EAST ALABAMA RHEUMATOLOGY CENTER a service of EAMC

INFORMATION SHEET

Patient Name: _____ **Preferred Name:** _____

DOB: _____ **SSN:** _____ **Sex:** _____ **Marital Status:** _____

Patient Ethnicity: Hispanic or Non-Hispanic *Please circle one* **Patient Race:** _____

Patient Address: _____

City/State/Zip _____

Contact numbers:

Home: _____ **Cell:** _____ **Work:** _____

Email: _____

Employer: _____

Preferred Pharmacy: _____ **City:** _____

Primary Care Provider: _____ **Referring MD:** _____

Emergency Contact: _____

Relation: _____ **Phone:** _____

Person Financially Responsible for charges: _____ *Name/Relation*

Address: _____

Primary Insurance: _____

Policy Number: _____ **Grp:** _____

Policy Holder (name/relation _____ **DOB:** _____ *If not Pt.

Secondary Insurance: _____

Policy Number: _____ **Grp:** _____

Policy Holder: _____ **DOB:** _____ *If not Pt.

I authorize all East AL Rheumatology Center (a service of EAMC) Physicians and/or whomsoever he/she may designate as his/her professional representative/assistant to discuss any aspect of my care, to include: appointments, tests, test results, surgical procedures, prescriptions, and any other pertinent information pertaining to my care with the following designated people. (if no one, leave blank)

1: _____ **4:** _____

2: _____ **5:** _____

3: _____ **6:** _____

This document will be a part of your permanent record. In the event that any of the selected representatives that you have designated change, it will be necessary to update our records with a written notification.

Authorization for Medical and Diagnostic Treatments

(1) I wish to receive treatment at East Alabama Rheumatology Center (EARC), a service of East Alabama Medical Center. While I am at EARC, I permit my doctor, EARC, and its employees, and all other persons caring for me to treat me in ways they judge are beneficial to me. (2) EARC sometimes serves as a training center for students in a variety of different health care professions. Students will sometimes be allowed to observe procedures which would benefit their educational experience. I do not object to students observing my care, treatment or procedures performed upon me. (3) I understand that medical equipment/supply company representatives will sometimes be present during a procedure to instruct medical personnel on new equipment or supplies. I do not object to these representatives being present during my care, treatment, or procedures performed upon me. (4) I understand that photographs or films may be taken during the course of my treatment to be made a part of my medical record. I do not object to the taking of these photographs or films

Release of Medical Information

I, the undersigned as the patient or his/her authorized representative, authorize EARC and any other professionals who provided care, treatment or services to release to my insurance company (ies) or their authorized representative or other appropriate agency (ies) that information which is necessary to validate this claim for payment purposes. This includes my employer if workers' compensation is claimed. EARC is also authorized to release to my physician(s), or the persons authorized to bill for them, such information as necessary for billing purposes, including, without limitation, all records and information pertaining to my medical treatment (including that for drug & alcohol abuse), laboratory & other diagnostic tests results, x-rays, therapy, diagnoses and prognosis. In the event that I am transferred to another healthcare facility, I authorize EARC to make a copy of my medical records for the receiving healthcare facility.

Release of Responsibility for Loss of Valuables

I understand that EARC will not be responsible for valuables, including jewelry, watches, money, etc., not specifically placed in the care of EARC through proper procedures. I also understand that EARC cannot be responsible for personal items such as clothing, glasses, dentures, etc., inadvertently damaged or misplaced during my course of treatment. I accept full responsibility for those valuables or personal items which I choose to keep in my possession.

Medicare and/or Medicaid Patient's Certification

I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release such information to the Social Security Administration of the State of Alabama or any of their intermediaries or carriers for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made to EARC and/or other physicians involved in my care on my behalf.

Patient's Signature: _____ **Date:** _____

or authorized representative **Authorized Representative: Relationship:** _____

If the patient or their authorized representative is unable to sign, state the reason why here: _____

Assignment of Insurance and Financial Responsibility

I authorize payment of all insurance benefits, basic and major medical, for this period of medical, emergency and/or diagnostic treatments, to be made directly to EARC. I understand that I am financially responsible for all charges not covered by my insurance plan, including but not limited to co-pays, deductibles, non-covered charges, professional fees and nurse practitioner professional fees. All efforts for collection of the benefits are for my convenience and do not represent a guarantee for collection or a credit to my account until such time as payment is received by EARC. I also assign the benefits payable for physicians' services to the physicians(s) furnishing the services, or authorize such physicians or physician group to submit a claim to my insurance company (ies), Medicare and/or Medicaid. I will be responsible for any collection fees, court cost and/or attorney fees incurred by EARC or any physician participating in my care while collecting on my account(s). Photocopies of this authorization are as valid as the original. I authorize EARC, its employees and agents to contact me at any/all phone numbers (including cell phone numbers) for the purpose of treatment, insurance and payment. I acknowledge that I may be contacted by telephone at any telephone number associated with my account including wireless telephone numbers, which could result in charges to me. I also may be contacted by text messages or emails, using any email address that is provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices. By my admission to EARC, I acknowledge that I am entering into a credit transaction as defined under The Fair Credit Reporting Act 15 U.S.C.§ 1681and that EARC may, with or without my knowledge, obtain a consumer credit report for all permissible purposes, including, but not limited to, debt collection activities and use the information in connection with a determination of the consumer's eligibility for a license or other benefit granted by a governmental instrumentality required by law to consider an applicant's financial responsibility or status.

Patient's Signature: _____ **Date:** _____

or authorized representative **Authorized Representative: Relationship:** _____

If the patient or their authorized representative is unable to sign, state the reason why here: _____