Sunny B. Patel, MD
Phone: 469-552-6630
Fax: 469-552-6930
106 Plaza Drive, Red Oak, TX 75154

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

____
Last First Middle

OTHER NAME(S) USED ______________________

DATE OF BIRTH Month ________ Day ________ Year ________

ADDRESS ______________________

____

CITY ______________ **STATE** ______ **ZIP** ______

PHONE (____) __________ **ALT. PHONE** (____) __________

EMAIL ADDRESS (Optional): ______________________

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name ______________________
Address ______________________
City ______________________ State ________ Zip Code ________
Phone (______)______________ Fax (______)______________

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name: **DFW Rheumatology and Wellness, PLLC**
Sunny Patel, MD, Jake Hutto, MD and Jasmine Milledge, FNP-C
Address _**106 Plaza Drive**_ City _**Red Oak**_ State _**TX**_ Zip Code _**75154**_
Phone (469)552-6630 Fax (469) 552-6930

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other ______________

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ Other______________________
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports

Your initials are required to release the following information:

______Mental Health Records (excluding psychotherapy notes)
______Drug, Alcohol, or Substance Abuse Records
______Genetic Information (including Genetic Test Results)
______HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month ________ Day ________ Year ________

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X______________________________ ______________
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): ______________________
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other ______________

DFW RHEUMATOLOGY

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Patient Registration Form

First Name:______________________ Middle Initial:______ Last Name:____________________
Date of Birth:______________________ Social Security Number: __________________________
Sex:_________________ Marital Status: _____________________
Address:____
City:______________________________ State: _______ Zip Code:__________________
Mobile Phone: _________________________ Home Phone: ___________________________
Email:_______________________________ Preferred Language:___________________________
Employment Status:_____________________ Employer Name: ________________________________

Race:
[ ] White [ ] Black/African American
[ ] Asian [ ] American Indian Unknown
[ ] Hawaiian [ ] Declined to Specify

Ethnicity:
[ ] Hispanic/Latino [ ] Unknown
[ ] Non-Hispanic/Latino
[ ] Declined to Specify

Primary Care Physician:___________________________________Phone:_____________________
Referring Physician:______________________________________Phone:______________________

Primary Insurance
Insurance Carrier Name: ______________________________ PolicyType:___________________
Policy Holder Name:_________________________________ Date of Birth:______________________
Social Security Number: __________________________ Relationship to Patient:________________
Subscriber ID Number: ____________________________ Group ID Number: __________________

Secondary Insurance
Insurance Carrier Name: ______________________________ Policy Type:____________________
Policy Holder Name:_________________________________ Date of Birth:____________________
Social Security Number:_________________________ Relationship to Patient:_________________
Subscriber ID Number:_____________________________ Group ID Number:__________________

Emergency Contact Information:
Name: _________________________________ Relationship to Patient:______________________
Phone: ______________________________

_____________________________________ ______________________
Signature of Patient Date

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HIPAA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. **The notice contains a patient's rights section describing your rights under the law.** You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage for health research. You have the right to revoke this consent in writing, signed by you. **However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent.**

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

This consent was signed by: ________________________________
(PRINT NAME PLEASE)

Signature: ________________________________ Date: ______________

Witness: ________________________________ Date: ______________

Patient name: ______________________________
Date of birth: ______________________________
Practice Name: DFW Rheumatology and Wellness

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, the practice may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge the practice may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to the practice any insurance or other third-party benefits available for health care services provided to me. I understand the practice has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to the practice I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the practice by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for the practice, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that the practice or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or the practice or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: ______________________________ **Date:** ________________

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

☐ Spouse
☐ Parent
☐ Legal Guardian
☐ Guarantor
☐ Healthcare Power of Attorney
☐ Other (please specify) ______________________________

CREDIT CARD ON FILE CONSENT FORM

DFW Rheumatology and Wellness has implemented a new credit card policy. Like many other practices and medical offices, we have adopted a similar policy. We kindly request our patients' guardian/guarantor for a credit card which may be used later to pay any balance that may be due on your bill. Co-pays are still due at the time of service. At registration and/or check-in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any.

The information will be held securely until your insurance has paid their portion of the claim and notified us of any additional amount owed by the patient. You may call our office if you have a question about your balance. We will send you a receipt for the charge. Your statements will be available via your patient portal and our billing team is available to answer any questions about the balance due. You have the right to request a paper copy of this document.

By signing below, I authorize DFW Rheumatology and Wellness to keep my signature and my credit card information securely on-file in my account. I authorize DFW Rheumatology and Wellness to charge my credit card for any outstanding balances when due.

Visa [ ] Mastercard [ ] Discover [ ] American Express [ ]

Name on Card (print):____

Cardholder Relationship to Patient: _______________________________________

Credit Card Number: _____________________________________Exp Date: _____ / _____ CVC: ______

Max Charge ($): ______________________ Agreement Valid till: 3M [ ] 6M [ ] 9M [ ] 1Y [ ]

Credit Card Holder's Signature: _______________________________________ Date: _______________

[ ] CHECK BOX TO DECLINE AND SIGN AND DATE

Signature: ___________________________________ Date: _______________

DFW RHEUMATOLOGY

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NO SHOW / LATE CANCELLATION POLICY

A missed appointment without notifying our office or cancellation within 48 hours of your scheduled appointment will result in:

A **$25 fee** for **Established Patients**
A **$75 fee** for **New Patients**

This fee will be charged to the patient and not the insurance company.

Please contact our office directly to cancel or reschedule appointments. You can also cancel appointments through your Healow Patient Portal.

This policy allows us to provide high-quality, patient-centered care to another patient who is in need of our services.