Chart:_____
Phys.:_____
Date:_____

GARNER RHEUMATOLOGY
& INFUSION CENTER

810 Timber Drive, Garner, NC 27529 • Tel 919-747-9040 • Fax 1-866-837-8477
www.garnerrheumatology.com

PATIENT REGISTRATION FORM

Patient Information:

Last Name:_____ First Name:_____ Middle Initial:_____

Address:_____ Apartment No.:_____

City:_____ State:_____ Zip Code:_____

Telephone (Primary):_____ Secondary:_____

Cell Phone for Receiving Text Messages:_____ Email:_____

Birthdate:_____ Sex (Circle One): M / F Marital Status (Circle One): M / S / Other

Social Security Number:_____-__-_____ Drivers License No. (If Applicable):_____

Employer:_____

Preferred Method of Contact (Check One): ☐ Primary Phone ☐ Mail ☐ Email (Patient Portal Secure Message)

Please note that these questions are being asked in compliance with CMS Meaningful Use:

Race (Check All That Apply): ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Decline to Provide

Ethnicity (Check One): ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline to Provide

Language (Check All That Apply): ☐ English ☐ Spanish ☐ Other

Primary Physician:_____

Address:_____

Primary Phys. Phone:_____ Primary Phsy. Fax:_____

Preferred Pharmacy and Location:_____

Emergency Contacts (Please Provide Two):

Name:_____ Relationship: _____ Phone:_____

Address:_____

Name:_____ Relationship: _____ Phone:_____

Address:_____

Responsible Party: Party Responsible for Payment (Check One): ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name (if other than Self):_____

Address:_____

City:_____ State:_____ Zip Code:_____

Employer:_____

See Next Page➔

Chart:_____
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INSURANCE AND BILLING INFORMATION

Insured Party (Primary Cardholder) Name:_____

Date of Birth:_____

Primary Insurer:_____

Insurance ID No.:_____ Group No.:_____

Secondary Insurer:_____

Insurance ID No.:_____ Group No.:_____

Pharmacy Insurer:_____

Insurance ID No.:_____ Group No.:_____

How did you hear about us? (Check One): ☐ Physician Referral ☐ Family/Friend ☐ Google or Web Search ☐ Yelp ☐ Insurance Carrier ☐ Direct Mailer ☐ GRIC Website ☐ Yellow Pages ☐ Other (Please Specify):_____

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See Next Page➔

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PERMISSION FOR TELEHEALTH VISITS

What is Telehealth? Telemedicine, also referred to as telehealth medicine, is the real-time, audio-visual visit between a provider and patient. It can be used as an alternative to traditional in-person care delivery and, in certain circumstances, can be used to deliver care including the diagnosis, consultation, treatment, education, care management and patient self-management.

How Do I Use Telehealth? You talk to your provider with a phone, computer or tablet. Sometimes, you use video so you and your provider can see each other.

How Does Telehealth Help Me And What Are Its Benefits? You don't have to go to a clinic or hospital to see your provider. It also reduces your risk of getting sick from other people. No transportation time or costs, reduced wait time, and more detailed and personalized care compared to a telephone call.

What Are Some of The Challenges of Telehealth Visits? You and your provider won't be in the same room, so it may feel different from an office visit. Your provider cannot examine you as closely as they might at an in-office visit. Your provider may decide you still need an office visit. Technical problems may interrupt or stop your visit before you are done.

Will My Telehealth Visit Be Private? We will not record visits with your provider. If people are close to you, they may hear something you do not want them to know. You should be in a private place so other people cannot hear you. Your provider will tell you if someone else from their office can hear or see you. We use HIPAA-compliant, encrypted telehealth technology that is designed to protect your privacy. If you use the internet for telehealth, use a network that is private and secure. There is a very small chance that someone could use technology to hear or see your telehealth visit.

What Types of Visits Can Telehealth Be Used For? Telehealth is best suited for interactions with established patients who do not require a physical exam or lab work.

What Types of Visits Are Not Appropriate For Telehealth? Telehealth is not suited for a physical examination or lab testing, and cannot be used for new-patient evaluations.

What if I Want an Office Visit, Not a Telehealth Visit? That decision is up to you and your provider. Find out what options are available to you by calling the practice.

What if I Try Telehealth and Don't Like It? You can stop using telehealth any time, even during a telehealth visit. You can still get an office visit if you no longer want a telehealth visit. If you decide you do not want to use telehealth again, call **(919) 747-9040** and say you want to stop, or sign into your patient portal and **[add your EHR-specific instructions here]**.

How Much Does a Telehealth Visit Cost? What you pay depends on your insurance. If your provider decides you need an office visit in addition to your telehealth visit, you may have to pay for both visits.

Do I Have to Sign this Authorization Document? No. Only sign this document if you want to use telehealth.

What Does it Mean if I Sign This Authorization Document? If you sign this document, you agree that: We talked about the information in this document. We answered all your questions. You want a telehealth visit. If you sign this document, we will give you a copy.

Patient Signature: _____ Date: _____

Print Name: _____

Patient Representative / Parent Signature: _____ Date: _____

Print Name: _____

See Next Page➔

GARNER RHEUMATOLOGY
& INFUSION CENTER

_____ By providing us your email address you are consenting to the use of secure messaging and our patient portal.
Initials

CREDIT POLICY AND AGREEMENT OF RESPONSIBILITY

_____ Garner Rheumatology and Infusion Center, PLLC, will be happy to file claims to your insurance company as a courtesy to you.
Initials However, seeing that your account is paid is your responsibility. We do expect timely settlement of your account, and payment at the time of service is due and expected. Any delinquent accounts may be reported to the Credit Bureau. I, the undersigned, understand that I am financially responsible for all charges whether or not paid by my insurance and I also agree to pay any attorney's fees or costs if this matter is referred to collections. All returned checks are subject to a $35.00 fee in addition to the underlying debt, and will prevent me from paying by check in the future.

ASSIGNMENT OF BENEFITS

_____ I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s)
Initials directly to my provider or practice for services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation.

RELEASE OF INFORMATION

_____ I authorize Garner Rheumatology and Infusion Center, PLLC to disclose and release to my insurance carrier(s), including
Initials Medicare, Medicaid, Medigap/Supplemental benefits providers, and private insurers, as applicable, any medical and treatment information needed for payment purposes for services rendered. I authorize use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize my provider/practice to act as my agent in helping obtain payment from my insurance companies.

MEDICARE PATIENTS ONLY

_____ If a Medicare beneficiary, I understand my signature requests payment to be made and authorize the release of medical
Initials information necessary to pay claims. If 'other health insurance' is indicated in item 9 of the HCFA-1500 Form, or elsewhere on approved claim forms, or electronically submitted claims, my signature authorizes the release of information to insurance companies or its authorized agents. In Medicare-assigned cases, the physician or supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and I agree I am responsible for deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

_____ I hereby acknowledge receipt, before any medical services were provided, of a "Notice of Privacy Practices of Garner
Initials Rheumatology and Infusion Center, PLLC" for protected health information. I acknowledge that I have been given the opportunity to ask any questions that I may have regarding such policy. I understand that Garner Rheumatology and Infusion Center, PLLC may use or disclose personal health information relating to me for purposes of treatment, payment, and health operations as disclosed in the notice. I hereby provide Garner Rheumatology and Infusion Center, PLLC permission to:

- Leave a message on my answering machine: ☐ Yes ☐ No
- Confirm appointments by leaving messages or speaking with my family: ☐ Yes ☐ No
- Leave pre-medication reminders (as applicable): ☐ Yes ☐ No
- Speak to household members concerning my care: ☐ Yes ☐ No

NO SHOW/LATE CANCELLATION POLICY

_____ I acknowledge that Garner Rheumatology and Infusion Center, PLLC reserves the right to charge a fee of $75.00 for missed
Initials appointments or procedures. A missed appointment is defined as failure to show for your scheduled appointment within fifteen (15) minutes of the scheduled time or cancellation/reschedule within less than 24 business hours of the appointment time slot. A second no-show or late cancellation is charged at two (2) times the amount. A third no-show or late cancellation results in dismissal from the practice. This tabulation resets annually. All fees must be paid prior to the next appointment being scheduled.

Patient Signature: _____ Date: _____

Print Name: _____

Patient Representative / Parent Signature: _____ Date: _____

Print Name: _____