TRIANGLE ARTHRITIS & RHEUMATOLOGY ASSOCIATES
3101 JOHN HUMPHRIES WYND
RALEIGH, NORTH CAROLINA 27612
TELEPHONE: (919) 881-8272
FAX: (919) 881-2026

Patient: _____
(First) (Middle) (Last)

Parent's Name (If minor): _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Phone :(h): _____ **(w)**: _____ **(c)**: _____

DOB: _____ **SS#**: _____ **Sex**: _____

Single: _____ Married: _____ Widowed: _____ Other: _____

Primary Physician: _____ Phone: _____

Referred by: _____ **Phone**: _____

Occupation: _____ **Employer**: _____

Name of Insured (If different from patient): _____

Relationship to insured: _____ Insured's **DOB**: _____

Insured SS# _____

Insured's Address (if different): _____

IN CASE OF EMERGENCY NOTIFY:

1) _____ PHONE: _____

2) _____ PHONE: _____

Signature: _____ **Date:** _____

TRIANGLE ARTHRITIS & RHEUMATOLOGY ASSOCIATES
CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I authorize Triangle Arthritis & Rheumatology Associates to use and disclose the health and medical information of _____ (print your name) For the following purposes:

1) Treatment (includes activities performed by a physician or other health care Provider directly delivering care to you, coordination or managing care provided to you with third parties, and consultations with and between Physicians and other health care providers).
2) **Payment (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims and utilization management activities, including review of health care services for medical necessity, justification of charges, precertification and preauthorization of services.)**
3) Health care operations (includes the necessary administrative and business functions of your health care provider.)
4) Person (s) who you authorize your information to be disclosed to.

_____ _____
Name (s) Phone number

You may review our Notice of Privacy practices for additional information about the uses and disclosures of information described in this consent prior to signing this consent. Please verify that you have received a copy of our Notice by placing your initials here: _____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change. Also, we will post a copy of the Notice in the lobby of our office, and the Notice will have, in the upper left corner of the first page, the effective date of the Notice. We will offer you a copy of the Notice on your first visit to us after the effective date of the current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment.

You have the right to revoke this CONSENT provided that you do so in writing, except the extent that we have already used or disclosed the information in reliance upon this CONSENT.

_____ _____
Date ***Signature of patient***

_____ _____
Date ***Signature of person authorized by law***

TRIANGLE ARTHRITIS & RHEUMATOLOGY ASSOCIATES
FINANCIAL POLICY

I understand that I may be responsible for the payment of services rendered if the services are not covered by my insurance. T.A.R.A. physicians participate with BCBS, United Healthcare insurance plans, however plan participation is subject to change. I understand that it will be MY responsibility to verify with my insurance plan the participation status of my physician PRIOR to any service being rendered. Insurance will be billed according to the guidelines of my primary insurance. IT is MY responsibility to update the T.A.R.A staff of any new insurance plans or any changes in insurance and failure to do so may result in changes being denied and transferred to my balance due.

SELF-PAY: **ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE**. Please let our staff know prior to being seen if you need an estimated cost of the visit or cannot pay the full 100% that day.

PAYMENT AGREEMENT: All applicable co-payments, deductibles, co-insurances, non-covered services (including pre-existing conditions) missed appointment fees and other services denied by insurance are my responsibility. Accounts are due within 30 DAYS of the date of service, regardless if claims are denied, unsettled, or unpaid, unless otherwise determined by your insurance plan. If I do not abide by this payment agreement, and my balance becomes delinquent, I understand that my account will be turned over to a collection agency and I will be responsible for all fees associated with the collection process as well as the original debt. I also understand that I will not be allowed to schedule further appointments until my debt is resolved.

RETURNED CHECKS: There is a $35.00 fee for all checks returned by the bank. I will be responsible for the original debt plus the returned check fee.

MISSED APPOINTEMNTS/ CANCELLATION FEE: Due to the volume of patients in need of appointments we strictly enforce this policy. I understand that if I fail to give a 24 hours prior notice of cancellation or fail to show up for my appointment I will be charged **$25.00** for the **FIRST** missed appointment, **$50.00** for the **SECOND** missed appointment and **$75.00** for the **THIRD** missed appointment. After **THREE** missed appointments, I will be DISMISSED from the practice. I understand that this fee is non-negotiable and cannot be filed to insurance. I also understand that there are no "first time" exceptions to this policy and that **ALL FEES MUST BE PAID PRIOR TO MY NEXT APPOINTMENT**. I also understand that I will not be able to schedule further appointments until all fees/debts are paid in full.

EFFECTIVE DATE: Once you have signed this agreement, you have agreed to all terms and conditions contained herein and this agreement will be in full force and effective immediately.

Patient Signature: _____
(or Responsible Party)

Date: _____