**NORTH HOUSTON RHEUMATOLOGY REGISTRATION FORM**

**Please fill out the entire packet** (**Please Print**)

|  |  |
| --- | --- |
| Today’s Date: | PCP or referring provider: |
| **PATIENT INFORMATION** | |
| Patient’s last name: First: Middle: Mr.  Mrs.  Ms. | |
| Preferred Language Birth Date: Age: Gender :  M F | |
| Street address: Social Security #: Contact Number: | |
| P.O. Box: City: State: Zip Code: | |
| Employer: Employer Phone Number:  ( ) | |
| Preferred Pharmacy: Pharmacy Address: Pharmacy Phone Number: | |
| Other family members seen here: | |
| **INSURANCE INFORMATION** | |
| **Please give your insurance card to the receptionist.** | |
| **IN CASE OF EMERGENCY** | |
| Name of local friend or relative/ Next of Kin:  Relationship to patient: Home Phone Number: Cell Phone Number:  ( ) ( ) | |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize North Houston Rheumatology Associates or insurance company to release any information required to process my claims.  Patient/ Guardian Signature Date | |
| Ethnicity:  Race:  E-Mail Address: | |

**Please Read this form and sign**

**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**SUMMARY:**

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this notice.

We want to assure you that your medical/ protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

|  |  |
| --- | --- |
| Effective date of this Notice | 01/01/2016 |
| Contact person | Homai Madisetty |
| Phone number | (281)319-4700 |

**Acknowledgement of Notice of Privacy Practices**

**“I hereby acknowledge that I have received a copy of this practice’s NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way.”**

**Patient or Representative Name (PLEASE PRINT) Patient of Representative Signature**

**Patient refused to sign Patient was unable to sign because Date:**

**NORTH HOUSTON RHEUMATOLOGY ASSOCIATES P.A.**

**CONSENT FORM**

Due to the new laws enacted by Congress, we are required to have signed this consent form prior to receiving treatment.

Do you consent to a medical examination and any procedures or tests deemed necessary by Dr. Prashanth Palwai and Dr. Rama Palwai, while you are in our office?

YES NO

Do you consent to the staff releasing information about appointments and or test results to someone on your list?

YES NO

Do you consent to the staff leaving messages on an answering machine or voice mail system, or receiving emails regarding appointments and/or test results?

YES NO

**Please list the names of the person or persons to whom we can discuss medical information with:**

**NAME RELATIONSHIP**

**If you wish this consent to be effective indefinitely or until you have revokes it please sign this form.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**You may revoke this consent at any time. By revoking consent you will receive no further treatment from this office.**