ARTHRITIS CENTER OF NEBRASKA

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

1. PRIOR AUTHORIZATION/ REFERRAL FOR INSURANCE

I understand that it is my responsibility to obtain prior authorization and/or physician referrals if required by insurance carrier. I understand that if I am treated without authorization, I will be responsible personally for all or part of the cost of professional services.

AUTHORIZATION TO RELEASE AND CONSENT TO OBTAIN HEALTH INFORMATION

- **I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM**
- I hereby authorize photocopies of the Patient Information Form to be valid as the original. I understand I can withdraw this authorization at any time, by notifying this office in writing.
- I hereby authorize treatment of the above patient and agree to pay all fees and charges for treatment, procedures and tests (including testing for HIV (AIDS) and Hepatitis, **if ordered by provider**) regardless of insurance coverage or the pending of insurance processing.
- I hereby authorize the Arthritis Center of Nebraska Providers to view the external prescription history via the RxHub service for the patient listed above.
- I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

X_____ Date_____

Patient's or authorized person's signature (if not the Patient, relationship to the patient) _____

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2. RELEASE OF MEDICAL AND BILLING INFORMATION

(Complete this section of this Form if you wish to allow family or others access to your Medical and Billing information.)

I, _____ do hereby authorize personnel to release information concerning any and all diagnostic studies and findings contained within my clinic chart (whether performed here or elsewhere), my billing, insurance, or other account information to the family member(s)/ parties listed below:

Name_____ **Relationship**_____ **Phone #**_____

Name_____ **Relationship**_____ **Phone#**_____

Name_____ **Relationship**_____ **Phone#**_____

X _____ _____

Patient's or authorized person's signature **Date**

(Please note: This form is valid from the date signed until another form is requested by the patient.)

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3. I AUTHORIZE THAT VOICE MESSAGES MAY BE LEFT ON MY PHONE(S). ☐ Yes ☐ No

X _____ _____

Patient's or authorized person's signature **Date**

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4. ACKNOWLEDGEMENT PLEASE CHECK ONE AND SIGN:

☐ I acknowledge that I am aware of **Notice of Privacy Act Practices** & **decline** to be given a copy of the document.

☐ I request to be given a copy of the **Arthritis Center of Nebraska's Notice of Privacy Practices** document

X _____ _____

Patient's or authorized person's signature **Date**

Office Use Only: Copy given to patient	_____	_____	_____
	Staff Initials	**Date**	**Account Number**