The Arthritis Center
of the Palm Beaches
Specializing in Non-Surgical Orthopedics

New Patient Registration Form

Patient Name_____ Date of Birth_____ Sex ☐ M ☐ F

Social Security #:_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address _____

City _____ State _____ Zip _____ Name of Community _____

Home Telephone _____ Work Telephone _____ Mobile Telephone_____

Employment Status: ☐ Employed ☐ Not Employed ☐ Student ☐ Retired

Employer: _____ Occupation _____

Race: ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black or African American

☐ White ☐ Hispanic ☐ Other ☐ Decline

Language: ☐ English ☐ Spanish ☐ Sign Language ☐ Decline

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown ☐ Decline

How did you hear about us? ☐ Spouse ☐ Friend ☐ Physician ☐ Employee ☐ Lecture ☐ Newspaper

☐ Other _____

E-mail Address: _____

Primary Insurance Information

Insurance Name _____ Subscriber Name _____

Member ID# _____ Date of Birth _____ Relationship to Subscriber_____

Secondary Insurance Information

Insurance Name_____ Subscriber Name _____

Member ID# _____ Date of Birth _____ Relationship to Subscriber_____

Physician Information

Primary Care Physician_____ Telephone _____

Referring Physician _____ Specialty _____

Pharmacy Information

Pharmacy Name _____ Telephone _____ Fax _____

Acknowledgement of Receipt of Privacy Practices

The Arthritis Center of the Palm Beaches is required to provide you with a copy of our Notice of Privacy Practices which states how we may disclose/use your health information. I acknowledge that I have received a copy of The Arthritis Center of the Palm Beaches Notice of Privacy Practices.

Patient Signature _____ **Date** _____

Acknowledgement of Special Accommodations

Under The Americans with Disabilities Act of 1990 (ADA), "Providers are responsible for incurring all costs of providing reasonable aid and cannot pass that charge onto the patient or to his/her insurance company." If you require special accommodations for your appointment, you (or your appointed legal representative) must notify The Arthritis Center of the Palm Beaches of the required accommodation at least 5 business days prior to your scheduled appointment. Future appointments also require this notice.

If a patient who requests special accommodations fails to provide a minimum of 24 hours' notice to cancel their scheduled appointment or they do not appear to their scheduled appointment, all special accommodation charges incurred by The Arthritis Center of the Palm Beaches will be the patient's full responsibility.

Patient Signature _____ **Date** _____

Patient Emergency Contact Consent

I authorize The Arthritis Center of the Palm Beaches to communicate directly with the following individual in regards to my health care:
Emergency Contact Name _____ Relationship _____ Telephone_____

Patient Telephone Consent

At The Arthritis Center of the Palm Beaches, we are required to call the patient to confirm scheduled appointments or to release test result information ordered by this practice. This acknowledges that you authorize The Arthritis Center of the Palm Beaches to:

Yes_____ No _____ (please initial yes or no) Leave a detailed message with the party answering your telephone
Yes_____ No _____ (please initial yes or not) Leave a detailed message on your answering machine or voicemail

Patient Authorization for Medicare Patients

I authorize Brett R. Hutton, M.D., P.A., to release to The Centers for Medicare & Medicaid Services, Social Security Administration or its intermediaries information required for any Medicare claim. I authorize a copy of this authorization to be used in place of the original and request payment of insurance benefits either to myself or to the party in which Medicare payment information automatically spans to my supplemental insurer. I also understand that I am financially responsible for all services considered non-covered by Medicare.

Patient Signature _____ Date _____

Patient Authorization for All Patients

I understand that I am financially responsible for all services rendered at The Arthritis Center of the Palm Beaches. All questions regarding fees should be asked prior to service. If my insurance changes, I am responsible for notifying The Arthritis Center of the Palm Beaches prior to my appointment, otherwise I will be responsible for the full payment of the visit. I understand that if my account balance is not paid in full, it may be forwarded to a collection agency. If any delinquent account balance is referred to a collection agency, I understand that I will be financially responsible for all costs relating to the collection of my debt.

If my insurance plan requires a referral, I am responsible for providing the referral, otherwise I am financially responsible for all services considered non-covered by my insurance company. I authorize The Arthritis Center of the Palm Beaches to release my medical information to my insurance plan in order to secure payment for services rendered. Additionally, I permit The Arthritis Center of the Palm Beaches to communicate and act as my designated representative in regards to any appeal process associated with my insurance plan.

I understand that The Arthritis Center of the Palm Beaches reserves my appointment time and that a 24-hour notice of cancellation is required. We reserve the right to charge a 'No Show' or cancelled appointment fee the same day of the visit. The practice is aware that emergencies can arise but repeated cancellations can result in dismissal from the practice. First time patients who cancel or no show to their first appointment can also be dismissed from the practice.

Patient Signature _____ **Date** _____