RheumCare

CARE THAT MOVES YOU

6605 Hillway Circle, Ste 101
Naples FL 34112
Phone: (239)262-6550
Fax: (239)261-9658

PATIENT DEMOGRAPHIC

First Name: _____ Last Name: _____

D.O.B: _____ Sex: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

REFERRING PHYSICIAN

Primary Care Physician: _____

Phone: _____ Address: _____

Referring Physician: _____

Phone: _____ Address: _____

EMPLOYMENT INFORMATION

Employer: _____

Phone: _____ Address: _____

INSURANCE INFORMATION

Primary Payer: _____ Member ID: _____

Group #: _____ Phone: _____

Claims Mailing Address: _____

Secondary Payer: _____ Member ID: _____

Group #: _____ Phone: _____

EMERGENCY CONTACT INFO

First Name: _____ Last Name: _____

Relation: _____ Phone: _____

AARA
American Arthritis & Rheumatology Associates

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PATIENT COMMUNICATION CONSENT FORM

Patient First Name: _____ Last Name: _____

D.O.B: _____ Primary Care Physician: _____

I agree to allow RheumCare LLC office to contact me in the following methods listed below regarding my private health information, appointment reminders, labs, medications, treatment plans and/or billing information. I authorize RheumCare LLC office to leave messages on my voicemail or answering machine when I am unavailable.

Method	Number/ Email Address	Messages (Circle One)
___ Home Phone	(____) _____ - _____	Yes | No
___ Cell Phone	(____) _____ - _____	Yes | No
___ Alternate Phone	(____) _____ - _____	Yes | No
___ Personal Email	_____	Yes | No

Must provide email address for patient portal access

I authorize RheumCare LLC and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below. I understand that by leaving spaces blank I am indicating my choice to be a "No Information" and I do not want any information released to anyone else.

Name	Relationship to Patient	Contact Info

By my signature below I acknowledge that I have read and understand the information provided on this consent form. I understand the risk associated with the different methods of communications, especially e-mail and texting, and consent to the conditions, restrictions and patient responsibilities as well as any other instruction that Jeffrey A. Alper M.D PA may impose.

Patient Signature: _____ **Today's Date:**_____

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CONSENT TO TREAT AND BILLING AUTHORIZATION (PAGE 1)

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

CONSENT TO TREATMENT: The patient and/or authorized representative of the patient, whose signature is affixed below, does hereby consent to any and all medical treatments and diagnostic examination administered at or offered in association with the healthcare operations of the office of RHEUMCARE LLC

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION: I hereby authorized the office of RHEUMCARE LLC, and each of my physician(s) to release medical, psychiatric, and substance abuse information, whether contained now or in the future, in my/the patient's records to the following: Insurance carriers(s) and/or employer(s) and/or organization(s) for the limited purpose of obtaining payment of all or part of the medical care services rendered at the office of RHEUMCARE LLC, including professional fees of physicians practicing at the office of RHEUMCARE LLC, which may include financial and medical record information to substantiate the need for the medical care rendered and the cost associated with the medical charges incurred.

The Federal HIPAA Privacy Regulations authorize health care providers to share your medical information for treatment purposes, without your consent, including treatment received after you leave. Florida law, however, restricts (in some instances) the ability of RHEUMCARE LLC, to share your medical information with health care providers for treatment purposes, if treatment is sought after your discharge. By signing this consent, you authorize the release of your records (current and historical) to health care providers with whom you or your treating physician(s) may consult for medical treatment. If you do to want to consent, you must cross through the paragraph and place your initials in the margin next to the paragraph.

This consent will remain in force during the period that I/the patient is accepted as patient of RHEUMCARE LLC You may revoke this authorization at any time by notifying the office of RHEUMCARE LLC, P.A., in writing, however, your revocation will not affect action taken by RHEUMCARE LLC, prior to receipt of notice of your revocation and had reasonable opportunity to act upon the revocation. Information disclosed pursuant to your authorization is from records whose confidentiality is protected by Federal or State law. Federal regulations or State law prohibit making any further disclosures of HIV antibody/substance abuse information without the specific written consent of the person to whom it pertains, or as otherwise permitted by Federal/State law.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all medical, dental and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical and dental plan, to issue payment directly to RHEUMCARE LLC, for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

If the office of RHEUMCARE LLC, has not received my/the patient's insurance payment within 30 days of billing, I/The patient agrees to actively and vigorously pursue collecting the insurance payment. If my/the patient's insurance has not remitted charges due within 45 days of receipt of treatment, I understand the entire balance becomes due and that RHEUMCARE LLC, may seek payment direct from me/the patient. THIS ASSIGNMENT OF BENEFITS IS IRREVOCABLE.

Patient Initials_____ **Today's Date** _____

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CONSENT TO TREAT AND BILLING AUTHORIZATION (PAGE 2)

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

MEDICARE PATIENTS: I request that payment of authorized Medicare benefits be made on my/the patient's behalf to RHEUMCARE LLC, I authorize any holder of medical information about me/the patient to release to the Health Care Financial Administration and its agents, any information to determine benefits payable for related services. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA--1500 claim is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co--insurance, and non--covered services. Co--insurance and the deductible are based upon the charged authorized by the Medicare carrier.

INSURANCE RECORD OF UNDERSTANDING: Your insurance company may require pre--authorization (precert), usually through your physician, to determine for which service(s) they will pay. Your insurance company may not pay your claim or may reduce your benefits if you do not provide us with a proper authorization. After the pre--authorization is obtained, additional information may be required by your insurance company for each visit to be covered. I understand that if I do not obtain the proper authorization, I will personally be liable to pay any penalty up to the total amount charged for the service received.

PATIENT/GUARANTOR AGREEMENT: I/we understand that RHEUMCARE LLC, is not in the business of extending credit and, therefore, the policy of RHEUMCARE LLC, is to require PAYMENT IN FULL AT THE TIME OF TREATMENT IS RENDERED. If RHEUMCARE LLC, must use the services of a collection agency or service to encourage prompt payment; a collection charge may be imposed. We may also choose to provide you with notice that you are being discharged as a patient of RHEUMCARE LLC,

NOTICE TO GUARANTOR: Do not sign this contract before you read it or if it contains any blank spaces. You are entitled to an exact copy of the agreement you sign. The undersigned hereby acknowledges receipt of a copy of the above disclosure statement containing all information pertinent to this transaction. By signing this patient/guarantor agreement, the guarantor(s) agree(s) to guarantee payment of all charges incurred by the patient for services at RHEUMCARE LLC, This is an absolute guaranty and it shall continue as long as any balance is due and owing for medical care rendered by RHEUMCARE LLC, I understand I am financially responsible for my account with RHEUMCARE LLC, regardless of any insurance benefits.

(By my signature below, I acknowledge reviewing the information contained in this document.)

Patient Signature_____ **Today's Date** _____

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HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: 1/1/2026

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests

- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law

- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Acknowledgment of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand the Notice of Privacy Practices document containing a more complete description of the uses and disclosures of my health information. I understand that RheumCare LLC ("Practice") has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below for a current copy of the Notice of Privacy Practices document.

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Patient Signature: _____ **Today's Date:** _____

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Financial & No Show Policy

- **Cancellation Policy:** A $75.00 fee may be charged for office visits, infusions, and/or other appointments not cancelled at least 24 hours in advance.

- **Payments at Time of Service:** Out-of-pocket expenses are due upon arrival. These may include co-payments, deductibles, co-insurance, or payment for services not covered by your insurance.

- **Outstanding Balances:** Any prior balances determined by your insurance to be your responsibility will also be collected upon check-in. Any future visits, diagnostic testing, and/or infusions may be rescheduled until balances are paid or payment arrangements with our office is made.

- **Insurance Billing:** We are pleased to file claims with your insurance company; however, you are ultimately financially responsible for all healthcare services rendered. If your primary or secondary insurance does not pay within 60 days of claims submission, direct payment may be required from you.

Patient Name _____ **Date of Birth**_____

Patient Signature_____ **Today's Date** _____

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MEDICAL INFORMATION

First Name: _____ **Last Name:** _____

Date of Birth: _____

ALLERGIES: Do you have any Drug Allergies? (Circle One) **YES** | **NO**

If the answer is YES, which one?

Name of Drug	Type of Reaction/Side Effect

MEDICATIONS: List any medications you are taking at this time. Include such items as aspirin, vitamins, laxatives, calcium supplements, etc.

Name of Drug	Dose/Strength # of Pills per Day	How Long have you taken this medication?	Has it Helped? (Check one)		
			A lot	Some	Not at all

NAME OF PHARMACY: _____

Phone: _____

Address: _____

Patient Signature: _____ **Date:**_____

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EXTERNAL PROVIDER RECORDS RELEASE FORM

Patient Name: _____
Date of Birth: _____
Email Address: _____
Phone Number: _____

Section A – Requesting Records from Another Provider / Facility
I authorize the use and disclosure of all my health information, including sensitive information, from:

- Office Name: _____
- Phone: _____
- Address: _____
- Fax: _____

To be sent to:
RheumCare LLC
6605 Hillway Circle, Suite 101
Naples, FL 34112
Fax: 239-261-9658

Purpose: To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.
Effective Period: Until my death or written revocation.

Section B – Releasing Records to Another Provider / PCP
I authorize RheumCare LLC to release my medical records to:

- Provider / Organization Name: _____
- Address: _____
- Phone: _____
- Fax: _____
- Email: _____

Purpose: To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

Delivery Method (select one):
☐ Fax ☐ Email ☐ Mail

Fees: No charge when faxing or emailing directly to another provider.

Acknowledgment & Authorization
I understand my records may include sensitive information (alcohol/drug use, communicable diseases, HIV, psychiatric/psychological treatment). I authorize the use of this form (including electronic copy) for disclosure. I understand that records may be redisclosed to others as allowed by law. Refusing to sign does not stop disclosures permitted by law. I have read and agree to the disclosures above.

Patient Signature: _____ **Date:** _____

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