

ARTHRITIS & RHEUMATOLOGY CARE, P.C.

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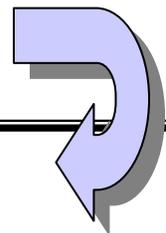
First Name _____ Today's Date _____
Last Name _____
SS# _____ Date of Birth _____
Gender Male Female
Mobile # _____ Home # _____
Address _____ Apt _____
City _____ State _____ Zip _____
e-Mail _____
Marital Status Single Married Widowed Divorced Separated
Occupation _____ Work # _____
Emergency Contact & 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 _____
