I am personally responsible to pay North Fulton Rheumatology PC directly and in full for charges for any and all medical services rendered to me which :

a. **I have no insurance at all**
b. **I have insurance but the insurance does not cover the service(s.)**

Signature of Patient or Responsible Party _____ Date _____

C. Certification of Information Accuracy:

I certify that I have provided complete, current and accurate information to North Fulton Rheumatology, PC
regarding my personal, medical, and insurance information, including current and legitimate copies of my insurance card and driver's license.

Signature of Patient or Responsible Party _____ Date _____

North Fulton Rheumatology, P.C.

Arthritis, Bone and Connective Tissue Disease

Ciela Lopez-Armstrong, M.D.

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name_____ Date of Birth _____

Address _____ City _____

State _____ Zip Code _____ Phone _____

I HEREBY AUTHORIZE NORTH FULTON RHEUMATOLOGY P.C.:

____ Release my medical records to the following person/facility:_____

____ Speak or correspond with the following person or clinician regarding my treatment At North Fulton Rheumatology P.C.:

Name (or Facility): _____ Phone:_____

Address: _____ Fax: _____

Specify information to be released:

Treatment dates: From: _____ To: _____

Other: _____

_____ I HEREBY AUTHORIZE NORTH FULTON RHEUMATOLOGY P.C. TO **REQUEST** MY MEDICAL RECORDS FROM:

Name: _____

Address: _____ City, State, Zip Code: _____

Phone: _____ Fax: _____

_____ Sent via USPS / _____ Patient pick up / _____ send via Fax

I UNDERSTAND THAT NORTH FULTON RHEUMATOLOGY, P.C. MAY CHARGE A FEE FOR COPYING AND/OR MAILING MY MEDICAL RECORDS.

_____

Patient Signature_____ **Date:** _____

1300 Upper Hembree Rd. • Building 100, Suite A • Roswell, GA 30076
770-619-0004 • Fax 770-619-0252 • nfrpc@yahoo.com

NORTH FULTON RHEUMATOLOGY, PC
ACKNOWLEDGEMENT
OF
NOTIFICATION OF HIPAA PRIVACY PRACTICES

PATIENT SECTION:

North Fulton Rheumatology, PC, (the" Practice") has provided me a copy their current Notice of Privacy Practices on the date below and in accordance with requirements of the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I have been further advised that:

1. Any future changes to the Notice of Privacy Practices will be posted in the Practice office.
2. I may request additional copies of the Notice of Privacy Practices at any time.
3. I may direct my questions about the Notice of Privacy Practices to:

OFFICE MANAGER
NORTH FULTON RHEUMATOLOGY
1300 UPPER HEMBREE RD
BLDG 100-A
(770) 619-0004 / (770) 619-0252 FAX

Patient's Signature **Date Signed**

Patient's Printed Name:

PRACTICE NOTES ONLY:

The patient refused to sign this Acknowledgement on: _____

The patient refused to sign because:

Employee's Signature **Date Signed**

Employee's Printed Name:

HIPAA; Patient Acknowledgement
File: Patient Medical Record