Comprehensive Arthritis Care

A Division of CRC, PLLC
242 Indian Lake Blvd, Ste. 100, Hendersonville, TN 37075
Tel: 615-822-5660 Fax: 615-822-5611

Registration Form

Today's Date:			
PATIENT INFORMATION			
Patient's Last Name:		First:	Middle (I):
Suffix:	Is this your legal name? Y \ N	If not, what is your legal name?	
Address:			
Cell Phone:		Home Phone:	
Can we leave a voice message to confirm appointment? Y \ N		Email Address:	
Birth Date: _____ / _____ / _____		Sex:	SSN:
IN CASE OF EMERGENCY			
Name of Emergency Contact:		Relationship to Patient:	
Home Phone:		Cell Phone:	
Address:			
ADDITIONAL INFORMATION			
Primary Care Physician Name:		Referred to CRC by:	
Marital Status:	Language:	Race:	Ethnicity: Hispanic or Latino \ Not Hispanic or Latino
Circle One: Employed \ Retired \ Unemployed \ Other		Patient Employment:	
Employer:		Employer Phone:	
Employer Address:			
INSURANCE INFORMATION (Please give your insurance card to the receptionist.)			
Primary Insurance:		Subscriber's Name:	
Subscriber's S.S.N.:	Policy / ID No.:	Group No.:	
Birth Date: _____ / _____ / _____	Patient's relationship to subscriber: Self Spouse Child Other		
Subscriber's Employer:			
Secondary Insurance (if applicable):		Subscriber's Name:	
Subscriber's S.S.N.:	Policy / ID No.:	Group No.:	
Birth Date: _____ / _____ / _____	Patient's relationship to subscriber: Self Spouse Child Other		
Subscriber's Employer:			
PHARMACY INFORMATION			
Pharmacy Name:	Pharmacy Phone No.:		
Pharmacy Address:			

The Center for Medicare and Medicaid Services (CMS) has made it mandatory for all medical offices to capture patient demographic data through Electronic Health Records. In order to comply with these rules, we request that you fill out all forms in their entirety. Thank you for your cooperation and understanding.

Assignment of Benefits:

I verify that the information provided above is complete and correct. I request that the payment of authorized insurance or Medicare benefits be made on my behalf to CRC for all medical services furnished. I understand that I am financially responsible for any changes not covered by my health insurance benefits plan.

Patient/Guardian Signature:_____ **Date:**_____

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Acknowledgement of Financial Responsibility

1. It is the responsibility of the patient to know the extent of medical coverage and benefits of the health insurance plan they have signed up for. **Patient is responsible for Co Pay/ Co insurance/ Deductible / Non covered charges at the time of service. In lieu of high deductible plans we will need to collect estimated amount towards deductible at each office visit when applicable.**
2. Patient is responsible to obtain a proper referral in order to be seen at CRC. In an event that a patient is seen without proper referral, the patient will be held responsible for the entire cost of the visit. Patient may choose to be self-pay or reschedule the appointment.
3. As a courtesy to patients, CRC will file the medical insurance claim to the carrier. The insurance carrier will send an EOB to the patient explaining the patient responsibility portion for instance co insurance or deductible. We require 2 working phone numbers at all times.
4. We have a **15 minute window** for appointment times. There may be a need to reschedule if arrival time is outside of the15 minute window.
5. In an effort to keep appointments on time, we may need to reschedule if outside tests are not received prior to appointment time.
6. Patient agrees to pay any and all unpaid balances, including but not limited to the principal balance of the bill, and if turned over to collection agency, or attorney for collections, the costs of collection, attorney fees and court costs. In an event that CRC does not receive payments after 30 days from the date of statement, the account will be turned over to a collection agency.
7. **Self pay patients are expected to pay at the time of service**.
8. Non Sufficient Funds will be turned over to collections agency and a fine of $25 will be applied to that account.
9. Patients with delinquent accounts **will not be seen** and **no refills** will be authorized unless the account is paid in full. CRC will pursue legal action against patients who fail to satisfy their debt.
10. Kindly give 24 hours' notice if you are unable to keep your appointment. Without notice, we reserve the right to bill $50 for no-show fees. The practice may choose to discharge patients due to non-compliance and delinquent account reasons.
11. **CRC will provide medical records for attorneys and the State of TN for disability benefits upon request. We will not fill out disability/ FMLA forms. At CRC it is our goal to keep our patients active and able to work.**

I have read this policy and understand that this Acknowledgement of Financial Responsibility will remain in effect until I provide written notice of cancellation to Comprehensive Arthritis Care.

_____ _____

Patient Signature Patient Guardian

_____ _____

Social Security Number Date

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HIPPA Authorization Form

_____

Patient Name

AUTHORITIZATION FOR TREATMENT: I hereby voluntarily consent to such clinical care including diagnostic procedures and medical treatment by the physician in charge of my care.

_____

Patient Initials

RELEASE OF INFORMATION: I authorize CRC to release any medical information to any insurance carrier or person employed by such carrier for the purpose of collecting Insurance Benefits as long as I am listed as having coverage with such carrier. I hereby release CRC from any and all responsibility relative to the release of such information.

_____

Patient Initials

PERSONS I ALLOW MY INFORMATION TO BE GIVEN TO:

_____ _____ _____ _____

Anyone not listed will not be given any information pertaining to you or your care.

_____

Patient Initials

NOTICE OF PRIVACY PRACTICES (HIPPA): I have been offered a copy of or already read and am aware of my rights under the Privacy Practice Law.

_____

Patient Initials

I understand that I have the right to revoke this authorization in writing at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

_____ _____ _____

Patient Signature Social Security Number Date of Signing

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Medical Records Release Form

I authorize _____to use and disclose my following protected health information (PHI) listed below for the purpose(s) listed elsewhere on the page.

Name of entity or person(s) to receive information:

Comprehensive Arthritis Care
242 Indian Lake Blvd. Ste. 100
Hendersonville, TN 37075
P: 615-822-5660
F: 615-822-5611

Consent to obtain external prescription history:
I give permission, without limitation or exclusion, for CRC to view my external prescription history via Surescripts for the purpose of care & treatment. I understand that my medication history from multiple providers, insurance companies and pharmacy benefit managers may be reviewed. Granting this permission will allow providers to coordinate care & treatment plan.

I understand that I have the right to revoke this authorization in writing, at any time by sending such written notification to the practice's Privacy Officer at the above address.

I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. The use or disclosure requested under this authorization may result in direct or indirect remuneration to the physician from a third party.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Relation to Patient

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Patient Attendance Compliance & Prescription Policy

We at CRC appreciate the opportunity to serve your healthcare needs. In order to effectively treat our patients, we encourage patient compliance for greater results.

Follow up appointments are the key for continuity of care. During this visit your most recent lab results are discussed and your medication & dosage is adjusted appropriately. **If you miss your follow up appointment, test results will NOT be discussed over the phone. To continue receiving services, patient account information must be current.**

In an effort to keep appointments on time, please understand that if you are 15 minutes late for your appointment, you would need to reschedule. Same applies if out side tests are not received prior to appointment time. We do our best to accommodate emergency situations. It is your responsibility to make this office aware of any changes to your address, phone number, insurance, and pharmacy. We require two working phone numbers at all times for our records.

No Show appointments are discouraged and perceived as a total lack of respect for the Physician's valuable time. It is also discourteous to your fellow patients who could have been seen in that allotted time. We work diligently on cancellation list. With your help we can eliminate No Show appointments and reduce wait time for our patients.

In the event that you need to cancel/reschedule your appointment please contact the office 24 hours prior to your appointment time and we will accommodate your request. However, if you accrue several missed appointments without prior notice, we reserve the right to discharge you from the practice. For your convenience we routinely make reminder phone calls for upcoming appointments.

In order to comply with new DEA guidelines and State laws **CRC does not prescribe narcotics**. If you feel these medications are beneficial in treating your illness please contact your primary care provider. If your PCP holds the same policy as we do regarding narcotics then it is the responsibility of your PCP to refer you to Pain Management Specialist (due to insurance regulations).

Please do not wait until you run out of the medication. We need 48 hour notice to get authorization to process refill requests. This office will NOT give any prescription that was originally given by your PCP or any other physician. In an event that you need a prescription and were not seen for more than 6 months, you will have to make an appointment to be seen.

We value you as a patient and expect you to value our time & policies.
Please help us in helping patients fight pain. We look forward to a great professional relationship and truly appreciate the trust you have demonstrated in us.

Your referral is our privilege. Thank you for your cooperation.

Signature_____ Date_____

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Multi-Dimensional Health Assessment Questionnaire (R791-NP2)

Please try to answer each question, even if you don't think it is related to you at this time. Try to complete as much as you can yourself, but if you need help, please ask. There are no right or wrong answers. Please answer exactly as you think or feel by filling in the circle completely. Thank you.

Dress yourself, including tying shoelaces and doing buttons?
❒ without ANY difficulty ❒ with SOME difficulty ❒ with MUCH difficulty ❒ UNABLE to do

Get in and out of bed?
❒ without ANY difficulty ❒ with SOME difficulty ❒ with MUCH difficulty ❒ UNABLE to do

Lift a full cup or glass to your mouth?
❒ without ANY difficulty ❒ with SOME difficulty ❒ with MUCH difficulty ❒ UNABLE to do

Walk outdoors on flat ground?
❒ without ANY difficulty ❒ with SOME difficulty ❒ with MUCH difficulty ❒ UNABLE to do

Wash and dry your entire body?
❒ without ANY difficulty ❒ with SOME difficulty ❒ with MUCH difficulty ❒ UNABLE to do

Bend down to pick up clothing from the floor?
❒ without ANY difficulty ❒ with SOME difficulty ❒ with MUCH difficulty ❒ UNABLE to do

Turn regular faucets on and off?
❒ without ANY difficulty ❒ with SOME difficulty ❒ with MUCH difficulty ❒ UNABLE to do

Get in and out of a car, bus, train, or airplane?
❒ without ANY difficulty ❒ with SOME difficulty ❒ with MUCH difficulty ❒ UNABLE to do

Walk two miles or three kilometers, if you wish?
❒ without ANY difficulty ❒ with SOME difficulty ❒ with MUCH difficulty ❒ UNABLE to do

Participate in recreational activities and sports as you would like, if you wish?
❒ without ANY difficulty ❒ with SOME difficulty ❒ with MUCH difficulty ❒ UNABLE to do

Get a good night's sleep?
❒ without ANY difficulty ❒ with SOME difficulty ❒ with MUCH difficulty ❒ UNABLE to do

Deal with feelings of anxiety or being nervous?
❒ without ANY difficulty ❒ with SOME difficulty ❒ with MUCH difficulty ❒ UNABLE to do

Deal with feelings of depression or feeling blue?
❒ without ANY difficulty ❒ with SOME difficulty ❒ with MUCH difficulty ❒ UNABLE to do

How much pain have you had because of your condition OVER THE PAST WEEK?
❒ without ANY difficulty ❒ with SOME difficulty ❒ with MUCH difficulty ❒ UNABLE to do

Please indicate below how severe your pain has been: 10 being pain as bad as it could be

❒ No pain ❒0.5 ❒1.0 ❒1.5 ❒2.0 ❒2.5 ❒3.0 ❒3.5 ❒4.0 ❒4.5
❒5.0 ❒5.5 ❒6.0 ❒6.5 ❒7.0 ❒7.5 ❒8.0 ❒8.5 ❒9.0 ❒9.5 ❒10.0

Considering all the ways in which illness and health conditions may affect you at this time, please indicate how you are doing. 10 being very poorly

❒ No pain ❒0.5 ❒1.0 ❒1.5 ❒2.0 ❒2.5 ❒3.0 ❒3.5 ❒4.0 ❒4.5
❒5.0 ❒5.5 ❒6.0 ❒6.5 ❒7.0 ❒7.5 ❒8.0 ❒8.5 ❒9.0 ❒9.5 ❒10.0

Patient Name (print): _____ Date: _____ Time: _____

Consent to Treat (sign): _____

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Medication/Vitamin/Herb Log

_____ _____ _____

Name DOB Today's Date

_____ _____

Pharmacy Pharmacy Phone #

_____

Pharmacy Address

Medication Name	Dosage	Frequency
asprin	81mg	1 per day