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

TATIANA KECK, M.D., F.A.C.R.
MICHAEL R. CANNON, M.D., F.A.C.R.
JANICE SHERWOOD, M.D., F.A.C.R.
ROOPA ACHURI, PA-C
FAYE TOMAWIS, FNP

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 # ____________________________

TURN OVER

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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.

Acknowledge 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.

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: ___________________