COLUMBUS ARTHRITIS CENTER

Leaders in Rheumatology Care since 1955.

Rheumatologists

Sterling W. Hedrick, M.D., FACR

Catherine Lee, M.D., FACR

Kevin D. Schlessel, M.D., FACR

Jennifer M. Richardson, M.D., FACR

Anupama Chauhan, M.D., FACR

Marc A. Antonchak, M.D., FACR

Joseph Flood, M.D., MACR, FACP

Matthew L. Mundwiler, M.D., FACR

Namrata Dhillon, M.D., FACR

Navya Parsa, M.D., FACR

Jacob W. Seymour, D.O., FACR

Physician Assistants

Shannon Ghizzoni, PA-C

Candice Devol, PA-C

S. Mallory Fatseas, PA-C

Chelsea Austen, PA-C

Sarah Riley, PA-C

Riddhi Patel, PA-C

Elizabeth Pinta, PA-C

Michelle DeVilbiss, PA-C

Welcome to the Columbus Arthritis Center. Thank you for choosing our physicians for your rheumatology services. Our goal is to meet your individual needs and to provide quality medical care in a convenient, comfortable setting.

Our Physicians are Board Certified Rheumatologists and Fellows in the American College of Rheumatology. Our staff is highly qualified, efficient, courteous, and they work very hard to do their best for our patients.

Our office is open five days a week, Monday through Friday, from 8:00 am until 4:30 pm. To contact us during regular hours, just dial 614-486-5200 and follow the prompts for your Doctor's Nurse, for appointments, for billing questions, etc.

Once you have completed your first visit with your doctor and you have an urgent medical need after regular hours of operation, your doctor is available to you. Just call 614-486-5200 and follow the prompts to leave a message for your doctor. This will page your doctor automatically. He/She will return your call within a short period of time.

Enclosed you will find a number of papers for you to read, complete, and sign. Please bring this packet with you to your appointment and ensure that it is completely filled out prior to your arrival. Check both front and back of each page for required documentation.

We ask that you arrive at our office at 30 mins prior to your scheduled appointment time. Please bring your insurance card(s), your copay, a photo ID, this packet entirely filled out, and any results from recent lab work or x-rays. If you do not arrive 30 minutes early with your entire packet completely filled out, your appointment may be rescheduled for a later available date. Please contact our office at least 48 hours prior to your arrival date to confirm your appointment. All unconfirmed appointments may be cancelled.

We look forward to meeting you and providing you with high quality medical care.

For this information and more please visit our website
www.columbusarthritis.com

Financial Policy

Thank you for choosing us as your health care provider. We are committed to providing you with quality medical care. Please understand that payment of your bill is considered part of your obligation as a patient. The following information is provided to avoid any misunderstanding or disagreement concerning payment of services provided by our office.

1.) Our office participates with a variety of insurance plans. It is your responsibility to:

- Bring your current insurance card to every visit and notify us of changes in coverage
- Pay your co-pay at each visit. Payment can be made by cash, check, MasterCard, Visa or Discover.
- Obtain any referrals your insurance carrier requires. Your appointment may be rescheduled if a referral is required and is not in place at the time of service.

2.) We will submit a claim to your insurance company for you. Balances not paid, per our contract by your primary insurance company, may be billed to your secondary payer. A monthly statement will be sent to you. Ultimately, you are responsible for payment of charges.

3.) If you do not have insurance coverage or are insured by a company with which we are not contracted; a deposit of $150.00 for new patients or $50.00 for established patients is expected prior to delivery of services. If you do not have insurance coverage we offer a discount of 30% when balance due is paid in full on the date of service. We understand the financial burden that this may present and therefore will be offering an additional credit option for those interested.

4.) If you have questions about your insurance, we will be happy to assist you. Specific coverage issues however, should be directed to your insurance company's member services department (the contact number is on your insurance card).

5.) All balances billed are due within 30 days of the statement date. Unpaid balances greater than 30 days are subject to our collection process. Accounts sent to our collection agency are subject to a 35% surcharge.

6.) A fee of $125.00 for a new patient or $25.00 for an established patient will be charged for all appointments that are not kept or cancelled within 24 hours prior to the appointment time. Upon request, your physician may agree to waive this fee for unforeseen circumstances.

7.) There is a fee of $25.00 on all returned checks.

8.) There is a fee to copy any and all medical records based on the number of pages copied, after a one time courtesy.

9.) Your physician may order a procedure to be performed either in our office or outside the office; you will need to contact your insurance provider to check your benefits for outpatient procedures. This coverage determination is not a guarantee of payment and is subject to coverage and benefits at the time of service. You may also ask our office for the procedure/diagnosis codes to verify that the procedure is a covered benefit.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

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FINANCIAL INTEREST DISCLOSURE FORM

To Our Patients Being Referred for MRI:

We wish to notify you that the physicians of the Columbus Arthritis Center, Inc are owners of the MRI services located at 1211 Dublin Rd, Columbus, OH 43215

We refer our patients to this location because we believe our staff provides quality medical care and excellent service to our patients. The services are convenient to our patients in terms of location, access, scheduling, hours of operation, and continuity of care.

We believe that our patients have a choice in the selection of facility where they may receive their care. If you prefer to obtain radiology services at another facility, please let us know and we will refer you to the facility of your choice. Below is a list of other facilities providing MRI services in this area. Please note that inclusion in this list is NOT an endorsement or recommendation of these providers or suppliers by Columbus Arthritis Center, Inc.

Advantage Diagnostics
1430 South High Street
Columbus, OH 43207
614-220-0001

Center for Diagnostic Imaging
866 West Broad Street
Columbus, OH 43222
614-221-4860

Polaris Open MRI
2141 Polaris Parkway
Columbus, OH 43240
614-841-0800

ProScan Imaging Dublin
4351 Dale Drive, Suite 100
Dublin, OH 43017
614-855-8740

ProScan Imaging-Pickerington
417 Hill Rd N
Pickerington, OH 43147
614-855-8740

Riverside Methodist Hospital
3535 Olentangy River Rd
Columbus, OH 43214
614-566-1111

Dublin Methodist Hospital
7500 Hospital Drive
Dublin, OH 43016
614-566-1111

Ohio State University Medical Ctr
410 W 10th Ave
Columbus, OH 43210
800-293-5123

Mount Carmel Health- West
739 West State Street
Columbus, OH 43222
614-234-5000

OhioHealth Doctors Hospital
5100 West Broad Street
Columbus, OH 43228
614-544-1000

These other facility addresses are NOT for your initial consult at Columbus Arthritis Center. Our providers are not at these other locations.

To Our Patients:

The Columbus Arthritis Center shall comply with federal and state laws that require health care facilities to inform patients of their rights to execute advance directives, such as a Living Will, Health Care Power of Attorney, or Do-Not Resuscitate Directive.

If you have advance directives that you would like added to your medical record or if you would like more information about them please let us know.

Thank you!

Additional information may also be found on the internet at:
http://www.ohpco.org/aws/MCA/pt/sp/livingwills
http://www.caringinfo.org

COLUMBUS ARTHRITIS CENTER, INC.

Patient Registration

PATIENT INFORMATION- ***DO NOT MAIL BACK PLEASE BRING TO YOUR APPOINTMENT***

Last Name _____ First _____ MI _____

Street Address _____ City _____ State _____ Zip_____

Social Security #_____-_____ -_____ **(required)** Home Phone (_____) _____

Cell Phone (_____) _____ Work Phone (_____) _____

You have my permission to leave a detailed personal message on my: Home Y / N Cell Y / N Work Y / N

Age _____ Date of Birth _____/_____/_____ Gender _____ Marital Status _____

Preferred Language_____ Race_____ Ethnicity ____ Hispanic ____ Latino ____Other

Employer Name _____ Occupation _____

To Be Notified In Case of Emergency _____ Phone (_____) _____

Your e-mail address:_____

Referring Doctor_____ Phone (_____) _____

Referring Doctor Address_____ City_____State _____ Zip _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ Address _____

Policy # _____ Group # _____

Name of Policy Holder:_____ Date of Birth _____/_____/_____ Relationship to Patient __ _____

Policy Holder's Social Security #_____-_____-_____ **(required)**

Employer Name_____ Phone (_____) _____

Employer Address_____ City_____State _____ Zip _____

SECONDARY INSURANCE _____ Address _____

Policy # _____ Group # _____

Name of Policy Holder:_____ Date of Birth _____/_____/_____ Relationship to Patient __ _____

Policy Holder's Social Security #_____-_____-_____ **(required)**

Employer Name_____ Phone (_____) _____

Employer Address_____ City_____State _____ Zip _____

RX Insurance Policy # Phone (_____) _____

OTHER PHYSICIANS

Identification of other physicians involved with my medical care whom I authorize ongoing release of information for continuity of care:

Provider _____ Phone (_____) _____

Address _____ City _____ State _____ Zip_____

Type of physician / health care provided: _____

Provider _____ Phone (_____) _____

Address _____ City _____ State _____ Zip_____

Type of physician / health care provided: _____

Patient Name:_____ Date of Birth:____/____/____

Preliminary History Sheet

Where is most of your pain? Please Check. Please Circle Right, Left or Both where appropriate.

Neck___	Elbows___ R L B	Knees___ R L B	Fingers___
Mid Back___	Wrist___ R L B	Ankles___ R L B	Toes___
Low Back___	Hand___ R L B	Mid-foot___ R L B	Other_____
Shoulders___ R L B	Hip___ R L B	Forefoot___ R L B	Other_____

Is your pain aggravated by any of the following? Please Check.

Activity___	Gripping___	Arising from a chair___
Rest___	Standing___	Cold or rainy weather___
Sleep___	Walking___	Other_____
Reaching___	Climbing Stairs___	Other_____

Is your pain relived by any of the following? Please Check.

Activity___	Heat___	Rest___	OTC Medication____ Type?
Bracing___	Rest___	Sitting___	Prescription Medication___
Cold___	Injection____	Other____	Other_____

Do you have any of these related symptoms? Please Check.

Abdominal Pain___	Fatigue___	Morning Stiffness___	How long?____
Activity Limitations___	Headaches___	Rashes___	Where?_____
Anorexia___	Weakness___	Joint swelling___	Where?_____
Eye symptoms___	Limping___	Weight loss/gain___	

When did your pain start? Please Circle.

1 2 3 4 5 6 7 8 9 10 Months Years Days ago

Specific date ____/____/____

On a scale of 1-10, with ten being the highest, what is the level of your pain? Please Circle.

1 2 3 4 5 6 7 8 9 10

How often do you have pain? Please Check.

Frequent__ Occasional__ Intermittent__ Persistent__ Rare__

Preliminary History Sheet

Patient Name:_____ Date of Birth: ____/____/_____ Today's Date___/____/_____

Medication	Dose	Instructions	Year started		Medication	Dose	Instructions	Year started

Allergies: **No Known Allergies** ☐

Name	Reaction	Name	Reaction

Social History:

Tobacco Use: Yes ☐ No ☐ Former ☐ Year Quit____

Type_____ Amount per day _____

Drinks Alcohol: Yes ☐ No ☐ Former ☐ Year Quit____

Type_____ Frequency_____

Amount_____

Drinks Caffeine: Yes ☐ No ☐ Amount_____

Females only:

Are you currently breast feeding? Yes ☐ No ☐

Vaccinations:

Vaccine	**Dose#/Mfr**	**Date/Year**
Covid-19 vaccine		
Hepatitis B Vaccine		
Influenza Vaccine		
Shingles Vaccine		
BCG Vaccine		
Pneumovac		
Tests	**Result**	**Year**
TB Skin Test		
Chest X-ray		

Columbus Arthritis Center, Inc.

Medical History Sheet

Name: _____ Date:____/____/_____

Are you taking or have you ever taken any of the following? If you answer yes, please list the stop date.

Allopurinol (Zyloprim)		Ansaid (Flurbiprofen)	
Arava (Leflunomide)		Arthrotec (Diclofenac Sodium)	
Auranotin (Gold Tablets)		Aspirin / Ecotrin / Trilisate / Disalcid	
Azulfidine (Sulfasalazine)		Bextra (Valdecoxib)	
Colchicine (Probenecid)		Celebrex (Celecoxib)	
Cuprimine, Depen (Penicillamine)		Clinoril (Sulindac)	
Cytoxan (Cyclophosphamide)		Daypro (Oxaprozin)	
Enbrel (Etanercept)		Feldene (Piroxicam)	
Humira (Adalimumab)		Indocin (Indomethacin)	
Remicade (Infliximab)		Lodine (Etodolac)	
Imuran (Azathioprine)		Meclomen (Meclofenamote)	
Methotrexate (Methotrexate Sodium)		Motrin / Nuprin / Advil (Ibuprofen)	
Plaquenil (Hydroxychloroquine)		Mobic (Meloxicam)	
Solganol, Myochrisine (Gold Shots)		Nalfon (Fenoprofen)	
Cortisone, Prednisone, or Deltasone		Naprosyn (Naproxen / Aleve)	
a. Tablets		Orudis / Oruvail (Ketaprofen)	
b. Injections in the Joints		Relafen (Nabumetone)	
c. IM Injections		Tolectin (Tolmetion Sodium)	
Hyalgan Injections		Toradol (Ketorolac Tromethamine)	
Supartz Injections		Vioxx (Rofecoxib)	
Synvisc Injections		Voltaren (Diclofenac Sodium)	
Oral Bonvia		Actonel or Actonel w/ Calcium	
Atelvia (risedronate)		Didronel (etidronate)	
Skelid (tiludronate		Fosamax or Fosamax plus D	
Tamoxifen (nolvadex)		Evista (raloxifene)	
Femara (letrozole)		Fareston (toremifene)	

Below, please list the medications stopped because of allergy, contraindication, failure or intolerance.

_____ _____

_____ _____

_____ _____

Patient Name:_____ Date Of Birth:____/_____/____

Family History

Please check if any member of your immediate family had or has had any of these conditions.

	Family Member	Cause of Death: Y/N
Alzheimer ’s disease __	_____	_____
Coronary Artery Disease __	_____	_____
Premature Coronary Artery Disease__	_____	_____
Cancer__ Type_____	_____	_____
Depression__	_____	_____
Diabetes__	_____	_____
Eczema__	_____	_____
Fibromyalgia __	_____	_____
Hypertension__	_____	_____
Irritable Bowel Syndrome __	_____	_____
Lupus__	_____	_____
Mental Illness __	_____	_____
Migraines __	_____	_____
Obesity __	_____	_____
Osteoarthritis __	_____	_____
Osteoporosis__	_____	_____
Peripheral Artery Disease__	_____	_____
Psoriasis__	_____	_____
Renal Disease__	_____	_____
Rheumatoid Arthritis__	_____	_____
Stroke __	_____	_____

Patient Name:_____ Date of Birth ____/____/____

Preliminary History Sheet

Please check if you have any of these medical problems.

Allergies __	Cancer __ Type_____	Hepatitis__	Renal Disease__
Anemia __	COPD __	High Cholesterol__	Peptic Ulcer __
Anxiety __	Coronary Disease __	High Blood Pressure__	Seizures __
Arthritis __	Crohn's Disease __	IBS__	Stroke __
Asthma __	Depression__	Liver disease __	Thyroid Disease __
Atrial Fibrillation __	Diabetes __	MI __	Shingles_____
BPH__	Gall Bladder Disease __	Osteoarthritis __	Other_____
Blood Clots__	GERD__	Osteoporosis __	Other_____

Please check if you have had any of these procedures and list the year of the procedure.

Procedure	Year	Procedure	Year	Procedure	Year
Angioplasty__	____	Hernia Repair __	____	Breast Biopsy __	____
Angioplasty with a stent__	____	Hip Replacement __	____	Cesarean Section __	____
Appendectomy__	____	Knee Replacement__	____	D & C __	____
Back surgery__	____	Knee Arthroscopy __	____	Hysterectomy __	____
CABG__	____	LASIK __	____	Mastectomy __	____
Carpal tunnel release__	____	Liver Biopsy__	____	Prostate Biopsy __	____
Cataract Extraction__	____	ORIF __	____	Tubal Ligation __	____
Gall Bladder Removed__	____	Pacemaker __	____	TAH/BSO __	____
Colectomy__	____	Small Bowel Resection__	____	TURP __	____
Colostomy__	____	Thyroidectomy __	____	Vasectomy __	____
Gastric Bypass __	____	Tonsilectomy __	____	Other_____	

The Columbus Arthritis Center

Patient Disease Activity and Symptom Form

OVER THE PAST WEEK, were you able to **(Check only one)**:	*No Difficulty*	*Some Difficulty*	*Much Difficulty*	*Unable to do*
Dress yourself, including tying shoes and doing buttons?	☐	☐	☐	☐
Get in and out of bed?	☐	☐	☐	☐
Lift a full cup or glass to your mouth?	☐	☐	☐	☐
Walk outside on flat ground?	☐	☐	☐	☐
Wash and dry your entire body?	☐	☐	☐	☐
Bend down to pick clothing from the floor?	☐	☐	☐	☐
Turn regular faucets on and off?	☐	☐	☐	☐
Get in and out of the car, bus, train or plane?	☐	☐	☐	☐
Walk two miles, if you wish?	☐	☐	☐	☐
Participate in recreational activities and sports as you would like, if you wish?	☐	☐	☐	☐

How much pain have you had because of your condition **OVER THE PAST WEEK**? Please indicate below how severe your pain has been:

NO PAIN	0	0.5	1	1.5	2	2.5	3	3.5	4	4.5	5	5.5	6	6.5	7	7.5	8	8.5	9	9.5	10	PAIN AS BAD AS IT COULD BE
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Considering all the ways in which illness and health conditions may affect you **AT THIS TIME**. Please indicate how you are doing:

VERY WELL	0	0.5	1	1.5	2	2.5	3	3.5	4	4.5	5	5.5	6	6.5	7	7.5	8	8.5	9	9.5	10	VERY POORLY
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Please check **Yes** if you have any of the following symptoms/problems:

Yes		Yes		Yes		Yes		Yes		Yes	
○	Joint pain	○	Fatigue	○	Body rash	○	Weakness	○	Shortness of breath	○	Depression
○	Back pain	○	Persistent fever	○	Face rash	○	Chronic headaches	○	Chest pain	○	Anxiety
○	History of broken bones	○	Unexplained weight loss	○	Rash from the sun	○	Numbness or tingling	○	Abdominal pain	○	Dizziness
○	Dry mouth	○	Unexplained weight gain	○	Nose bleeds	○	Memory loss	○	Diarrhea	○	Double vision
○	Dry eyes	○	Night sweats	○	Mouth ulcers/sores	○	Muscle spasm	○	Constipation	○	Vision loss
○	Hair loss	○	Hives	○	Raynaud's (blue fingers)	○	Pleurisy or Pericarditis	○	Difficulty swallowing	○	Hearing loss
										○	History blood clots

○	**Joint swelling**	Location of swelling: _____
○	**Morning stiffness**	If yes, how long: _____

Dear Patient: Please only check the symptoms that you are experiencing at this time. If no symptoms apply please mark all negative, an unchecked box indicates a negative response. Thank you!

Constitutional ○ **All Neg**

Neg	Positive
○	○ Chills
○	○ Fatigue
○	○ Fever
○	○ Malaise
○	○ Night sweats
○	○ Weight gain
○	○ Weight loss

other pos:_____

HEENT ○ **All Neg**

Neg	Positive
○	○ Ear drainage
○	○ Ear pain
○	○ Eye discharge
○	○ Eye pain
○	○ Hearing loss
○	○ Nasal drainage
○	○ Sinus pressure
○	○ Sore throat
○	○ Visual changes

other pos: _____

Respiratory ○ **All Neg**

Neg	Positive
○	○ Chronic cough
○	○ Cough
○	○ Known TB exposure
○	○ Shortness of breath
○	○ Wheezing

other pos: _____

Cardiovascular ○ **All Neg**

Neg	Positive
○	○ Chest pain
○	○ Claudication *pain in limbs from exertion
○	○ Edema *swelling from fluid
○	○ Palpitations

other pos:_____

Gastrointestinal ○ **All Neg**

Neg	Positive
○	○ Abdominal pain
○	○ Blood in stool
○	○ Changes in stools
○	○ Constipation
○	○ Diarrhea
○	○ Heartburn
○	○ Loss of appetite
○	○ Nausea
○	○ Vomiting

other pos: _____

Genitourinary ○ **All Neg**

Neg	Positive
○	○ Dribbling (male only)
○	○ Dysuria (painful urination)
○	○ Hematuria (blood in urine)
○	○ Polyuria (excessive urine)
○	○ Slow stream (male only)
○	○ Urinary frequency
○	○ Urinary incontinence
○	○ Urinary retention

other pos: _____

Psychiatric ○ **All Neg**

Neg	Positive
○	○ Anxiety
○	○ Depression
○	○ Insomnia

other pos: _____

Metabolic/Endocrine ○ **All Neg**

Neg	Positive
○	○ Brittle hair
○	○ Brittle nails
○	○ Cold intolerance
○	○ Hair changes
○	○ Heat intolerance
○	○ Hirsutism (male only)
○	○ Polydipsia (great thirst)
○	○ Polyphagia (excessive hunger)

other pos: _____

Neurological ○ **All Neg**

Neg	Positive
○	○ Dizziness
○	○ Extremity numbness
○	○ Extremity weakness
○	○ Gait disturbance
○	○ Headache
○	○ Memory loss
○	○ Seizures
○	○ Tremors

other pos: _____

Hematologic/Lymphatic ○ **All Neg**

Neg	Positive
○	○ Easy bleeding
○	○ Easy bruising
○	○ Lymphadenopathy

other pos: _____

Integumentary ○ **All Neg**

Neg	Positive
○	○ Contact allergy
○	○ Hives
○	○ Itching
○	○ Mole changes
○	○ Rash
○	○ Skin lesion

other pos: _____

Musculoskeletal ○ **All Neg**

Neg	Positive
○	○ Back pain
○	○ Joint pain
○	○ Joint swelling
○	○ Muscle weakness
○	○ Neck pain

other pos: _____

Limited Patient Authorization for Disclosure of Protected Health Information Form 7.31

Authorization to release information to friends/family

Please print all information. Form must be signed and dated.

Patient Name: _____

SSN (last four digits): _____ Date of Birth: _____

Entity Requested to Release Information: _____ Columbus Arthritis Center _____

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual/entity listed below.

Who will be authorized to receive information (the individual/entity who is to receive your PHI):

Individual/Entity Name: _____

Address: _____

Phone/Fax: _____ / _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

- ☐ office notes
- ☐ lab results, pathology reports
- ☐ x-rays
- ☐ financial history report (previous 3 years only).
- ☐ nursing home, home health, hospice, and other physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment
- ☐ Only send the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): _____

- This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____

Patient or authorized representative signature date

You have the right to receive a copy of signed authorizations upon request.

Leaders in Rheumatology Care since 1955.

COLUMBUS ARTHRITIS CENTER
GENERAL CONSENT

Patient Name:_____

Date of Birth: _____

Home Address: _____ _____ _____ _____
Street and Unit City State Zip Code

Primary Phone Number: _____

Provider: _____

I am requesting that health care services be provided to me (or my minor child or the patient named above) at Columbus Arthritis Center ("CAC"). I voluntarily consent to all medical treatment and health care related services that the caregivers at CAC consider to be necessary for me (or the patient named below). These services may include diagnostic, therapeutic, imaging, and laboratory services. My blood may be used to perform routine quality assurance testing. I am aware that the practice of medicine and surgery is not an exact science; no guarantees have been made to me about the results of treatments or examinations.

I understand that I have the right to discuss any treatment plan with my physician about the purpose, potential risks and benefits of any test ordered for me. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I further understand that if I have any concerns regarding any test or treatment recommended by my health care provider, I am encouraged to ask questions.

I understand that my protected health information may be used or disclosed by CAC for my treatment, to obtain payment for this treatment, for its health care operations and in accordance with CAC's Notice of Privacy Practices. I also understand that my protected health information will be disclosed to other CAC affiliates if needed for the purpose of furthering my treatment, to obtain payment for treatment, and for its health care operations, and I consent to the practices contained in this section.

Financial Responsibility: Subject to applicable law and the terms and conditions of any applicable contract between CAC and a third-party payer, and in consideration of all health care services rendered or about to be rendered to me (or the below-named patient), I agree to be financially responsible and obligated to pay CAC for any balance not paid under the "Assignment of Benefits/ Third Party Payers" paragraph below;

OR Subject to applicable law and in consideration of all health care services rendered or about to be rendered to me (or the below named patient), I agree to be financially responsible and obligated to pay CAC for the patient balances due.

Assignment of Benefits/Third-Party Payers: In consideration of all health care services rendered or about to be rendered to me (or the below-named patient), I hereby assign to CAC all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding CAC's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third-parties. A list of usual and customary charges is available upon request. I consent to any request for review or appeal by CAC to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third party payer.

I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to CAC on this form or updated at a later time, text messages and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from CAC and its affiliates, clinical providers, and business associates, along with any billing services, collection agencies, agents, or other third parties who may act on their behalf. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered. I understand this consent to communications is not required to receive services from CAC or any of the other authorized callers and that data usage and other charges may apply. I may revoke this consent to these communications at any time.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Name of Signatory **Relationship to Patient (if Applicable)**

Signature of Patient (18 years old or older) or Legal Guardian **Date/Time**

Acknowledgment of Receipt of Notice of Privacy Practices

HIPAA requires that CAC give you a Notice of Privacy Practices that describes how CAC will use and disclose your protected health information and explains your HIPAA Privacy Rights.

I have read the Notice of Privacy at www.columbusarthritis.com under the "FORMS" tab or received a copy of the Notice of Privacy Practices.

Signature of Patient (18 years old or older) or Legal Guardian **Date**