Orlando Arthritis and Rheumatology Clinic
7932 West Sand Lake Road, Suite 200
Orlando, FL 32819
PH: 407-355-7759 FAX: 407-355-4987

SECTION 1. Patient Demographic Information

Last Name	First Name	Middle Initial	Preferred Name
Date of Birth	Gender	Social Security Number	
Address	City	State	Zip
Email Address			Language Spoken
Home Phone	Work Phone		Cell Phone
Race	Ethnicity		Marital Status
Employer's name & Address			Occupation

SECTION 2. Responsible Party / Guarantor

☐ **SELF** (Initial here if patient is the responsible party for the account, then go to next section 3)

If the Responsible party is not the patient, then please provide the guarantor's information below:

Last Name	First Name	Middle Initial	
Date of Birth	Social Security Number	Guarantor's Relationship to patient	
Address	City	State	Zip
Email	Home Phone	Work Phone	Cell Phone
Employer's name	Address	Occupation	

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SECTION 3. Emergency Contact (Minimum 1 required)

First Emergency contact:

Name | Relationship to patient | Home Phone/Work Phone/Cell Phone

Address | City | State | Zip

Second Emergency contact:

Name | Relationship to patient | Home Phone/Work Phone/Cell Phone

Address | City | State | Zip

SECTION 4. Insurance Information

Note: Please be ready to provide your current Insurance Card and Photo ID at the front desk

Primary Insurance name & Policy number **Secondary insurance name & Policy number**

SECTION 5. Assignment of benefits

I authorize GK BANSAL RHEUMATOLOGY PLLC, DBA ORLANDO ARTHRITIS AND RHEUMATOLOGY CLINIC, and its related entities and their providers to file claims on my behalf for the services rendered. I authorize my insurance(s) to pay directly to the provider for the services rendered. ANY CLAIM DENIED IS AUTOMATICALLY BILLED TO ME. I hereby certify that, to the best of my knowledge, all statements contained hereon are true.

Signature **Print Full Name (Patient or Authorized Representative)** **Date**

SECTION 6. Release of Billing Information

I hereby authorize GK BANSAL RHEUMATOLOGY PLLC, DBA ORLANDO ARTHRITIS AND RHEUMATOLOGY CLINIC, its related entities and their providers to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and healthcare operations as described in the Notice of Privacy Practices.

Signature **Print Full Name (Patient or Authorized Representative)** **Date**

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SECTION 7. General Consent for Treatment

1. I, the undersigned, hereby consent to the following:
    1.1. Administration and performance of general treatment,
    1.2. use of prescribed medications,
    1.3. Administration of immunizations or therapeutic injections as medically necessary
    1.4. performance of diagnostic imaging/ procedures/ tests and cultures,
    1.5. performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees.
    1.6. Performance of remote patient monitoring services if medically necessary
    1.7. Performance of Chronic Care Management Services if medically necessary

2. I fully understand that this consent is given in advance of any specific diagnosis or treatment.
3. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended.
4. The consent will remain in full force until revoked in writing. I understand that this form includes consent for treatment by the providers at any locations of GK BANSAL RHEUMATOLOGY PLLC, DBA ORLANDO ARTHRITIS AND RHEUMATOLOGY CLINIC and its related entities. A photocopy of this consent shall be considered as valid as the original.
5. I understand that while my consent is voluntary, if I refuse to sign this consent, the healthcare providers of GK BANSAL RHEUMATOLOGY PLLC, DBA ORLANDO ARTHRITIS AND RHEUMATOLOGY CLINIC and its related entities may refuse to treat me.
6. I understand that these services are voluntary and that I have the right to refuse these services.

Signature **Print Full Name (Patient or Authorized Representative)** **Date**

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SECTION 8. Financial Policy and Payment Agreement

1. GK BANSAL RHEUMATOLOGY PLLC, DBA ORLANDO ARTHRITIS AND RHEUMATOLOGY CLINIC, and it's related entities (collectively referred to as Practice) and it's providers are committed to providing the best treatment for our patients and we are looking forward to a healthy long lasting financial relationship with our patients.
2. This agreement is between you and our Practice. Your insurance policy is between you and your insurance company.
3. Irrespective of your insurance coverage, you, the patient or the guarantor, are personally responsible for all the charges from the time a service or treatment is rendered by this practice. As a service to you, on your behalf, we will submit claim to the insurance carrier you ask us to bill. However, the primary responsibility for your account is yours.
4. Providing accurate insurance information is patient's responsibility. If your coverage has expired or changed you must update us at the point of service (POS). Failure to do so can result in incorrectly billing insurance company, which is a healthcare fraud. ANY PENALTIES ARE PATIENT'S RESPONSIBILITY.
5. Copay or Coinsurance or patient's share of payment are due at POS. However if your insurance coverage is not verified we reserve the right to ask for full payment at the POS. Amount will be refunded if your insurance pays us.
6. If your insurance denies payment, amount will be automatically billed to you. It is your responsibility to contact your insurance company if you feel that it shouldn't be denied.
7. All balances are due within 30 days of statement date. Accounts with balances over 30 days due will be assessed an administrative fee each month.
8. Unpaid balances exceeding 30 days from the time of second statement date may be sent to an outside collection agency and patient will be billed for additional charges arising from collections process. Patient may be discharged from our care in such circumstance, unless patient has contacted our office to make payment arrangement. If dismissed, medical care will not be withheld for a medical emergency for thirty days from date of dismissal.
9. If you have any questions about your bill or if you are unable to pay the balance in full and would like to inquire about the payment plan options, please contact our office at 407-355-7759.
10. We normally accept payment by Cash, Check, Credit Card (visa, master card, American Express) at the POS. You may be able to pay yourself at the time of check-in.
11. For each returned check patient will be billed $50 administrative fee.
12. Although we participate in most major insurances, it is ultimately your responsibility to confirm the coverage with your insurance.
13. Please be aware that some or perhaps all of the services you receive may be non-covered services and not considered reasonable and necessary under your insurance plan. Irrespective of your insurance coverage patient is personally responsible for all the charges and services rendered.
14. We don't take WORKERS COMP or accept responsibility for billing claims in litigation.
15. NO SHOW POLICY: A 24 hour advance notice is required if you are unable to keep an appointment. If you don't reschedule 24 hours before or don't show up for a scheduled appointment WITHIN 15 MINUTES past your appointment time, a no-show administrative fee of $50 will be charged to your account. We may waive this fee at our discretion if such a no-show is due to an unexpected emergency and if you can provide such proof.
16. Where allowed by law, patients will be billed directly for filing forms or affidavits. copying or mailing or faxing medical records to the authorized person or entity.
17. Self-pay policy: If you are without insurance coverage or if our practice does not accept your insurance plan, you are completely responsible for payment for any services provided to you. Self-Pay visit requires full payment of the service allowable payable in cash, or credit card (visa, master card, American express) at the time of service.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature **Print Full Name (Patient or Authorized Representative)** **Date**

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SECTION 9. CONSENT TO TREAT USING TELEMEDICINE AND VIRTUAL VISITS

Please read the following and sign this form below to indicate your consent and agreement concerning these terms:

1. Telemedicine includes all Telehealth Visits, Virtual Check-Ins and E-visits as defined by Medicare (CMS) and private insurances.
2. Patients may communicate with their doctors without going to the doctor's office by using EMR online patient portals or do a live real time audio video conference (synchronous) or asynchronous (save and forward) method of communication or a basic telephone encounter.
3. Patient may be responsible for copay, coinsurance and deductible based on the insurance plan.
4. All existing confidentiality protections under federal and state law apply to a telemedicine consultation. Any patient-identifying information from a telemedicine consultation will not be provided to researchers or other entities without the written consent of you or of your personal representative.
5. The advantages of telemedicine include the ability to be treated from almost any location and at almost any time. Telemedicine may also enhance the continuity of care for patients.
6. You or your personal representative can withhold or withdraw consent to receive services through telemedicine at any time. Doing so will not affect your right to receive future care or treatment in our offices.
7. The originating location for telemedicine is required to be in the state where the provider has the license to practice telemedicine.
8. The risks of using telemedicine services include the potential for unauthorized disclosure of your confidential information when it is transmitted between you and us over the Internet.
9. Additionally, you may be overheard by anyone near you if you are not in a private area during a telemedicine session, especially you if not present in our office location.
10. It is your responsibility to create an environment at your location for each telemedicine transmission that is private and protective of your personal information and communications with us.
11. For telemedicine sessions, please be available for us to call you by videoconference at the time your session is scheduled.
12. Please be ready to receive a videoconference call from us beginning two minutes before to fifteen (15) minutes after the scheduled time for your session.
13. If you are not available for more than fifteen (15) minutes after your scheduled time, your session may be rescheduled, and you may be considered a "no-show" and billed according to our office policies and procedures.
14. When you receive a videoconference call from our office for your session, please be in a place where you feel comfortable talking about your personal and private information.
15. Barring technology failure, we do not anticipate having telemedicine sessions by phone. There may be times, however, when we need to contact you by phone. If you are using a cell phone or other wireless or mobile phone, be advised that such phones are not secure, and the privacy and security of information transmitted may be compromised. If you choose to contact us using a cell phone or other wireless or mobile phone, you agree to accept the risk to the privacy and confidentiality of your information that the use of such phones may pose. We recommend you use the teleconferencing system we provide for your telemedicine sessions.

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TELEMEDICINE ACKNOWLEDGMENT:

1. I, the undersigned, have read this Consent to Use Telemedicine Technology.
2. I understand the risks and benefits that have been described.
3. I also understand that because technology is changing rapidly, there may be other risks to the confidentiality and security of my personal information that neither GK BANSAL RHEUMATOLOGY PLLC, DBA ORLANDO ARTHRITIS AND RHEUMATOLOGY CLINIC (OARC), its related entities, their providers nor I can anticipate at this time.
4. I understand that OARC will follow its Notice of Privacy Practices in using and disclosing my personal and confidential information consistent with applicable law.
5. I acknowledge that I have received a copy of the Notice of Privacy Practices. Where possible, I agree to use video conferencing system provided by OARC for my telemedicine sessions.
6. If I decide to use other telemedicine technologies, I acknowledge that there may be additional risks to the privacy, confidentiality, and security of my personal information, and I agree to accept the risks of doing so.
7. I agree to accept and receive OARC telemedicine services from a location that is private, confidential, and free from distractions during my session.
8. I understand that OARC does not consider the use of wireless, mobile or cell phone technology as secure. If I utilize wireless, mobile or cell phone technology to contact or to communicate with OARC, I understand that doing so poses additional risks to the privacy and confidentiality of the information shared between me and OARC.
9. I agree to hold harmless OARC, its related entities, their officers and employees, from all liability arising out of the improper use or disclosure of my confidential and private information due to the use of wireless, mobile or cell phone technology or video conferencing technology chosen and utilized by me for my telemedicine sessions or otherwise.
10. If I choose to use a telemedicine technology or other communications technology not recommended by OARC for my telemedicine sessions or otherwise, I authorize OARC to communicate with me using my chosen communication methods.
11. I understand that OARC's providers are licensed to practice medicine in the state of Florida.
12. Patients receiving our services must be physically located in Florida at the time of their appointment with us. I certify that at the time of my appointment I will be located in Florida to receive OARC telemedicine services.
13. I agree to call 911 or go to the nearest emergency room if I experience a crisis or life-threatening emergency.
14. I understand the information above and have had an opportunity to discuss it with OARC or designee.
15. I understand that this document when signed by me will become part of my patient medical record with OARC.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature **Print Full Name (Patient or Authorized Representative)** **Date**

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SECTION 10. PRIVACY POLICY AND HIPAA PREFERENCES

1. I understand that GK BANSAL RHEUMATOLOGY PLLC, DBA ORLANDO ARTHRITIS AND RHEUMATOLOGY CLINIC, its related entities, their providers and staffs will not disclose my protected health information (PHI) to anyone except me or as stated in this form or as required by law or upon my written authorization only.

2. I authorize this practice to discuss my PHI with the following person:

Full Name:

Relationship:

Phone Number:

Email:

What information may we release: (Check below)

_____All PHI (Personal Health Information)
_____Billing information
_____Office notes
_____Psychotherapy/mental health
_____Lab/ Diagnostic test results
_____Prescription
_____Appointment information
_____Other _____

3. I authorize my provider's office and its authorized affiliates to contact me by telephone call, SMS Text Messaging, email to remind me of my appointments, health announcements and balance due. I understand that I will have to inform the office regarding my contact preferences. I understand that I will have to provide a written authorization if I want any other person to get access to my PHI.

   a. Consent to automated phone calls: YES _____ NO_____

   b. Preferred Method to contact by practice staff: (check 1 option only)
      i. Home Phone _____
      ii. Mobile Phone_____
      iii. Work Phone_____
      iv. Portal_____

c. Choose the following options (Check All or 1 or more preferred methods for each)

i. Health Notifications:
1. All methods_____
2. Email _____
3. Phone_____
4. Text _____

ii. Appointments:
1. All methods_____
2. Email _____
3. Phone_____
4. Text _____

iii. Announcements:
1. All methods_____
2. Email _____
3. Phone_____
4. Text _____

iv. Billing:
1. All methods_____
2. Email _____
3. Phone_____
4. Text _____

4. HIPAA Acknowledgement: I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices and understand that if I have any questions or complaints, I should contact the Privacy Officer.
5. Release of Info: I authorize this office to release my insurance information and protected private health information (PHI) that is required to process medical claims and to perform treatment, payment and healthcare operations (TPHO).
6. I authorize Electronic Record Sharing which allows the practice to share and receive my medical records with the patient's other providers at connected care locations to enable Interoperability in healthcare.
7. I consent to submit my PHI data to the state immunization registry if applicable.
8. Rx history consent: I authorize this office to obtain my medication history from pharmacies, insurances and other providers to assist my provider in delivering my health care.
9. I understand that I may request individuals to leave the exam room at any time to maintain my privacy.
10. PHOTO DOCUMENTATION: I hereby grant authorization for the clerical staff to make a copy of my photo identification to be included in my confidential record as well as take a digital picture for additional protection against the theft of my medical identity. I further grant authorization for the clinical staff to take photo documentation of any physical finding, lesions, injury or procedure that they feel is medically necessary to include in my confidential medical record.

Signature **Print Full Name (Patient or Authorized Representative)** **Date**

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SECTION 11. LABORATORY RESULTS, REFILLS, FORMS AND PAPERWORK POLICY

1. GK BANSAL RHEUMATOLOGY PLLC, DBA ORLANDO ARTHRITIS AND RHEUMATOLOGY CLINIC, and it's related entities and it's providers are committed to providing the best treatment for our patients. GK BANSAL RHEUMATOLOGY PLLC, DBA ORLANDO ARTHRITIS AND RHEUMATOLOGY CLINIC, and it's related entities (collectively referred to as Practice) and it's providers only provide prescription refills during an office visit with a physician/provider. Regular office visits are required for all patients taking prescription medications.
2. I agree to come to my follow-up appointments or schedule a telephone encounter so I can discuss the results of any of my laboratory results and what they mean to my care. I agree to request all refills at the time of my visit. I understand that if I cancel or reschedule an appointment, I may run out of my required medication. I agree to bring all prescription bottles and a current detailed medication list with me to my appointment. I understand that requesting paperwork and form completion is best done during my appointment. I agree to pay the out-of-pocket fee of $50 for any letters, forms, or other paperwork that require completion by GK BANSAL RHEUMATOLOGY PLLC, DBA ORLANDO ARTHRITIS AND RHEUMATOLOGY CLINIC, and it's related entities and it's providers outside of scheduled appointment times. I understand that I can avoid this charge by scheduling an appointment and bringing the forms with me to the office visit.

Signature **Print Full Name (Patient or Authorized Representative)** **Date**

SECTION 12. CONTROLLED MEDICATIONS/MARIJUANA POLICY

1. GK BANSAL RHEUMATOLOGY PLLC, DBA ORLANDO ARTHRITIS AND RHEUMATOLOGY CLINIC, and it's related entities and any of it's providers do not prescribe opiates or medical marijuana for the treatment of chronic pain, or benzodiazepines for the treatment of chronic anxiety or insomnia; and do not take over the prescribing of these medications from another physician.
2. I understand that GK BANSAL RHEUMATOLOGY PLLC, DBA ORLANDO ARTHRITIS AND RHEUMATOLOGY CLINIC is required by law to review my prescription refill habits through the Prescription Monitoring Program, even if not prescribing me a controlled substance. I also understand that providers at GK BANSAL RHEUMATOLOGY PLLC, DBA ORLANDO ARTHRITIS AND RHEUMATOLOGY CLINIC always communicate with prescribing physicians about my treatment plan if it is related, even if not also prescribing me controlled substances.

Signature **Print Full Name (Patient or Authorized Representative)** **Date**

SECTION 12. ATTORNEYS/LEGAL POLICY

1. In the event GK BANSAL RHEUMATOLOGY PLLC, DBA ORLANDO ARTHRITIS AND RHEUMATOLOGY CLINIC, and it's related entities and any of it's providers is required to work with an attorney, or is required to appear in court, the current hourly rate, billed by the quarter hour, will be charged, based on the most recent Attorney Fee Schedule.

Signature **Print Full Name (Patient or Authorized Representative)** **Date**