



RHEUMATOLOGY · OSTEOPOROSIS & INFUSION CENTERS
PHONE (757) 491-7359 · FAX (757) 491-9359

GARY R. SIEGEL, M.D., F.A.C.R.
MICHAEL R. CANNON, M.D., F.A.C.R.
SALLY CLARK, FNP-C

TATIANA KECK, M.D., F.A.C.R.
JANICE SHERWOOD, M.D., F.A.C.R.
FREDILYNN LANSANGAN, FNP-C

Patient Information

Name: Last _____ First _____ Middle _____

Date of Birth _____ Social Security No. (not required) _____

Mailing Street Address _____

City _____ State _____ Zip _____

Primary phone number (circle one): Home | Cell | Work

Home Phone _____ Cell Phone _____

Email _____

Employer _____ Work Phone _____

Emergency Contact Name _____ Relationship _____

Emergency Contact Phone _____

Gender (circle one): Male | Female | Other: _____

Which pronoun do you prefer: He | She | Other: _____

Marital Status (circle one): Single | Married | Divorced | Widow | Significant Other

Race (circle one): African American | Asian | Caucasian | Native American | Native Alaskan | Native Hawaiian | Pacific Islander

Ethnicity (circle one): Hispanic | Non-Hispanic

Primary Language (circle one): English | French | Spanish | Other: _____

Primary Care Physician _____ Phone # _____

Referring Physician _____ Phone # _____

933 First Colonial Road, Suite 100, Virginia Beach VA 23454
680-C Kingsborough Square, Chesapeake VA 23320
216 Mason Ave, Cape Charles VA 23310



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Insurance Information

Primary Insurance: _____

ID # _____ Group # _____

Subscriber's Name _____ DOB _____ SS# _____

Secondary Insurance: _____

ID # _____ Group # _____

Subscriber's Name _____ DOB _____ SS# _____

Third Insurance: _____

ID # _____ Group # _____

Subscriber's Name _____ DOB _____ SS# _____

Medicare Part D Prescription Insurance: _____

ID # _____ Group # _____

Subscriber's Name _____ DOB _____ SS# _____

Guarantor Information

Person responsible for the bill (if other than the patient) OR Parent if patient is a minor

Legal Guardian's relationship to patient (circle one): Parent | Step Parent | Other: _____

Last Name _____ First Name _____ Middle Name _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

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Payment of Medicare/Medicaid Benefits

I request that payment of authorized Medicare/Medicaid benefits be made either to me or on my behalf to Arthritis Consultants of Tidewater for services rendered. I authorize Arthritis Consultants of Tidewater to release the Health Care Financing Administration and its agents, any medical information needed to determine benefits or the benefits payable for related services.

Assignment of Insurance Benefits

I hereby authorize direct payment of medical benefits to Arthritis Consultants of Tidewater for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization for Release of Information

I consent to the use or disclosure of my protected health information by Arthritis Consultants of Tidewater and if needed information from other providers, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the healthcare operations of Arthritis Consultants of Tidewater. I understand that diagnosis or treatment of me by Arthritis Consultants of Tidewater may be conditioned upon my consent as evidenced by my signature on this document.

Cancellation Policy

If you are unable to make your appointment, please notify our office one day (24 hours) prior to the appointment. We reserve the right to charge a \$25 fee for missed appointments. Three no shows or cancellations (24 hours prior to appt.) may result in discharge from the practice.

I have read and acknowledge that I understand the terms above.

Printed Name: _____

Patient's Signature: _____ Date: _____



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Acknowledgement of Receipt of Privacy Notice

By signing below, I am acknowledging that I have been provided with a copy of Arthritis Consultants of Tidewater's Privacy Notice pursuant to the Federal regulations known as HIPAA Privacy Rule.

Printed Name: _____

Patient Signature: _____ Date: _____



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Patient Information Release

The Privacy Act of 1977 was designed to protect your privacy. It is to give you a feeling of security that when you visit our office, your medical affairs and financial affairs will not be discussed with anyone without your permission. This includes your spouse, family members, friends, and employer. In order for us to speak with anyone regarding your care, even in the event of an emergency, you must specify to whom we may speak.

If you wish for us to be able to release information regarding your care, please indicate below. Our staff cannot give out this information without your permission.

I give permission for the staff of Arthritis Consultants of Tidewater to discuss information indicated, regarding myself to:

Name	Relationship	Phone	Information to be released
_____	_____	_____	Medical / Financial
_____	_____	_____	Medical / Financial
_____	_____	_____	Medical / Financial
_____	_____	_____	Medical / Financial

Printed Name: _____

Patient Signature: _____ Date: _____

We ask that you update this information annually, or as circumstances change. Thank you.

Updated: _____
 Initials/Date Initials/Date Initials/Date Initials/Date

*****THIS FORM IS GOOD FOR 1 YEAR FROM THE DATE OF SIGNATURE*****



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Prescription Refill Policy

If in need of medication refills that have been prescribed by the doctor, please give your pharmacy 48-72 hours notice and they will contact our office.

We request refills to be handled during regular office hours, 8:30 am to 4:00 pm. Please plan on checking with your pharmacy before going to pick them up to be certain they have been filled. Some narcotic pain medications require a hand-written prescription so please be prepared to have someone pick up the prescriptions at our office. Identification may be required. The doctor cannot call these in on the weekend and need to be requested only during normal office hours.

If you are requesting a written prescription for mail order, please confirm with us if you want to pick it up or have it mailed to you.

Please note that our providers at Arthritis Consultants of Tidewater may request reports from the Virginia Prescription Drug Monitoring Program before refilling or prescribing controlled substances as an effort to comply with Virginia regulations regarding appropriate use of narcotic agents.

Pharmacy: _____ Phone #: _____

City: _____ State: _____

I have read and acknowledge that I understand the terms of the above policy.

Signature: _____ Date: _____



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Patient Portal

Our patient portal is a secure online website that gives you convenient 24-hour access to your personal health information and medical records—called an Electronic Health Record or EHR—from anywhere with an Internet connection. Please complete the information below to let us know if you would like access to your portal.

Patient Name _____ DOB _____ Date _____

Opt In:

Email Address: _____

Opt Out:

If you change your mind later, you can call the office at 757-491-7359 to join the portal.

