Island Rheumatology
and Osteoporosis, PC

Sanjay Godhwani, MD
Kyle Eskridge, PA

6144 Route 25A
Building C, Suite 13
Wading River, NY 11792

Phone: 631-886-2844
Fax: 631-886-2842

www.IslandRheumatology.com

NEW PATIENT INFORMATION FORM

Patient Name: _____ **Date of Birth/Age:** _____

Home Address: _____

Email Address: _____ **Best Phone Number** _____

Primary Care Doctor (phone/fax#): _____

Referring Doctor (phone/fax#): _____

Reason for your visit today: _____

INSURANCE INFORMATION

Primary Insurance Holder's Name		D.O.B.	
Relationship			
Employer		Phone	
Address		Supervisor	
City/Zip		Notes	
Primary Insurance Company		Insured's ID #	
Contact		Policy #	
Phone		Group #	
Notes		Claim #	
Secondary **Insurance Company**		Insured's ID #	
Contact		Policy #	
Phone		Group #	
Notes		Claim #	
Additional Information			

Height_____ Weight_____

Do you Smoke tobacco? **Yes** **No**

Have you ever smoked tobacco? **Yes** **No**

Do you drink any alcohol? **Yes** **No**

How often do you drink alcohol? **Rarely Socially Daily**

Preferred Pharmacy Name/Location: _____

_____

Occupation: _____

Thank you for allowing us to participate in your health care and welcome to our Rheumatology Practice

Island Rheumatology and Osteoporosis, PC

Past Medical History :(please circle)

Acid Reflux
Anemia – Low blood count
Arthritis
Asthma
Cancer or Malignancy
Colitis
COPD (Emphysema/Bronchitis)
Diabetes
Fibromyalgia
Gout
Headaches/Migraines
Heart Disease (Stents or Heart Failure)
Hepatitis B or C
High Blood Pressure
HIV/AIDS
Kidney Disease
Leukemia/Lymphoma
Liver Disease
Lupus or SLE
Osteoporosis/Osteopenia
Psoriasis
Rheumatoid Arthritis
Stomach Ulcers
Stroke/ TIA
Thyroid disorder

OTHER MEDICAL CONDITIONS: _____

Allergies to Medications or Latex: _____

Current Medications: Please bring a medication list with dose and frequency taken.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Surgical History: Please any surgeries you may have had and the approximate Month and Year

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Family Medical History: Please list any major family medical problems *especially any* autoimmune or rheumatology history

Mother: _____

Father: _____

Siblings: _____

Extended Family: _____

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OFFICE POLICIES

(Effective January 1st, 2019)

PATIENT NAME: _____ DATE: _____

ON-TIME ARRIVAL POLICY: We ask that all patients arrive at least 15 minutes before their scheduled appointment so that they may have an adequate amount of time to complete any necessary documents and/or forms. Patients that arrive late for their scheduled appointment may have to reschedule their appointment for another day. However, please note that sometimes we have unexpected delays due to the urgent or complex needs of other patients and will make every effort to get you seen by a physician within a timely manner.

CO-PAYMENT/BALANCE: Please note any co-payment is due at check-in. If there is a previous balance, it is due at the time of the visit. If you are unable to make the co-payment or balance, you maybe asked to reschedule your appointment. You can fill out a credit card authorization form for co-payments and balances. I understand there will be a $25 charge for any check returned for insufficient or uncollected funds.

REFERRAL/AUTHORIZATION: Some medical insurance companies require a referral from a patient's provider in order to see a specialist. If a referral or authorization for services and procedure is not provided prior to the visit, we may have to reschedule your appointment. The patient is responsible for obtaining the required referral/authorization that their insurance plan specifically requires, or the patient may be financially responsible for the services rendered.

PHONE MESSAGES: By signing this document, patients consent that Island Rheumatology and Osteoporosis, PC is authorized to leave non-confidential information on their voicemail.

ANCILLARY SERVICES: Patients may be billed separately for services such as laboratory, imaging, or other ancillary services depending on their individual medical insurance.

SPECIAL LETTERS AND FORM COMPLETION: The Island Rheumatology and Osteoporosis, PC requires a separate visit and/or fees for any third-party forms/letters describing any medical conditions and/or treatments for their patients. This includes but is not limited to disability forms, FMLA documentation, life insurance, personalized medical letters, or legal documents, etc. The visit/fee is based to the length and complexity of the form or requested letter.

FEE FOR MEDICAL RECORDS: A signed medical release form will be required for any copies of patient medical records. Furthermore, the Island Rheumatology and Osteoporosis, PC may charge a fee ($0.10/page) for all copies of patient medical records, whether they are copied, faxed (if applicable), mailed or picked up from the medical office. The fee must be paid in full before any records will be released. Please be aware that it may take up to 2-3 business days to have a patient's medical records prepared.

CANCELLING/MISSING APPOINTMENTS: Our office requires that patients must cancel their appointment at least 24 hours in advance. If you do not or miss your appointment, you will be charged a $40 fee. NO EXCEPTIONS.

MEDICATION REFILLS/PRIOR AUTHORIZATIONS: Please note that most medications will not be refilled past 3 months without appropriate follow up and/or lab testing. A medication refill appointment will be required for renewal. Medication refills may take up to 48 business hours to be completed. Kindly request your pharmacy to electronically submit a refill to Island Rheumatology and Osteoporosis, PC. Please be aware that we do not call individual pharmacies. In addition, if a patient's prescription requires a prior authorization, the Island Rheumatology and Osteoporosis, PC may require up to 3-5 business days to complete this request. Furthermore, please note that some prescriptions will not be authorized or covered under their pharmacy benefits and may require additional time to file any necessary appeals. Lastly, in order to best serve the patient's medical needs, please ensure that we have the most current pharmacy information on file.

I certify that I have read, and/or received a copy of the updated office policies either in person, via email, or on the website – www.islandrheumatology.com and fully understand the sections on on-time arrival policy, cancelling/missing appointments, co-payment/balance, special letters and form completion, fee for medical records, referral policies, ancillary services, phone messages, and medication refills. I further recognize that I will be offered a copy of any amended Notice of Privacy Practices at future appointments. If I have questions, I can contact the staff at Island Rheumatology and Osteoporosis, PC.

_____

Signature of Patient /Legal Representative (specify relationship)

_____

Date

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ASSIGNMENT OF BENEFITS

I hereby authorize and request that payment of benefits by my primary insurance company, and my secondary insurance (if any), be made directly to Island Rheumatology and Osteoporosis, PC / Sanjay Godhwani, MD for services furnished to me or my dependent. I understand that my insurance company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment. In addition, I authorize Island Rheumatology and Osteoporosis, PC / Sanjay Godhwani, MD to disclose any and all written information from the above-named insurance company and/or its designated representatives, at the determination of Island Rheumatology and Osteoporosis, PC / Sanjay Godhwani, MD. Such disclosure shall be for reimbursement purposes for those services received.

I hereby release Island Rheumatology and Osteoporosis, PC / Sanjay Godhwani, MD, its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to the above-named insurance company(s) or their designated representatives.

By signing this assignment of benefits and release of information I acknowledge:

1. I am aware and understand that this authorization will not be used unless the above-named insurance company(s) or their designated representatives request records of information for reimbursement purposes; or seek to act reference payment for treatment services.
2. I agree to participate and assist Island Rheumatology and Osteoporosis, PC / Sanjay Godhwani, MD or its designated representatives with any appeal process necessary to collect payments for services rendered.
3. I am aware and have been advised of the provisions of Federal and State Statues, rules and regulations and provide for my right to confidentiality of these records.
4. I UNDERSTAND THAT THE PROVIDER IS LEGALLY OBLIGATED TO COLLECT ALL COPAYS, DEDUCTIBLES AND/OR COINSURANCE DEEMED TO BE PATIENT/INSURED RESPONSIBILITY BY THE INSURANCE COMPANY.
5. Island Rheumatology and Osteoporosis, PC / Sanjay Godhwani, MD is acting in filing for insurance benefits assigned to me/the patient and it can assume no responsibility for guaranteeing payment of any charges from the insurance company(s).
6. A firm contracted by Island Rheumatology and Osteoporosis, PC / Sanjay Godhwani, MD for billing and collection purposes. If necessary, the office may employ collection counsel and/or an attorney on my bill, I will be responsible for any said collection and/or attorney fees.
7. Island Rheumatology and Osteoporosis, PC / Sanjay Godhwani, MD is appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier. This includes receiving a copy of my insurance plan's documents.
8. Should an overpayment take place; a refund check will be mailed to the authorized party that is due the overpayment.
9. Island Rheumatology and Osteoporosis, PC / Sanjay Godhwani, MD shall be entitled to the full amount of its charges without offset.

I acknowledge receipt of a completed and signed copy of this assignment and release form.

Name of Patient /Legal Representative (specify relationship): _____

Signature of Patient /Legal Representative: _____ Date: _____

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HIPAA

Privacy and Release of Information Authorization

(Effective January 1st, 2019)

Patient Name: _____ Date of Birth: _____

I, _____ hereby authorize Island Rheumatology and Osteoporosis, PC and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have acted on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

<u>If applicable, Legal Representatives sign below:</u>
By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Signature of Patient /Legal Representative (specify relationship): _____

Date: _____

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Request for Medical Records

Patient Name:		**DOB:**	
Cell Phone:		Home Ph:	
Address:		City/Zip:	
	I Hereby authorize records **FROM**:		To be released **TO:**
PCP/Specialist:		Name:	
Address:		Address:	
City/State/Zip:		City/State/Zip:	
Phone:		Phone:	
Fax:		Fax:	
For the Purpose of:		**Dates of Service:__/__/__ to __/__/__**	
Self/Personal Copy		Physician's Office Notes	
Insurance		Lab Results	
Transfer or Continuity of Care		Imaging Results (XRAY, MRI, DEXA, etc)	
Disability		Procedure Notes	
Worker's Comp		Other:	

I understand that Island Rheumatology and Osteoporosis, PC does not require this form as a condition of evaluation or treatment and that I have the right to revoke this authorization at any time. I can do so by submitting my revocation in writing. I understand that my revocation will not apply to information that has already been released in response to this authorization. I also understand that I have the right to view and/or receive copies of my health information and that there may be a charge for copies. I understand that the information in my health record may include information relating to mental health, substance abuse, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human Immunodeficiency virus (HIV). I understand that if a recipient of the health information is not governed by federal and state confidentiality laws, the health information disclosed as a result of this authorization may be re-disclosed by the recipient and no longer be protected by such laws. *This authorization automatically expires in 1 year from date of the signature.*

Signature of Patient /Legal Representative (specify relationship): _____ Date_____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT, AIDS-RELATED MEDICAL INFORMATION OR GENETIC-RELATED INFORMATION.

I acknowledge that information to be released may include material that is protected by Federal and/or state law applicable to substance abuse, mental health and/or AIDS-related information, and/or genetic-related information. I SPECIFICALLY AUTHORIZE the release of confidential information relating to (Place "YES" or "NO" in all applicable boxes):

___ Substance Abuse (drug or alcohol) Information from: _____

___ Mental Health Information from: _____

___ AIDS-related Information, Diagnosis, and test results from:_____

___ Genetic testing, profiles, counseling, services, education and medical histories which focus on genetically related diseases or conditions information, diagnosis, and test results from: _____

Signature of Patient /Legal Representative (specify relationship): _____

Date _____