BONE MUSCLE and JOINT SPECIALISTS
ARTHRITIS TREATMENT CENTER

Scott M. Halista, MD, FACR
C. Bruce Tallman, Jr., MD, FACR
Donald R. Griger, MD, FACR
Antonio Valentin, MD, FACR
Dilpreet K. Singh, MD

Specialized Care of:

OSTEOPOROSIS
ARTHRITIS
BURSITIS
TENDINITIS
MUSCULOSKELETAL CONDITIONS
GOUT
BACK PAIN
NECK PAIN
CARPAL TUNNEL SYNDROME
CONNECTIVE TISSUE

Dear _____

Thank you for consulting our office about your musculoskeletal problems. Your appointment is scheduled on _____ at _____.

Please arrive at least 30 minutes prior to your scheduled appointment. If you cannot keep this appointment, please notify our office as soon as possible.

Any records about your condition from other physicians are very important. Please have your referring physician fax your records of visit notes, imaging and labs pertinent to your visit.

1. Get a note or letter from your referring physician.
2. Get copies of office imaging; test results; X-ray, CT scan, MRI, Bone Density or other imaging results regarding your musculoskeletal condition; recent laboratory tests **- bring these with you** to your appointment.
3. Bring actual **X-ray disc** that pertains to your visit, **not just the report.**
4. Bring any insurance forms you need completed.
5. Bring all of your prescription and over-the-counter medications.
6. Complete the attached questionnaires to the best of your ability - this is **extremely important** and will save you a great deal of time and confusion during your visit.
7. Come at least 30 minutes before your scheduled appointment time. We try to stay on time. If you are more than 15 minutes late, your visit may have to be moved to a new day or time. We also give everyone the time they need during their appointment. If we happen to be behind on your appointment, please try to be understanding.
8. Bring a **photo ID** and your current **Insurance Cards.**

If you need a referral for insurance purposes (such as Mass Health or **HMO** plans), please make sure you have this **before** your appointment.

Failing to make these arrangements with your primary doctor's office could create delays during your visit and your appointment may have to be rescheduled.

We do not accept Workman's Comp. or Accident Insurance. If the cost of treating your condition might be covered under one of these plans, you need to speak to our business office **before** your appointment.

BONE, MUSCLE and JOINT SPECIALISTS
at the **Arthritis Treatment Center**

NAME: _____ **DOB:**_____ **AGE:** _____ **DATE:**_____

HISTORY OF PRESENT ILLNESS

What is the reason for your visit today?_____

Did this pain start suddenly or did it come on gradually?_____

Have you noticed: (check those that apply) ☐ **redness** ☐ **swelling** ☐ **warmth**

What makes the pain worse? (standing up, walking, sitting, bending, etc.)_____

_____

What makes the pain better? (medication, rest, therapy) _____

Is the pain worse at any particular time of day? (morning is worse, worse after doing a lot, worse at the end of day)

_____

Are symptoms: (check one) **constant** ☐ **intermittent** ☐

What words would your use to describe your pain? (e.g., burning, aching, shooting, etc.)_____

_____

Does anything else happen when you have the pain? (e.g., My knee gives away; My shoulder catches)_____

_____

_____

Do these symptoms interfere with sleep? (check one) ☐ **Yes** ☐ **No** **How often?** _____

Do you have other areas of pain? If so, describe in the same manner. _____

_____

_____

Other health professionals consulted for this condition:_____

Have you had any tests to evaluate this condition (i.e. x-ray, MRI, CT scan) ☐ **Yes** ☐ **No**

Where? _____

List any other treatments (i.e., medications, physical therapy, chiropractor, etc.) **that you have tried for this condition.**

_____

_____

Please list your current medications including over the counters on attached index card.

NAME: _____ **DOB:**_____ **TODAY'S DATE:**_____

Reason for appointment: ☐ **Routine/scheduled follow-up** ☐ **Injection** ☐ **New problem** ☐ **Consultation**

What bothers you the most? (specify left or right) _____

How long has the above been a major problem? _____

Is the pain getting worse? Yes ☐ **No** ☐ **Where else do you have pain?**_____

Place an X	**Without any difficulty**	**With some difficulty**	**With much difficulty or with assistance**	**Unable**
Dress yourself	☐	☐	☐	☐
Get in and out of bed	☐	☐	☐	☐
Lift a full cup or glass to mouth	☐	☐	☐	☐
Walk outdoors on flat ground	☐	☐	☐	☐
Wash and dry entire body	☐	☐	☐	☐
Bend down and pick up clothing	☐	☐	☐	☐
Opening jars / bottles	☐	☐	☐	☐
Get in and out of car	☐	☐	☐	☐

When was your last colonoscopy performed?_____**Mammogram?**_____

Do you have morning stiffness: ☐ **Yes** ☐ **No** **How long does it last?**_____ **Hours**_____ **Minutes**_____**All Day Long**

Considering ALL THE WAYS THAT YOUR ILLNESS AFFECTS YOU, RATE HOW YOU ARE DOING on the following scale. Check the number below that best describes how you are doing on a scale of 0-10.

VERY WELL ☐ **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** **VERY POORLY** **VAS Global (0-10)**

SMOKING STATUS ☐ **CURRENT / EVERY DAY** ☐ **SOME DAYS** ☐ **FORMER** ☐ **NEVER**

Who is your PCP:_____

_____

What pharmacy do you use? _____

_____

BONE, MUSCLE and JOINT SPECIALISTS
at the Arthritis Treatment Center

NAME : _____ DOB : _____ DATE : _____

MEDICAL HISTORY

Do YOU have any past history or recent diagnosis of: (Please check yes or no)

Multiple sclerosis	Yes☐ No☐	Blood transfusions	Yes☐No☐
Hypertension	Yes☐ No☐	Cancer/lymphoma	Yes☐No☐
Congestive heart failure	Yes☐ No☐	Kidney disease (not stones or bladder infections)	Yes☐No☐
Heart disease	Yes☐ No☐	Gonorrhea/chlamydia/syphilis/HIV	Yes☐No☐
Inflammatory bowel disease (Ulcerative Colitis or Crohn's Disease)	Yes☐ No☐	Diabetes	Yes☐No☐
Stomach ulcer	Yes☐ No☐	Emphysema/COPD/asthma	Yes☐No☐
Psoriasis	Yes☐ No☐	Tuberculosis (TB)	Yes☐No☐
Osteoporosis	Yes☐ No☐	Fungal disease of the lungs	Yes☐No☐
Gout	Yes☐ No☐	Hepatitis	Yes☐No☐

Have you ever had a TB skin test? ☐Yes☐ No If so, was it positive? ☐Yes ☐ No If yes, were you treated? ☐Yes ☐No

List any other personal past illnesses, hospitalizations and current illnesses

_____

_____

List past surgeries.(You may exclude normal pregnancies) Please indicate left or right if applies

Year Operation Hospital City/State

_____

_____

_____

_____

Have you ever broken any bones? ☐Yes ☐ No

Have you ever been seriously injured in an automobile accident? ☐Yes ☐No

If yes, describe_____

List allergies (food and medications)_____

Have your had side effects from medications? ☐Yes / ☐No If yes, please list:_____

_____

Do you smoke? ☐Yes ☐ No If yes, how much?_____ How many years_____

Do you drink? ☐Yes ☐ No If yes, how much?_____ How often_____

Do you use recreational drugs? ☐Yes ☐ No If yes, how often?_____

Do you use marijuana? ☐Yes ☐No If yes, how often?_____

List all serious illness in your **IMMEDIATE FAMILY** (parents, brothers, sisters)? (Please check yes or no)

Gout	☐Yes ☐ No	Osteoporosis	☐Yes ☐No	Multiple sclerosis	☐Yes ☐No
Lupus	☐Yes ☐ No	Psoriasis	☐Yes ☐No	Hemochromatosis	☐Yes ☐No
Rheumatoid arthritis	☐Yes ☐ No	Colitis	☐Yes ☐No	Heart Disease	☐Yes ☐No
Osteoarthritis	☐Yes ☐ No	Cancer	☐Yes ☐No	Stroke	☐Yes ☐No
Spondylitis	☐Yes ☐ No	TB	☐Yes ☐No		

Other_____

Are you employed?☐Yes ☐No ☐FT or PT ☐Retired? ☐Yes / ☐No Disabled? ☐Yes / ☐No

What is your occupation? (e.g., carpenter, clerical work etc.)_____

Does your problem interfere with your job performance? ☐ Yes / ☐ Yes, If yes, explain_____

_____

Who lives at home with you?_____

Immunizations: "X" any tests that you have had and most recent year they were done (if recalled)

_____Flu (Year)_____ Pneumonia (Year)_____

If you are a female, have you gone through menopause? ☐ Yes ☐No If yes, how long ago?_____
Have you ever had a bone density (DEXA) test? ☐ Yes ☐ No

BONE, MUSCLE and JOINT SPECIALISTS
at the **Arthritis Treatment Center**

NAME: _____ DOB: _____ DATE: _____

REVIEW OF SYMPTOMS

Do you have any problems related to the following systems? Check Yes or No

(Please explain any Yes answers in the space provided)

Constitutinal Symptoms

Fever	Y ☐	N ☐
Chills	Y ☐	N ☐
Headache	Y ☐	N ☐
Fatigue	Y ☐	N ☐
Unexplained Weight Loss *(if yes, how much?)*	Y ☐	N ☐

Eye

Blurred Vision	Y ☐	N ☐
Double Vision	Y ☐	N ☐
Eye Pain	Y ☐	N ☐
Dry Eyes	Y ☐	N ☐

Ear/Nose/Throat/Mouth

Ringing in ears	Y ☐	N ☐
Deafness/hearing loss	Y ☐	N ☐
Swelling of parotid glands	Y ☐	N ☐
Sores in mouth	Y ☐	N ☐
Dry mouth	Y ☐	N ☐
Hair loss	Y ☐	N ☐

Allergic/Immunologic

Hay Fever	Y ☐	N ☐
Drug/food allergies	Y ☐	N ☐
Hives	Y ☐	N ☐

Neurological

Tremors	Y ☐	N ☐
Dizzy spells	Y ☐	N ☐
Numbness/tingling	Y ☐	N ☐
Seizures	Y ☐	N ☐

Endocrine

Excessive thirst	Y ☐	N ☐
Too hot/cold	Y ☐	N ☐
Tired/sluggish	Y ☐	N ☐

Gastrointestinal

Abdominal pain	Y ☐	N ☐
Nausea/vomiting	Y ☐	N ☐
Decreased appetite	Y ☐	N ☐
Difficulty swallowing	Y ☐	N ☐
Painful swallowing	Y ☐	N ☐
Yellow skin (jaundice)	Y ☐	N ☐
Bloody stools	Y ☐	N ☐
Black tarry stools	Y ☐	N ☐
Diarrhea	Y ☐	N ☐

Cardiovascular

Chest pain	Y ☐	N ☐
Angina	Y ☐	N ☐
Ankle swelling	Y ☐	N ☐
Do your fingers become dead white and blue when exposed to the cold?	Y ☐	N ☐

Pulmonary

Wheezing	Y ☐	N ☐
Frequent cough	Y ☐	N ☐
Shortness of breath	Y ☐	N ☐
Pleurisy	Y ☐	N ☐

Integumentary (skin)

Skin rash	Y ☐	N ☐
Skin ulcers/sores	Y ☐	N ☐
Skin tightening	Y ☐	N ☐
Psoriasis	Y ☐	N ☐
Does sun exposure cause you to break out in a rash?	Y ☐	N ☐

Hematologic(blood)/lymphatic

Anemia	Y ☐	N ☐
Low white count	Y ☐	N ☐
Low platelets	Y ☐	N ☐
Blood clotting problems	Y ☐	N ☐

Genitourinary

Urine retention	Y ☐	N ☐
Painful urination	Y ☐	N ☐
Discharge from male or female organs	Y ☐	N ☐
Blood or protein in urine	Y ☐	N ☐
Have you ever had a sexually transmitted disease?	Y ☐	N ☐

Psychologic

Are you generally satisfied with life?	Y ☐	N ☐
Do you feel depressed?	Y ☐	N ☐

Please explain any Yes answer here: _____

WWW.ARTHRITISTREATMENTCTR.COM

3377 Main Street ▲ Springfield, MA 01107-1135 ▲ Telephone: (413) 734-5661

Name:

ARTHRITIS TREATMENT CENTER

Medication Schedule

PLEASE LIST MEDS AND BRING WITH YOU

Date Started	Name of Drug	Strength	Schedule	M.D.

Scott M. Halista, M.D., F.A.C.P., F.A.C.R.
C.Bruce Tallman, Jr., M.D., F.A.C.R.
Donald R. Griger, M.D., F.A.C.R.
Antonio Valentin, M.D., F.A.C.R.
Dilpreet K. Singh, M.D., F.A.C.R.

Verified patient identity _____
Method of verification _____

I. PATIENT INFORMATION RECORD

Name _____
Address _____ Marital Status_____
City/State/Zip _____ Spouse Name _____
DOB _____ Patients SS No_____
Home Phone (_____)_____Work Phone (_____)_____ Cell Phone (_____)_____
Sex: M☐ F☐ Employment Status _____ Language _____

PRIMARY INSURANCE INFORMATION: WE DIRECTY BILL ALL INSURANCES

Blue Shield No. _____ Subscriber Name: _____
Medicare No. _____ Subscriber SS # _____
Welfare/Medicaid No. _____ Subscriber DOB _____
Commercial Insurance Co. _____
Insurance Name _____
Subscriber Employer _____
Address _____
Certificate No. _____

If your insurance requires you to have a referral to see us, please make sure you have one before your appointment. We do not accept Workman's Comp, or Auto Accident Insurance.

II.SECONDARY INSURANCE

Insurance Co. Name _____ Subscriber SS # _____
Insurance Co. Address _____ Subscriber Date of Birth _____
Subscriber Name _____ Subscriber Employer _____
Is this insurance through an employer? ☐ Y/N ☐
Name of employer _____ Employer address _____

III. RACE

Caucasian (White)☐ ☐ American Indian or Alaskan Native☐ ☐ Native American ☐ Pacific Islander ☐
Black/African American ☐ Native Hawaiian ☐ Asian Pacific American ☐ Subcontinent Asian American ☐
Asian ☐ Other Race _____

IV. ETHNICITY

Non-Hispanic ☐_ Hispanic ☐_

V. Rheumatology Associates employs a staff of rehabilitative rheumatology physical therapists in order to provide therapy through our Arthritis Treatment Center. Although there may be alternative locations in which to receive physical therapy in your area, the Arthritis Treatment Center provides a team approach by specialists for your treatment through close proximity with, and supervised by, your physician.

Therapist's Signature 

I certify that the above information is correct. I authorize the payment of medical benefits to the Arthritis Treatment Center and/or Rheumatology Associates. PC for those charges covered by my insurance benefits. I understand that I am responsible for payment of charges not covered by this insurance. I also authorize release of information to my insurance company for payment purposes, utilization review or coordination of benefits. This authorization shall remain valid during the term of coverage under my group plan. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits to either myself or the party who accepts assignment. (Regulations pertaining to Medicare assignment of benefits apply). The privacy of your health information is important to us. We have on file a privacy disclosure form which you may request at any time.

_____
Patient's Signature

SIGNATURE ON FILE

1.MEDICARE

_____
Patient's Name: (Print)

_____
Medicare Identification No.

I request that payment of authorized Medicare benefits be made on my behalf to Rheumatology Associates P.C./ Arthritis Treatment Center for services furnished to me by Scott M. Halista, M.D., C. Bruce Tallman, Jr., M.D., Donald R. Griger, M.D., Antonio Valentin, M.D., Dilpreet K. Singh, M.D. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approval claim forms, my signature authorizes releasing the information to the insurer or agency shown. Rheumatology Associates P.C./Arthritis Treatment Center, Scott M. Halista, M.D., C. Bruce Tallman, Jr., M.D., Donald R. Griger, M.D., Antonio Valentin, M.D., Dilpreet K. Singh, M.D. accepts the charges determined by the Medicare carrier. National Heritage Insurance Company, as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charges determined by the Medicare carrier.

_____ _____
Signature Date

2. MEDIGAP/SECONDARY INSURANCE

If Medigap policy or other insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made either to me or on my behalf of Rheumatology Associates P.C./Arthritis Treatment Center, Scott M. Halista, M.D., C. Bruce Tallman, Jr., M.D., Donald R. Griger, M.D., Antonio Valentin, M.D., Dilpreet K. Singh, M.D.

_____ _____
Signature Date

3. OTHER INSURANCE

I hereby authorize payment of my medical and surgical insurance benefits to Rheumatology Associates P.C./Arthritis Treatment Center. I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Rheumatology Associates P.C./Arthritis Treatment Center to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

_____ _____
Signature Date

4. HIPPA CONSENT:

- When you receive treatment at Rheumatology Associates/ Arthritis Treatment Center information will be collected about you, and this office will generate information about your medical condition. This private health information falls under Federal regulation within a law called the Healthcare Information Portability and Accountability Act (HIPPA). **This information may be used or disclosed for treatment, payment, or to carry out healthcare operations.**
- There is a Notice of Privacy Practices posted in this office and available to you regarding the use of your private medical information. You have a right to review this document before giving consent for your care.
- You have the right to request that Rheumatology Associates restrict how your medical information is used or disclosed, but Rheumatology Associates has the right not to agree with your request. If Rheumatology Associates agrees to restrictions, they are binding on the physicians, providers, and staff.
- You have the right to revoke your consent to use your health information, except to the extent that your physician has already taken action based on previous consent.
- If you do not consent to this health information policy, Rheumatology Associates reserves the right not to provide care to you and to arrange for care from someone else. We will not restrict or refuse your care in a medical emergency.

_____
Signature of patient, Parent or guardian

Rheumatology Associates, P.C. dba Arthritis Treatment Center

Notice of Privacy Practices Acknowledgment Form

Name: _____

I have received a copy of the Rheumatology Associates, P.C. dba Arthritis Treatment Center Notice of Privacy Practices (Version _____ Effective Date _____)

_____ _____

Signature Date

Individual or Personal Representative with legal authority to make healthcare decisions

.

If signed by a Personal Representative:

Print Name _____ Role _____

(Parent, guardian, etc)

Witness _____ Date _____

If the individual has a personal representative with legal authority to make health care decisions on the individual's behalf the notice must be given to and acknowledgment obtained from the personal representative***. If the individual or Personal Representative did not sign above, staff must document when and how the notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it***.

Notice of Privacy Practices given to the individual on _____ by

- ☐ Face to face meeting
- ☐ Mailing
- ☐ Email
- ☐ Other _____

Reason Individual or Personal Representative did not sign this form:

- ☐ Individual or Personal Representative chose not to sign
- ☐ Individual or Personal Representative did not respond after more than one attempt
- ☐ Email receipt verification
- ☐ Other _____

Good Faith Efforts: The following good faith efforts were made to obtain the individual or Personal Representative's, if applicable, signature. Please document with detail (e.g., date(s), time(s), individuals spoken to and outcome of attempts) all efforts that were made to obtain the signature. More than one attempt must have been made.

- ☐ Face to face presentation(s)_____
- ☐ Telephone contact(s) _____
- ☐ Mailing(s) _____
- ☐ Email _____
- ☐ Other _____

Staff Signature _____ Title _____

Print Name _____

Date _____

Scott M. Halista, MD, FACR
C. Bruce Tallman, Jr., MD, FACR
Donald R. Griger, MD, FACR
Antonio Valentin, MD, FACR
Dilpreet K. Singh, MD

Specialized Care of:

OSTEOPOROSIS

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TENDINITIS

MUSCULOSKELETAL CONDITIONS

GOUT

BACK PAIN

NECK PAIN

CARPAL TUNNEL SYNDROME

CONNECTIVE TISSUE

Thank you for choosing to receive your health care at our medical office.
This document contains important information concerning financial responsibility for services received.

FINANCIAL GUIDELINES FOR HEALTH CARE SERVICES

Please present your insurance card at every visit.

As a courtesy to you, we will bill your health insurance company directly in most cases.
You will be responsible for payment of any copayment, coinsurance or deductibles required by your insurance plan. If your insurance company denies or delays payment, we will bill you directly. Copayments are due and payable at the time of your visit. We accept MasterCard, Visa and Discover Card. If you pay by check and it is returned, it will be necessary to apply a $25 fee to your account.

REFERRALS, SPECIALTY CARE

Your insurance plan may require that prior authorization be obtained for certain services in order to provide reimbursement. Please contact your insurance company to determine referral requirements before receiving services. If the visit requires a referral, you are responsible for obtaining this referral through your primary care physician. A referral is not a guarantee of coverage.

NON-COVERED SERVICES

It is very important that you take the time to read and understand the information provided to you by your insurance company including your member handbook. All insurance companies have limits on the services they cover, and it is extremely important that you know your membership eligibility, benefits, limitations and exclusions under your specific plan. **If we bill your insurance and payment is denied for any valid reason, payment remains your responsibility.**

LABORATORY

Certain lab tests are provided by a third party company. Please be aware that you may be billed separately for these services. If you have questions about this bill, please contact your insurance company. Some insurance companies have identified specific laboratories for you to use. Your insurance company can tell you these arrangements.

WHERE TO GO IF YOU HAVE QUESTIONS

Our billing staff are available to help you if you have questions regarding this policy or other customer service issues regarding your balance. They can be reached Monday through Friday, 8 a.m. - 4 p.m. at 413-734-5661.

For questions regarding your insurance policy and guidelines, call the telephone number on your ID card.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND AGREE TO ABIDE BY THESE GUIDELINES. This will remain in effect for any services provided to me by the **ARTHRITIS TREATMENT CENTER.**

_____	_____
Patient's Name (Print)	Patient's Social Security Number
_____	_____
Patient's Signature	Date

Arthritis Treatment Center
SPECIALISTS IN BONES, MUSCLES, AND JOINTS

3377 Main Street Springfield MA 01107-1135
(413) 734-5661 Fax: (413) 739-2732

AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION AND REPORTS

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

1. I hereby authorize the Arthritis Treatment Center to provide copies of medical reports and medical information to the following:

Names:

Spouse:_____
Parent/Guardian:_____
Children:_____
Referring Physician or Primary Doctor:_____
Insurance Company:_____
Employer:_____
Attorney:_____
Other:_____

Please initial here:_____if you authorize us to release information to any physician who is also involved in your care.
Please initial here:_____if you authorize us to release information to your dentist, oral surgeon, Podiatrist or physical therapist.
Our office will not release any information regarding your health without your written consent.

2. I release the Arthritis Treatment Center and it's employees or agents from any claim, loss, or damage arising from the release of such reports or information to anyone whom I have indicated above.

_____ _____
(Signature) (Date)

I authorize release of other information regarding my treatment, hospitalization, and/or outpatient care for my condition, including psychological or psychiatric impairment, developmental disabilities, drug abuse and/or alcoholism, domestic abuse, or Acquired Immunodeficiency Syndrome (AIDS), or tests for or infection with Human Immunodeficiency Virus (HIV)

_____ _____
(Signature) (Date)

As you know, our practice is limited to Rheumatology. You should have a primary care physician (e.g., internist). who can provide care for any non-rheumatologic illnesses, monitor general health, etc. I have read and understand the above.

_____ _____
(Signature) (Date)

Arthritis Treatment Center
SPECIALISTS IN BONES, MUSCLES, AND JOINTS

3377 Main Street Springfield MA 01107-1135
(413) 734-5661 Fax: (413) 739-2732

AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION AND REPORTS

Nombre del paciente: _____ **Fecha de nacimiento:**_____

1. Por la presente autorizo al Arthritis Treatment Center a que entregue copias de informes medicos y de informacion medica a los siguientus interesados:

Nombres:

Esposa/ o: _____

Padre/ Madre/ Tutor:_____

Hijos:_____

Doctor Principal o medico consultado:_____

Compania de seguros:_____

Empresa para la que trabaja:_____

Abogado:_____

Otros:_____

Ponga sus iniciales aqui:_____en el caso que nos qutorice a entregar informacion a cualquier medico que este involucrado en su cuidado medico.

Ponga sus iniciales aqui:_____ en el caso que nos autorice a entregar informacion a su dentisat, cirujano dental, padologo o terapeuta de tratamiento fisico.

Nuestras oficinas no revelaran ninguna informacion relacionada con su salud sin su consentimiento escrito.

La presente autorizacion para la difusion de informacion medica sera valida hasta que Ud. nos notifique por escrito que quiere lo contrario.

2. Absuelov a Athtris Treatment Center y todos sus empleados o agentes de toda responsabilidad con relacion a cualquier demanda, perdida o dano que surgiera como resultado de la difusion de los informes o la informacion menciondad a las personas que indicado anteriormente.

_____ _____
(Firma) (Fecha)

Autorizo la difusion de aquella informacion relacionada con mi tratamiento, hospitalizacion, y/o cuidados como paciente externo debido a mi condicion medica, incluyendose discapacidades psicologicas o psiquiatricas, desareglos del desarrollo, consumo de drogas y/ o alcohol, violencia domestica, o SIDA (Sindrome de inmunodeficiencia Adquirida), o analisis medicos para VIH (Virus de Inmunodeficiencia Humano).

_____ _____
(Firma) (Fecha)

Como ya sabe, nuestra practica se limita la reumatologia. Por otra parte Ud. deberia tener un medico principal de cuidados medicos que le ayude con el tratamiento de enformedades no reumatologicas y que le controle su salud en general.
He leido y comprendido lo caterior.

_____ _____
(Firma) (Fecha)