AB Rheumatology

1101 Santa Fe St.
Corpus Christi, TX 78404
Tel: (361)-882-7300 Fax: (361)-882-7308

History & Physical

Primary Care Physician: _____ Date: _____
Pharmacy: _____
Email address: _____

Patient Information:

Name: _____ Date of Birth: _____
Address: _____ SS #: _____
City & State & Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Marital Status: Single Married Widowed Divorced Other (please circle one)

Patient Employment/ Insurance Information:
Employer: _____ Occupation: _____
Insurance: _____ Policy #: _____
Group #: _____ Phone #: _____

Name of Insured: _____
DOB: _____ SS#: _____
Employer: _____

EMERGENCY CONTACT:
Name:_____
Address: _____
Phone Number: _____ Relationship: Spouse Parent Child Sibling Other

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Assignment & Release

I, the undersigned, have insurance with _____ and assign directly to AB Rheumatology all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefit. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured/Guardian Date

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on by behalf to AB Rheumatology for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Healthcare Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA-1500 form or electronic submitted claims, my signature authorizes the release of any information to the agency shown above. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services.

_____ _____

Signature of Insured/Guardian Date

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Consent to the USE and Disclosure of Health Information for Treatment

I understand that as part of my healthcare, AB Rheumatology PLLC originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among healthcare professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address provided. I understand that I have the right to object to the use of my health information for any directory purposes. I understand that I will have to pay a reasonable charge of $1.00 per page for any copies after the first requested in a 12 month period. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing except to the extent that the Practice has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information.

_____ _____

_____ _____

_____Accepted _____Denied

_____ _____

Signature of Patient/Legal Representative Date

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Authorization for Release of Medical Records

I hereby authorize: _____

Address: _____

To release the information from the health record of:

Patient Name: _____ DOB: _____

Address: _____ SS#: _____

Covering the period (s) of treatment from: _____ to _____

Information to be release:

- ○ Progress Notes
- ○ History & Physical
- ○ Radiology
- ○ Medication List
- ○ Lab
- ○ Complete Medical Record
- ○ Other: _____

Purpose of disclosure: _____

When my information is used or disclosed pursuant to this authorization it may be subject to disclosure by the recipient and may no longer be protected by the Federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Manager.

This authorization shall expire ninety days from the date signature. This authorization is applicable only to those identified above; no consent is given to release information or discuss information with others. The confidentiality of these records is protected by Federal Law (Federal Regulations 42CFR, part 2)

_____ _____

Signature of Patient or Legal Date

_____ _____

Patient Name Date