Rheumatology
of Central Indiana

NEW PATIENT REGISTRATION FORM

(PLEASE PRINT)

LAST NAME: _____ **FIRST NAME:** _____

MAILING ADDRESS: _____

_____

HOME PHONE #: _____ **CELL PHONE#:** _____

DATE OF BIRTH: _____ **AGE:** _____ **SEX:** _____

ETHNICITY: _____ **RACE:** _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

SOCIAL SECURITY #_____/_____/_____ **LANGUAGE:** _____

EMAIL ADDRESS: _____

EMPLOYMENT STATUS: FULL TIME PART TIME RETIRED NOT EMPLOYED

EMPLOYER NAME: _____

EMERGENCY CONTACT: _____

RELATIONSHIP TO PATIENT: _____ **PHONE#:** _____

ADDRESS: _____

_____

GUARANTOR'S NAME: _____

ADDRESS (IF DIFFERENT FROM PT): _____

_____

RELATIONSHIP TO PATIENT: _____

PHONE#_____**GUARANTOR'S DATE OF BIRTH:** _____

GUARANTOR'S SOCIAL SECURITY #: _____/_____/_____

Rheumatology
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MEDICAL HISTORY INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** _____

ARE YOU IN PAIN TODAY: _____ **PAIN LEVEL (1 LEAST- 10 MOST):** _____

WHERE IS YOUR PAIN LOCATED: _____

ALLERGIES: _____

MEDICAL HISTORY: DIABETES GOUT DEPRESSION ANXIETY OSTEOARTHRITIS

HIGH CHOLESTEROL HYPERTENSION RHEUMATOID ARTHRITIS ANKYLOSING SPONDYLITIS

PRIMARY CARE PHYSICIAN: _____

PREFERRED PHARMACY: _____

DO YOU SMOKE: _____ **HOW MANY PER DAY:** _____

DO YOU DRINK ALCOHOLIC BEVERAGES: _____ **HOW MANY PER MONTH:** _____

HAVE YOU EVER SEEN A RHEUMATOLOGIST? _____

PAST SURGERIES: _____

_____

PAST HOSPITALIZATIONS: _____

_____

FAMILY HISTORY: RHEUMATOID ARTHRITIS OSTEOARTHRITIS GOUT FIBROMYALGIA

LUPUS POLYMYALGIA RHEUMATICA PSORIATIC ARTHRITIS SJOGREN'S SYDROME

ANKYLOSING SPONDYLITIS

ANY OTHER AUTO IMMUNE DISEASES: _____

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LIST OF CURRENT MEDICATIONS: _____

NAME: _____ DOB: _____ TODAYS DATE: _____

ROUTINE ASSESSMENT OF PATIENT INDEX DATA

The RAPID3 includes a subset of core variables found in the Multi-dimensional HAQ (MD-HAQ). Page 1 of the MD-HAQ, shown here, includes an assessment of physical function (section 1), a patient global assessment (PGA) for pain (section 2), and a PGA for global health (section 3). RAPID3 scores are quickly tallied by adding subsets of the MD-HAQ as follows:

1. PLEASE CHECK THE ONE BEST ANSWER FOR YOUR ABILITIES AT THIS TIME:

OVER THE LAST WEEK, WERE YOU ABLE TO:	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
a. Dress yourself, including tying shoelaces and doing buttons?	___ 0	___ 1	___ 2	___ 3
b. Get in and out of bed?	___ 0	___ 1	___ 2	___ 3
c. Lift a full cup or glass to your mouth?	___ 0	___ 1	___ 2	___ 3
d. Walk outdoors on flat ground?	___ 0	___ 1	___ 2	___ 3
e. Wash and dry your entire body?	___ 0	___ 1	___ 2	___ 3
f. Bend down to pick up clothing from the floor?	___ 0	___ 1	___ 2	___ 3
g. Turn regular faucets on and off?	___ 0	___ 1	___ 2	___ 3
h. Get in and out of a car, bus, train, or airplane?	___ 0	___ 1	___ 2	___ 3
i. Walk two miles or three kilometers, if you wish?	___ 0	___ 1	___ 2	___ 3
j. Participate in recreational activities and sports as you would like, if you wish?	___ 0	___ 1	___ 2	___ 3
k. Get a good night's sleep?	___ 0	___ 1.1	___ 2.2	___ 3.3
l. Deal with feelings of anxiety or being nervous?	___ 0	___ 1.1	___ 2.2	___ 3.3
m. Deal with feelings of depression or feeling blue?	___ 0	___ 1.1	___ 2.2	___ 3.3

1. a-j FN (0-10):

1=0.3 16=5.3
2=0.7 17=5.7
3=1.0 18=6.0
4=1.3 19=6.3
5=1.7 20=6.7
6=2.0 21=7.0
7=2.3 22=7.3
8=2.7 23=7.7
9=3.0 24=8.0
10=3.3 25=8.3
11=3.7 26=8.7
12=4.0 27=9.0
13=4.3 28=9.3
14=4.7 29=9.7
15=5.0 30=10

2. PN (0-10):

3. PTGE (0-10):

RAPID3 (0-30)

2. HOW MUCH PAIN HAVE YOU HAD BECAUSE OF YOUR CONDITION OVER THE PAST WEEK? PLEASE INDICATE BELOW HOW SEVERE YOUR PAIN HAS BEEN:

NO PAIN — PAIN AS BAD AS IT COULD BE

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

3. CONSIDERING ALL THE WAYS IN WHICH ILLNESS AND HEALTH CONDITIONS MAY AFFECT YOU AT THIS TIME, PLEASE INDICATE BELOW HOW YOU ARE DOING:

VERY WELL — VERY POORLY

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

CONVERSION TABLE

Near Remission (NR): 1=0.3; 2=0.7; 3=1.0
Low Severity (LS): 4=1.3; 5=1.7; 6=2.0
Moderate Severity (MS): 7=2.3; 8=2.7; 9=3.0; 10=3.3; 11=3.7; 12=4.0
High Severity (HS): 13=4.3; 14=4.7; 15=5.0; 16=5.3; 17=5.7; 18=6.0; 19=6.3; 20=6.7; 21=7.0; 22=7.3; 23=7.7; 24=8.0; 25=8.3; 26=8.7; 27=9.0; 28=9.3; 29=9.7; 30=10.0

HOW TO CALCULATE RAPID 3 SCORES

1. Ask the patient to complete questions 1, 2, and 3 while in the waiting room prior to his/her visit.
2. For question 1, add up the scores in questions A-J only (questions K-M have been found to be informative, but are not scored formally). Use the formula in the box on the right to calculate the formal score (0-10). For example, a patient whose answers total 19 would score a 6.3. Enter this score as an evaluation of the patient's functional status (FN).
3. For question 2, enter the raw score (0-10) in the box on the right as an evaluation of the patient's pain tolerance (PN).
4. For question 3, enter the raw score (0-10) in the box on the right as an evaluation of the patient's global estimate (PTGE).
5. Add the total score (0-30) from questions 1, 2, and 3 and enter them as the patient's RAPID 3 cumulative score. Use the final conversion table to simplify the patient's weighed RAPID 3 score. For example, a patient who scores 11 on the cumulative RAPID 3 scale would score a weighed 3.7. A patient who scores between 0–1.0 is defined as near remission (NR); 1.3–2.0 as low severity (LS); 2.3–4.0 as moderate severity (MS); and 4.3–10.0 as high severity (HS).

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PRESCRIPTION REFILL POLICY

- NO PRESCRIPTION REFILLS WILL BE SENT ON WEEKENDS OR HOLIDAYS
- WE REQUIRE 48 HOURS MINUMUM TO PROCESS REQUESTS
- THE PATIENT IS RESPONSIBLE FOR KNOWING WHEN MEDICATIONS NEED TO BE REFILLED (WE WILL NOT CALL PRESCRIPTIONS IN EARLY)
- PRESCRIPTIONS WILL NOT BE FILLED FOR WALK IN PATIENTS (ONLY PTS SEEN)
- CONTROLLED SUBSTANCES/NARCOTIC PRESCRIPTIONS REQUIRE A FOLLOW UP APPOINTMENT EVERY 30-90 DAYS AND WILL NOT BE DONE FOR MAIL ORDER
- NEW SYMPTOMS REQUIRE AN APPOINTMENT
- NO REFILLS ON LOST, STOLEN, MISPLACED, OVERUSED PRESCRIPTIONS
- PATIENT MUST PICK UP HIS/HER SCRIPT IN PERSON, UNLESS PRE-ARRANGED BY STAFF
- MEDICATIONS ARE FOR THE SCRIBED INDIVIDUAL'S USE ONLY. SHARING PRESCRIBED MEDICATIONS WITH OTHERS IS ILLEGAL

THESE PROTOCOLS ARE PER RECOMMENDATIONS OF THE INDIANA BOARD OF MEDICAL EXAMINERS AND DEA

I UNDERSTAND AND ACCEPT THE PROTOCOL LISTED ABOVE. FAILURE TO COMPLY MAY RESULT IN IMMEDIATE TERMINATION OF PRESCRIPTION MEDICATIONS.

_____ _____

PATIENT SIGNATURE DATE

_____

PRINTED NAME

_____ _____

WITNESS SIGNATURE DATE

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BIOLOGIC INFUSION AND INJECTION FINANCIAL POLICY

(THIS IS SIGNED IN CASE YOU ARE PRESCRIBED THESE MEDICATIONS IN THE FUTURE)

I AUTHORIZE ANY RELEASE OF ANY INFORMATION ACQUIRED IN THE COURSE OF TREATMENT NECESSARY TO COMPLETE AND FILE MEDICAL CLAIMS TO MY INSURANCE COMPANY OR MEDICARE ON MY BEHALF. I HEREBY ACKNOWLEDGE FINANCIAL RESPONSIBILITIES FOR COSTS OF SERVICES RENDERED FOR ME OR FOR THE PERSON WHOSE ACCOUNT I AM ACTING AS GUANTOR. I AUTHORIZE (ASSIGN) ANY INSURANCE OR MEDICARE BENEFITS TO BE PAID DIRECTLY TO MEDICAL GROUP OF INDIANA, LLC (DBA: RHEUMATOLOGY OF CENTRAL INDIANA) OR ITS ASSIGNEES. I AM RESPONSIBLE FOR ANY NON-COVERED SERVICES, SUPPLIES, CO-PAYS, OR DEDUCTIBLES. I AM RESPONSIBLE FOR KNOWING HOW MY INSURANCE BENEFITS WORK AND I REQUEST MEDICAL SERVICES AT THIS OFFICE. THIS ACCEPTANCE AND ASSIGNMENT WILL BE IN FORCE FOR ALL FUTURE SERVICES BY PRACITIONERS FROM THIS OFFICE FROM THIS OFFICE.

I AGREE TO HAVE MY INSURANCE VERIFIED AT EVERY CHECK IN FOR ANY BIOLOGIC INFUSION OR INJECTIONS. AT ANY TIME THAT I HAVE AN ISURANCE CHANGE, I AGREE TO INFORM MEDICAL GROUP OF INDIANA (RHEUMATOLOGY OF CENTRAL INDIANA) IMMEDIATELY. FAILURE TO DO SO WILL RESULT IN IT BEING UNCOVERED BY INSURANCE AND THE BILLED AMOUNT WILL BE MY RESPONSIBILITY. PRIOR AUTHORIZATION MUST BE OBTAINED BEFORE INFUSION OR INJECTIONS MAY BE GIVEN. IN THE EVENT THAT MY INSURANCE PENDING AMOUNT OR MY RESPONSIBLE AMOUNT BECOMES TOO HIGH, I UNDERSTAND THAT MY INFUSION OR INJECTIONS WILL BE PUT ON HOLD UNTIL THE MATTER HAS BEEN RESOLVED.

IN THE EVENT THAT MY ACCOUNT BALANCE BECOMES PAST DUE OR DELINQUENT, I UNDERSTAND THAT COLLECTION PROCEEDINGS MAY ENSURE AND MY ACCOUNT MAY BE SENT TO A COLLECTION AGENCY. IN CONSIDERATION OF THE SERVICES PROVIDED TO ME, I HEREBY GUARANTEE PAYMENT IN FULL OF MY ACCOUNT IN ACCORDANCE WITH THE FINANCIAL ARRANGEMENTS MADE AT THE TIME OF SERVICE OR, IF NO SUCH ARRANGEMENTS ARE MADE, IN THE EVENT OF DEFAULT OF PAYMENT, REASONABLE COLLECTION AGENCY FEES EQUAL TO 30% OF THE DELINQUENT BALANCE AND REASONALE ATTORNEY FEES, SHALL BE ADDED TO THE ACCOUNT DUE ON THE ACCOUNT, PLUS ANY APPLICALBE COURT COSTS. BY SIGNING, I EXPRESSLY CONSENT AND AGREE TO MEDICAL GROUP OF INDIANA, LLC, (RHEUMATOLOGY OF CENTRAL INDIANA) AND THEIR AFFLIATES, AGENTS AND SERVICE PROVIDERS MAY USE WRITTEN, ELECTRONIC, OR VERBAL MEANS TO CONTACT ME. THIS CONSENT INCLUDES, BUT IT NOT LIMITED TO, CONTACT BY MANUAL METHODS, PRERECORDED OR ARTIFICIAL VOICE MESSAGES, TEXT MESSAGES, EMAILS/ AUTOMATIC TELEPHONE DIALING SYSTEMS. I AGREE THAT MEDICAL GROUP OF INDIANA (RHEUMATOLOGY OF CENTRAL INDIANA) AND THEIR AFFLIATE, AGENTS, AND SERVICE PROVIDERS MAY USE ANY EMAIL ADDRESS OR TELEPHONE NUMBER I PROVIDE, NOW OR IN THE FUTURE, INCLUDING A NUMBER FOR A CELLULAR PHONE OR OTHER WIRELESS DEVICE, REGARDLESS OF WHETHER I INCURE CHARGES AS A RESULT.

_____ _____

SIGNATURE OF PATIENT DATE

Rheumatology
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MEDICAL APPOINTMENT CANCELLATION/NO-SHOW POLICY

THANK YOU FOR TRUSTING YOUR MEDICAL CARE TO RHEUMATOLOGY OF CENTRAL INDIANA. WHEN YOU SCHEDULE WITH ROCI, WE SET ASIDE ENOUGH TIME TO PROVIDE YOU WITH THE HIGHEST QUALITY OF CARE. SHOULD YOU NEED TO CANCEL OR RESCHEDULE AN APPOINTMENT, PLEASE CONTACT OUR OFFICE NO LATER THAN **48 HOURS PRIOR** TO YOUR SCHEDULED APPOINTMENT TIME. THIS ALLOWS US TIME TO SCHEDULE OTHER PATIENTS WHO MAY BE WAITING FOR AN APPOINTMENT.

NEW PATIENTS WHO DO NOT SHOW FOR THEIR FIRST SCHEDULED APPOINTMENT WILL NOT BE ASSESSED A FEE FOR THE FIRST INFRACTION. HOWEVER, IF THEY ARE RESCHEDULED AND DO NOT SHOW FOR THE SECOND APPOINTMENT, THE PATIENT WILL BE ASSSESSED A $50 NO SHOW FEE AND THE PATIENT WILL NOT BE ACCEPTED INTO OUR PRACTICE.

ESTABLISHED PATIENTS WHO DO NOT GIVE A 48 HOUR NOTICE TO CANCEL AN APPOINTMENT COULD BE ASSESSED A $50 NO-SHOW FEE FOR THE FIRST AND SECOND INFRACTION. IF THERE IS A THIRD NO-SHOW, A FEE WILL BE ASSESSED AND THE PATIENT WILL BE DISMISSED FROM OUR PRACTICE.

A PATIENT IS CONSIDERED LATE IF THEY ARRIVE 15 MINUTES AFTER THEIR SCHEDULED APPOINTMENT TIME AND WILL NEED TO BE RESCHEDULED.

I HAVE READ AND UNDERSTAND THE MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY AND AGREE TO ITS TERMS.

_____ _____

PATIENT SIGNATURE **DATE**

_____ _____

PRINTED PATIENT NAME **DATE**

Rheumatology
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RELEASE OF INFORMATION

NAME: _____

DATE OF BIRTH: _____/_____/_____ **SOCIAL SECURITY#:** _____/_____/_____

I HEREBY GIVE MY CONSENT TO MEDICAL GROUP OF INDIANA, LLC (RHEUMATOLOGY OF CENTRAL INDIANA) TO DISCUSS MY CONDITION, RESULTS, AND MEDICAL EXAMINATIONS WITH:

NAME: _____ RELATIONSHIP TO PT: _____

NAME: _____ RELATIONSHIP TO PT: _____

NAME: _____ RELATIONSHIP TO PT: _____

MAY WE CONTACT YOU BY MAIL?	**YES**	**NO**
MAY WE LEAVE MESSAGES REGARDING APPOINTMENTS ON YOUR VOICEMAIL?	**YES**	**NO**
MAY WE LEAVE MESSAGES REGARDING TEST RESULTS ON YOUR VOICEMAIL?	**YES**	**NO**
MAY WE LEAVE MESSAGES REGARDING MEDICATIONS ON YOUR VOICEMAIL?	**YES**	**NO**
MAY WE CONTACT YOUR EMPLOYER CONCERNING INSURANCE DENIALS AND ANY ADDITIONAL INFORMATION FOR FILING A CLAIM?	**YES**	**NO**
MAY WE DISCUSS HEALTH INFORMATION VIA TEXT MESSAGES?	**YES**	**NO**

_____ _____

PATIENT SIGNATURE **DATE**

Rheumatology
of Central Indiana

FINANCIAL POLICY, ASSIGNMENT INFORMATION AND RELEASE OF INFORMATION

I AUTHORIZE RELEASE OF ANY INFORMATION ACQUIRED IN THE COURSE OF TREATMENT NECESSARY TO COMPLETE AND FILE MEDICAL CLAIMS TO MY INSURANCE COMPANY OR MEDICARE ON MY BEHALF. I HEREBY ACKNOWLEDGE FINANCIAL RESPONSIBILITY FOR COSTS OF SERVICES RENDERED FOR ME OR FOR THE PERSON WHO ACCOUNT I AM ACTING AS GUARANTOR. I AUTHORIZE ANY INSURANCE OR MEDICARE BENEFITS TO BE PAID DIRECTLY TO MEDICAL GROUP OF INDIANA, LLC. (RHEUMATOLOGY OF CENTRAL INDIANA) OR ITS ASSIGNEES. I AM RESPONSIBLE FOR ANY NON-COVERED SERVICES, SUPPLIES, CO-PAYS, OR DEDUCTIBLES. I AM RESPONSIBLE FOR KNOWING HOW MY INSURANCE BENEFITS WROK AND I REQUEST MEDICAL SERVICES AT THIS OFFICE. THIS ACCEPTANCE AND ASSIGNMENT WILL BE IN FORCE FOR ALL FUTURE SERVICES BY PRACTITIONERS FROM THIS OFFICE

IN THE EVENT THAT MY ACCOUNT BALANCE BECOMES PAST DUE OR DELINQUENT, I UNDERSTAND THAT COLLECTION PROCEEDINGS MAY ENSURE AND MY ACCOUNT MAY BE SENT TO A COLLECTION AGENCY. IN CONSIDERATION OF THE SERVICES PROVIDED TO ME, I HEREBY GUARANTEE PAYMENT IN FULL OF MY ACCOUNT IN ACCORDANCE WITH THE FINANCIAL ARRANGEMENTS MADE AT THE TIME OF SERVICE OR, IF NO SUCH ARRANGEMENTS ARE MADE, IN THE EVENT OF DEFAULT PAYMENT, REASONABLE COLLECTION AGENCY FEES EQUAL TO 30% OF THE DELINQUENT BALANCE AND REASONABLE ATTORNEY FEES SHALL BE ADDED TO THE AMOUNT DUE ON THE ACCOUNT, OLUS ANY APPLICALBE COURT COSTS. BY SIGNING, I EXPRESSLY CONSENT AND AGREE TO ROCI AND THEIR AFFLIATES, AGENTS, AND SERVICE PROVIDERS MAY USE WRITTEN, ELECTRONIC, TEXT MESSAGES, EMAILS AND/OR AUTOMATIC TELEPHONE DIALING SYSTEMS. I AGREE THAT MEDICAL GROUP OF INDIANA AND THEIR AFFLIATES, AGENTS, AND SERVICE PROVIDERS MAY USE ANY EMAIL ADDRESS OR ANY TELEPHONE NUMBER I PROVIDE, NOW OR IN THE FUTURE, INCLUDING A NUMBER FOR A CELLULAR PHONE OR OTHER WIRELESS DEVICE, REGARDLESS OF WHETHER I INCUR CHARGES AS A RESULT.

_____ _____

PATIENT SIGNATURE **DATE**

Rheumatology
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ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I UNDERSTAND THAT AS PART OF MY HEALTH CARE, MEDICAL GROUP OF INDIANA ORGINATES AND MAINTAINS PAPER AND/OR ELECTRONIC RECORDS DESCRIBING MY HEALTH HISTORY, SYMPTOMS, EXAMINATION, TEST RESULTS, DIAGNOSES, TREATMENT AND ANY PLANS FOR FUTURE CARE OR TREATMENT. I UNDERSTAND THAT THIS INFORMATION SERVES AS:

- A BASIS FOR PLANNING MY CARE AND TREATMENT
- A MEANS OF COMMUNICATION AMONG THE MANY HEALTH PROFESSIONALS WHO CONTRIBUTE TO MY CARE
- A SOURCE OF INFORMATION FOR APPLYING MY DIAGNOSIS AND SURGICAL INFORMATION TO MY BILL
- A MEANS BY WHICH A THIRD-PARTY PAYER CAN VERIFY THAT SERVICES BILLED WERE ACTUALLY PROVIDED, AND A TOOL FOR ROUTINE HEALTHCARE OPERATIONS SUCH AS ASSESSING QUALITY

I UNDERSTAND THAT MEDICAL GROUP OF INDIANA, LLC (RHEUMATOLOGY OF CENTRAL INDIANA) MAINTAINS A NOTICE OF PRIVACY PRACTICES THAT PROVIDES A MORE COMPLETE DESCRIPTION OF INFORMATION USES AND DISCLOSURES. THE MOST RECENT VERSION OF THIS NOTICE IS DISPLAYED IN THE WAITING ROOM AREA. I UNDERSTAND THAT MEDICAL GROUP OF INDIANA (ROCI), RESERVES THE RIGHT TO CHANGE THIS NOTICE AND ITS PRACTICES AS NEEDED AND WILL MAKE A REASONABLE ATTEMPT TO INFORM ME OF ANY CHANGES. I UNDERSTAND THAT I CAN REQUEST AN ADDITIONAL WRITTEN COPY OF THIS NOTICE AT ANY TIME. I UNDERSTAND THAT I HAVE THE FOLLOWING RIGHTS AND PRIVILEDGES:

- **THE RIGHT TO REVIEW THE NOTICE PRIOR TO SIGNING THIS CONSENT, AND THE RIGHT TO REQUEST RESTRICTIONS AS TO HOW MY HEALTH INFORMATION MAY BE USED OR DISCLOSED**

_____ _____

PATIENT SIGNATURE **DATE**

Rheumatology
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ADULT PATIENT CONSENT FOR TREATMENT FORM

I, _____, HEREBY GIVE MY CONSENT TO RECEIVE COMPREHENSIVE HEALTH SERVICES AT RHEUMATOLOGY OF CENTRAL INDIANA. I FURTHER AUTHORIZE ANY HEALTH PROFESSIONALD WORKING FOR RHEUMATOLOGY OF CENTRAL INDIANA TO PROVIDE MEDICAL TESTS, PROCEDURES, AND TREATMENTS THAT ARE NECESSARY OR ADVISABLE FOR THE MEDICAL EVALUATION AND MANAGEMENT OF MY HEALTH CARE. THIS INCLUDES EXAMINATIONS, BLOOD TESTS, LABORATORY AND IMAGING PROCEDURES, MEDICATIONS, UNFUSIONS, NURSING CARE, AND OTHER SERVICES/TREATMENTS RENDERED BY MY PHYSICIAN, CONSULTING PHYSICIANS, AND THEIR ASSOCIATES AND/OR ASSISTANTS, OR RENDERED BY RHEUMATOLOGY OF CENTRAL INDIANA PERSONNEL UNDER THE INSTRUCTIONS, ORDERS OR DIRECTION OF SUCH PHYSICIANS.

I, _____, HEREBY ASSIGN AND AUTHORIZE ALL OF MY INSURANCE BENEFITS, SICK BENEFITS, MEDICARE BENEFITS, AND INJURY BENEFITS DUE BECAUSE OF A THIRD-PARTY, PAYABLE BY ANY PARTY OR ORGANIZATION DIRECTLY TO ROCI, OR ANY ROCI-BASED PHYSICIAN, UNLESS THE ACCOUNT FOR THE FACILITY, OUTPATIENT VISIT OR SERIES OF OUTPATIENT VISITS IS PAID IN FULL UPON DISCHARGE OR UPON COMPLETION OF THE OUTPATIENT SERIES. IF ELIGIBLE FOR MEDICARE, I REQUEST MEDICARE SERVICES AND BENEFITS.

I UNDERSTAND THAT I AM RESPOSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE COMPANY. I UNDERSTAND THAT I AM OBLIGATED TO PAY IN FULL FOR ANY SERVICES RECEIVED IN ACCORDANCE WITH THE REGULAR RATES AND TERMS OF RHEUMATOLOGY OF CENTRAL INDIANA. IF I FAIL TO MAKE A PAYMENT WHEN DUE AND THE ACCOUNT BECOMES DELIQUENT, OR IS TURNED OVER TO A COLLECTION AGENCY OR AN ATTORNEY FOR COLLECTION, I AGREE TO PAY COLLECTION AGENCY FEES, COURT COSTS, AND ATTORNEY FEES. I ALSO AGREE THAT ANY PATIENT OR GUARANTOR OVERPAYMENTS ON THE ABOVE ROCI VISIT MAY BE APPLIED DIRECTLY TO ANY DELIQUENT ACCOUNT FOR WHICH I OR MY GUARANTOR IS LEGALLY RESPONSIBLE AT THE TIME OF THE COLLECTION OF THE OVERPAYMENT.

I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF THE RHEUMATOLOGY OF CENTRAL INDIANA'S NOTICE OF PRIVACY PRACTICES, THIS PROVIDES INFORMATION ABOUT HOW ROCI MAY USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION. I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION, AND GIVE MY PERMISSION FOR MY CARE AS DESCRIBED.

_____ _____

PATIENT SIGNATURE DATE