ARTHRITIS & RHEUMATOLOGY CARE, P.C.

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Brooklyn, NY 11219
http://www.nyarthritis.com
info@nyarthritis.com
P: (718) 906-MD-AR
F: (718) 303-0984

First Name ______________________________ Today's Date ___________________

Last Name ____

SS# ______________________________ Date of Birth ___________________

Gender ___ Male ___ Female

Mobile # ______________________________ Home # ________________________

Address ____ Apt ____________

City ______________________________ State _____ Zip ____________

e-Mail ____

Marital Status ___ Single ___ Married ___ Widowed ___ Divorced ___ Separated

Occupation _____________________________ Work # ________________________

Emergency Contact & Phone ____

Primary Care Doctor & Phone ____

Insurance Name/ID # ____

Pharmacy Name ____

Pharmacy Address ____

Pharmacy Phone ____

I hereby authorize direct payment of medical/surgical benefits to Arthritis & Rheumatology Care, P.C. (the Practice) for services rendered by Dr. Stella Bard at any time before, during, or after the creation of this document, in person or under her supervision. I understand that I am financially responsible for any co-payments, deductibles, balances not covered by my insurance, and/or any non-covered services rendered by the physician and/or associates. I hereby authorize the Practice to release any medical or incidental information that may be necessary for either medical care or processing medical claims.

I certify that the information provided by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

Signature ____

Print Name ____ Date ____________

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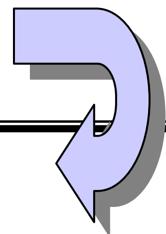

Authorization For Release Of Protected Health Information

I, the undersigned, have read the Arthritis & Rheumatology Care, P.C. (the Practice's) privacy policy and all my questions have been answered.

I hereby authorize the Practice to release any and all of my protected health information (including but not limited to history, physical findings, diagnosis, prognosis, diagnostic testing results, and/or consultant reports) to the following individuals / entities:

Name ______________________ Relationship to patient ____________

Name ______________________ Relationship to patient ____________

Name ______________________ Relationship to patient ____________

Name ______________________ Relationship to patient ____________

This authorization is valid until revoked by me, the patient, and can be revoked by me, the patient, via a written, signed, and dated statement at any time. I further understand that once information is disclosed to any authorized entities it may be subject to "re-disclosure" by these entities and may no longer be "protected".

I hereby authorize the Practice to release any medical or incidental information that may be necessary for either medical care or processing medical claims. A photocopy and/or computer image/printout shall be valid as the original.

Signature ______________________________

Print Name ______________________________ Date ____________

Authorization To Release Medical Record Information

I hereby authorize Arthritis & Rheumatology Care, P.C. to obtain any and all medical records concerning my care from any physician, hospital or other health care professional that has provided medical care to me in the past.

Signature ______________________________

Print Name ______________________________ Date ____________