GREENSBORO RHEUMATOLOGY

PATIENT REGISTRATION

Last Name _____ First Name _____Middle or Maiden_____

Preferred Name_____ Date of Birth _____/_____/_____SSN_____/_____/_____

Sex Assigned at Birth ☐MALE ☐FEMALE Current Gender Identity ☐MALE ☐FEMALE ☐_____ Preferred Pronouns_____

Marital Status _____ Race_____ Ethnicity_____ Preferred Language_____

Mailing Address_____City_____State_____Zip_____

Physical Address *(if different)* _____City_____State_____Zip_____

Telephone: Home(_____) _____Cell (_____) _____Work (_____) _____

Email: _____Preferred Communication ☐Phone ☐Text ☐Email (patient portal registration required)

Emergency Contact _____ Relationship_____Phone (_____)_____

Primary Care Physician _____City _____ Phone (_____)_____

Primary Pharmacy _____City _____ Phone (_____)_____

Do you have an Advanced Directive? ☐Yes ☐ No If yes, please specify: ☐ Living Will ☐ DNR ☐ Healthcare Power of Attorney

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO COLLECT PAYMENT

I give permission for the healthcare provider named above to receive any payments from my health insurance or other benefits that would normally be paid to me for the services, treatments, or medications I receive from them—even if they are not part of my insurance network. I understand that I'm still responsible for any charges, no matter what my insurance pays or doesn't pay.

I also give the provider permission to share my medical information if it's needed to process my insurance claims. I give my insurance company, plan administrator, or attorney permission to share any documents, policy details, or settlement information with the provider or their attorneys if they request it.

In addition to giving them the right to collect insurance payments, I'm also giving them the right to take legal or administrative action to get payment for the care I receive. This includes any rights I have under group health plans, employee benefit plans, insurance policies, or legal claims related to medical costs. I give the provider the right to collect what's owed for my care—even from legal settlements or lawsuits if needed. They can act on my behalf to get information, send or receive notices, make legal arguments, appeal denials, or take legal action against anyone who should be paying (like an insurance company or benefits plan). They can even file a lawsuit in my name to collect what's owed to them, at their own expense.

This agreement stays in effect for life unless I cancel it in writing. It applies to any health law reviews or actions under laws like the Affordable Care Act, ERISA, Medicare, and similar federal or state rules.

By signing this form, I give my healthcare provider permission to get paid directly by my insurance for any care I receive. I understand I am still responsible for any remaining balance not covered by insurance. I also allow my provider to share and request information needed to handle my claims and, if necessary, to take legal steps on my behalf to collect payment. This agreement stays in effect unless I cancel it in writing. A copy is just as valid as the original.

_____ _____ _____

Patient/Authorized Patient Representative Name (Printed) Patient Signature Date

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been informed that Greensboro Rheumatology, PA is required by law to maintain the privacy of my protected health information (PHI) and to provide me with a Notice of Privacy Practices describing how my medical information may be used and disclosed, as well as my rights regarding my health information.

I understand:
• I have the right to review or receive a copy of the Notice of Privacy Practices at any time.
• I may request restrictions on certain uses and disclosures.
• I may revoke permissions in writing as permitted by law.

I acknowledge receipt or availability of the Notice of Privacy Practices.

Patient/Authorized Patient Representative Name (Printed)	Patient Signature	Date

HEALTH INFORMATION EXCHANGE

Health Information Exchange allows authorized healthcare providers to securely access my electronic health information for purposes of medical treatment and care coordination. Information identifying me will not be sold or shared outside HIPAA-compliant healthcare organizations.

I understand:
• Consent is voluntary.
• My treatment is not dependent on my consent.
• I may revoke consent at any time in writing.
• If I consent, Greensboro Rheumatology may access all available records through the HIE.

- O **I GIVE CONSENT** for Greensboro Rheumatology to access ALL of my health information through the HIE for the purpose of providing medical services.
- O **I DO NOT CONSENT** for Greensboro Rheumatology to access ALL of my health information through the HIE for the purpose of providing medical services.

Patient/Authorized Patient Representative Name (Printed)	Patient Signature	Date

ELECTRONIC COMMUNICATION CONSENT

Greensboro Rheumatology uses secure systems for electronic communication but cannot guarantee absolute confidentiality due to inherent electronic risks including interception, forwarding, malware, or technical failure.

I understand:
• Electronic communications may be used for appointment reminders, billing, and general care coordination.
• Sensitive information (HIV, mental health, substance use, minors) will not be sent by email.
• I may revoke this consent in writing at any time.
• My treatment is not dependent on providing this consent.

- O **I DO hereby give consent to Greensboro Rheumatology to use PHONE/TEXT/EMAIL communications**.
- O **I DO NOT give consent to Greensboro Rheumatology to use PHONE/TEXT/EMAIL communications**.

Patient/Authorized Patient Representative Name (Printed)	Patient Signature	Date

E-PRESCRIBING CONSENT

E-prescriptions, or electronic prescriptions are computer generated prescriptions created by your provider and sent directly to your pharmacy. Greensboro Rheumatology, PA participates in e-prescribing because we care about your health and well-being and E-prescribing has multiple safety benefits.

By signing this consent form you are agreeing Greensboro Rheumatology can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

- O **I DO hereby give consent to Greensboro Rheumatology to use ePrescribing**.
- O **I DO NOT give consent to Greensboro Rheumatology to use ePrescribing**.

Patient/Authorized Patient Representative Name (Printed)	Patient Signature	Date

ADVANCED PRACTICE PROVIDER (APP) CONSENT

Greensboro Rheumatology, PA has on staff an Advanced Practice Provider (APP), i.e., Physician Assistant (PA) or Nurse Practitioner (NP), to assist in the delivery of medical care. Advance Practice Providers are not doctors. An Advanced Practice Provider is a graduate of a certified training program and is licensed by the state board. Under the supervision of a Physician, an Advanced Practice Provider can diagnose, treat, and monitor acute and chronic diseases as well as provide health maintenance care. Supervision does not require the constant physical presence of the supervising physician, rather the overseeing of activities of and accepting responsibility for the medical services provided.

- O **I DO hereby give consent to the services of an Advanced Practice Provider for my healthcare needs.**
- O **I DECLINE consent to the services of an Advanced Practice Provider for my healthcare needs.**

Patient/Authorized Patient Representative Name (Printed)	Patient Signature	Date

ZERO TOLERANCE POLICY FOR AGGRESSIVE BEHAVIOR

To ensure a safe, respectful, and professional environment for our patients, visitors, and staff, our practice maintains a **Zero Tolerance Policy** regarding aggressive, abusive, or threatening behavior.

Aggressive behavior will not be tolerated under any circumstances. This policy applies to all patients, family members, visitors, and anyone present on our premises or communicating with our staff in any manner.

Prohibited behaviors include, but are not limited to:
• Verbal abuse, yelling, or use of profanity
• Threats of harm or intimidation
• Physical aggression or attempts at physical harm
• Harassment, discriminatory remarks, or hostile gestures
• Destruction of property
• Refusal to comply with staff instructions related to safety

Consequences of Violating This Policy:
Any individual engaging in aggressive behavior may be subject to one or more of the following actions, depending on severity:
• Immediate removal from the premises
• Termination of the patient-provider relationship
• Denial of future services
• Involvement of law enforcement

Our staff has the right to perform their duties in a safe environment free of fear, intimidation, and abuse. We treat all individuals with courtesy and respect and expect the same in return.

I certify that I have read and understand the above information to the best of my knowledge.

Patient/Authorized Patient Representative Name (Printed)	Patient Signature	Date

NOTICE OF NO-SHOW/BROKEN APPOINTMENT POLICY

I understand that Greensboro Rheumatology charges a fee for no-shows and cancellations with less than a 24-hour notice. I understand that this fee is billed directly to the patient and must be paid before scheduling the next visit. I understand that after repeated broken appointments, dismissal from the practice may occur.

I certify that I have read and understand the above information to the best of my knowledge.

Patient/Authorized Patient Representative Name (Printed)	Patient Signature	Date

PHARMACY SERVICES AND PATIENT RIGHTS ADDENDUM

1. Notice of In-Office Pharmacy Services

Greensboro Rheumatology, PA offers in-office medication dispensing and pharmacy-related services in compliance with the North Carolina Pharmacy Practice Act and applicable federal regulations. These services are offered for patient convenience and continuity of care and are entirely optional.

2. Freedom of Choice – Pharmacy Services (North Carolina)

You have the right under North Carolina law and federal healthcare regulations to choose where your prescriptions are filled.

- You are not required to use Greensboro Rheumatology's in-office pharmacy or dispensary.
- Your choice of pharmacy will not affect your medical care, treatment decisions, or access to services.
- You may select any pharmacy of your choosing, including retail, specialty, or mail-order pharmacies.
- You may change your pharmacy choice at any time.

3. Patient Rights Related to Medications

You have the right to:

- Receive counseling regarding your medications, including use, dosage, risks, and side effects.
- Ask questions and receive clear answers from qualified clinical staff.
- Be informed of therapeutic alternatives and generic substitutions when applicable.
- Access your prescription information as permitted by law.

4. Informed Consent for Pharmacy Services

By signing below, you acknowledge and agree that:

- Greensboro Rheumatology providers may both prescribe and dispense medications.
- Use of in-office dispensing is voluntary.
- You may revoke this consent in writing at any time.
- No medication will be dispensed without proper authorization and documentation.

5. Privacy and Confidentiality

All pharmacy services are subject to HIPAA and North Carolina confidentiality laws. Prescription information will only be disclosed for treatment, payment, healthcare operations, or as otherwise permitted or required by law.

6. Billing and Insurance

If you choose to receive medications through the in-office pharmacy:

- Claims may be submitted to your insurance when applicable.
- You are responsible for applicable copays, coinsurance, deductibles, or non-covered charges.
- Pharmacy charges may be billed separately from professional medical services.

7. Complaints or Concerns

If you have a complaint related to pharmacy services, you may contact:
Greensboro Rheumatology, PA – Dispensary/Pharmacy Manager (336) 617-6568

If unresolved, you may contact:
North Carolina Board of Pharmacy
www.ncbop.org | (919) 246-1050

8. Acknowledgment and Signature

I acknowledge that I have read and understand this Pharmacy Services & Patient Rights Addendum and understand my right to choose where my prescriptions are filled.

Patient/Authorized Patient Representative Name (Printed)	Patient Signature	Date