Central Florida Rheumatology Consultants, LLC

Shikha Mehta, M.D,
ABIM board certified Adult Rheumatologist

PATIENT REGISTRATION

Patient

Full Name: _____ Age: _____ DOB: _____ Sex: ____

Mailing

Address: _____ City: _____ State: _____ Zip: _____

Physical

Address: _____City: _____ State: _____ Zip: _____

(IF P.O. BOX IS LISTED ABOVE)

Social Security

Number: _____ Home #: _____ Cell #: _____

Patient Employer: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

INSURANCE INFORMATION

Primary

Insurance: _____ Policy #: _____Group #: _____

Primary Card

Holders Name: _____ DOB: _____ Social Security #: _____

Secondary

Insurance: _____ Policy #: _____Group #: _____

Secondary Card

Holders Name: _____ DOB: _____ Social Security #: _____

915 Harley Strickland Blvd., Orange City, FL 32763
Phone: 386-561-9967

Fax: +1 844-815-1446
http://myrheumatology.com/

1319 S International Pkwy. Suite 1171, Lake Mary, Florida 32746
Tel: 407-268-3666

Central Florida Rheumatology Consultants, PL

HIPAA

Consent to the use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations.

I _____, understand that as part of my healthcare, **Central Florida Rheumatology Consultants,** originates and maintains paper and/or electronic records describing my history symptoms, examinations and test results, diagnosis, treatment and any future care or treatment.
I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for 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 that **Central Florida Rheumatology Consultants,** reserves the right to change their notice and practices and prior to implantation, in accordance with Section 164.520 of the code of Federal Regulations. Should **Central Florida Rheumatology Consultants,** change their notice, they will send a copy of any revised notice to the address I have provided. (whether by U.S.P.S. or by e-mail if selected).

I wish to have the following restrictions to us or disclosure of my health information: _____

_____

I understand that as part of this organization treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to other entity, and I consent to such disclosure for these permitted uses, including via fax.

We ask all patients to show their insurance cards and drivers license so that we can make copies of them. All services are charged directly to the patient, and he/she remains responsible for the payment. However, we will file any paperwork necessary to assist in making collections from the insurance company you provided to us. By signing below, I fully understand and accept the terms of this consent.

I authorize the Physicians of Central Florida Rheumatology Consultants render medical care to the above name patient. I acknowledge that all information listed above is true and correct. I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize release of any medical information necessary to process as insurance claim on my behalf. This signed agreement will act as a valid facsimile of the original.

Patient's Signature: _____ Date: _____

Office Use Only!

( ) Consent Received By: _____ _____Date: _____

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