ARTHRITIS ASSOCIATES

www.sebbaarthritis.com
33920 US 19N SUITE 241
PALM HARBOR, FL 34684
PHONE: 727-773-9793 FAX: 727-773-0674

ANTHONY SEBBA, MD ANJALI SHETTY, MD ROHAN CHAWLA, MD

Dear _____,

Welcome to Arthritis Associates.

This letter is to confirm your appointment for a consultation on _____ at _____.

Because we reserve more time for your first appointment, if you do not hear from us the day before your appointment, please call us at 727-773-9793, option zero, to confirm your appointment time. There may be a charge for missed appointments or appointments cancelled without 24 hours' notice.

We are located in the Harbor Park building complex on the west side of US 19, corner of Nebraska. There are two entrances, one on US Highway 19 and one on Nebraska, across from Sprouts. The building is located behind the Verizon and Grain & Berry stores on US 19.

Normal office hours are 7am – 4:30pm, Monday through Thursday. We are closed on Friday.

Please fill out necessary paperwork prior to your appointment time:

- Patient History forms
- Patient Information form
- Patient Assessment forms
- Financial Agreement
- Patient Consent form

If your insurance company requires a referral or authorization to see a specialist, please make sure we receive this from your primary care physician before the date of your appointment.

Please make sure you or your referring physician provides us with all relevant medical records including labs, x-rays, MRI, and CAT scans.

Thank you for choosing Arthritis Associates.

Sincerely,

The staff of Arthritis Associates

Arthritis Associates Patient Consent Form

Uses and Disclosures of Your Protected Health Information (PHI)

I understand that as part of my health care, the practice originates and maintains paper and electronic records describing my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care, such as referrals
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually rendered
- A tool for routine health care operation, such as assessing quality and reviewing the competence of staff

I have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

I hereby authorize Arthritis Associates to discuss my protected health information with the following:

Name	Relationship
_____	_____
_____	_____
_____	_____

Permission to Treat

Permission is hereby granted for physicians, employees or agents of the Practice to render the patient named below medical treatment as deemed necessary.

_____

Patient's name (please print)

_____ _____

Patient's or legal guardian's signature Date

Arthritis Associates
Financial Agreement

This is a financial agreement between you, the patient, and Arthritis Associates. Please review and initial each policy below:

_____Your insurance coverage is a legal contract between you and your insurance company and it is your responsibility to know your insurance benefits.

_____You will be expected to provide current insurance information prior to each visit and bring your insurance card to each appointment. Even small changes to your insurance may make a big difference. If we are not told of changes in your insurance, you could be responsible for medical charges.

_____Under the terms of your contract with your insurance company, we must collect any Copay prior to you being seen. If you cannot pay the Copay upon checking in, you may be rescheduled.

_____Under the terms of your contract with your insurance company, and our agreement with them, all referrals and prior authorizations are required before we see you. We respectfully ask that you contact your primary care physician for this authorization. If we do not receive the authorization before your visit, we will need to reschedule your appointment.

WE ARE NOT MEDICAID PROVIDERS. If you have a Medicaid plan, secondary or supplemental to your primary insurance plan, we cannot accept this insurance. By signing this Agreement, you agree to be responsible for copays, coinsurance, and/or deductibles. If you have Medicaid QMB eligibility, please let staff know.

A copy of the NOTICE OF PRIVACY PRACTICES has been made available to me.

The following name(s) are granted permission to discuss financial responsibility information:

Name	Relationship
_____	_____
_____	_____

By signing below, I agree to the policies above and I authorize the Practice to bill my insurance for services provided to me and request the payments for such services to be made to the Practice on my behalf.

_____

Patient's name (please print)

_____ _____

Patient's or legal guardian's signature Date

Arthritis Associates
Patient Information

Name: _____ Today's date:_____

Date of birth: _____ SSN _____

Address: _____ Marital Status: _____ Sex: ____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work/Other Phone: _____ Email: _____

Employer Name & Address: _____

Emergency Contact: _____

Relation to you: _____ Phone: _____

Pharmacy: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Address: _____

Referring Physician: _____Phone: _____

Address: _____

Primary Insurance Company: _____

Who is the policy holder: _____ DOB: _____

Policy ID: _____ Group: _____

Secondary Insurance Company: _____

Who is the policy holder: _____ DOB: _____

Policy ID: _____ Group: _____

Seasonal address: _____

Usual months at this address: _____ Phone: _____