ARTHRITIS CONSULTANTS OF TIDEWATER

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.
ROOPA ACHURI, PA-C
JANICE SHERWOOD, M.D., F.A.C.R

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 | Decline to Answer

Ethnicity (circle one): Hispanic | Non-Hispanic | Decline to Answer

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

Primary Care Physician _____ Phone # _____

Referring Physician _____ Phone # _____

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 $75 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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INSURANCE INFORMATION

Primary Insurance: _____

ID # _____ Group #_____

Subscriber's Name _____ DOB _____SS#_____

Secondary 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_____

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.

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

Printed Name: _____

Patient's Signature: _____ Date: _____

933 First Colonial Road, Suite 100, Virginia Beach VA 23454

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HIPAA PRIVACY FORM

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 (Please Circle One or Both)
_____	_____	_____	Medical / Financial
_____	_____	_____	Medical / Financial
_____	_____	_____	Medical / Financial
_____	_____	_____	Medical / Financial

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.

Printed Name: _____

Patient Signature: _____ 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: _____

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.

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PATIENT CONSENT TO THE USE OF TELEMEDICINE SERVICES

I have read and understand the information provided below regarding telemedicine, I have discussed it with my physician, or such assistants as may be designated, and all my questions have been answered to my satisfaction.

I hereby give my informed consent for the use of telemedicine in my medical care. I hereby authorize the providers at Arthritis Consultants of Tidewater to use telemedicine in the course of my diagnosis and treatment.

Patient Name (print): _____

Signature of Patient (or person authorized to sign for patient): _____

If authorized signer, relationship to patient: _____

Date: _____

Telemedicine involves the use of electronic communications to let health care providers communicate through a live two-way audio and video virtual visit with their patients at a different location e.g., home.
Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her home while having a virtual health visit with their physician/provider to obtain e.g., test results, medical consult, etc.
- More efficient medical evaluation and management.

Possible Risks: As with any medical procedure, there are potential risks associated with the use of telemedicine.
These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s).
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of my medical care may be available to me, and that I may choose one or more of these at any time. My provider/provider's office has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

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PLEASE PROVIDE INFORMATION FOR PCP, PRIOR RHEUMATOLOGIST, OR ANY OTHER PROVIDER THAT MAY HAVE SEEN YOU FOR YOUR CURRENT CONDITION/SYMPTOMS.

Authorization to Release/Receive/Exchange Confidential Medical Information I hereby authorize **Arthritis Consultants of Tidewater** to **RELEASE/RECEIVE/EXCHANGE (circle one)** my medical record including HIV/AIDS, psychiatric, drug abuse, and alcohol related information, if applicable **TO/FROM/WITH (circle one):**

	Provider/Facility Name	Phone Number	Fax Number	Type of Practice
1				
2				
3				
4				
5				

Specific type of information to be disclosed:

- ☐ All Medical Records
- ☐ Most recent visit notes & labs
- ☐ Most recent imaging studies.
- ☐ Medications
- ☐ Hospital Admission/Discharge Summary
- ☐ Physical
- ☐ Other:

_____

Purpose or need for such disclosure:

- ☐ Continuity of Care
- ☐ Discharge and/or follow up planning
- ☐ Other: _____

I understand that I have the right to revoke this authorization at any time by giving written notice however, I understand that any information released prior to my revoking this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke the authorization prior to such time, this authorization will expire 365 days from this date unless otherwise specified _____.

Last name (printed) First Middle Date

Birthdate Patient Signature