Keivan Dehghanpisheh
MD, PhD, FACR
Board Certified Rheumatology

Patient Registration

Patient Name:_____ **DOB:** _____ **Today's Date:** _____

Referring Doctor/Specialty: _____ **Primary Care:**_____

Support/Family Member Present: _____ **Relationship:** _____

Sex: __*Male* __*Female* **Marital Status:** __*M* __*S* __*W* __*D* **Race:** _____ **Ethnicity:** _____
Declined to state: _____

Local Address: _____

Insurance Address: _____

Cell Phone: _____ **Consent for office to leave information on Voicemail:** ___(Y) __(N)

E-mail: _____ **Occupation:** _____

Employment Status: ___ *PT* ___*FT* ___*Not working* ___*Student* ___*Retired* ___*Disabled*

Insurance Company:_____ **Insurance Policy Holder:**_____

Policy Holder DOB: _____ **Patient Relationship to Policy Holder:**_____

Clinic Emergency Contact:_____ **Phone:**_____

Local Pharmacy: _____ **Phone/Location:** _____

Mail Order Pharmacy: _____ **Specialty Pharmacy:** _____

Other Person(s) Authorized to Communicate on Patient behalf:

Name/Relationship:_____ _____ **Phone:** _____

____ No person other than my above stated emergency contact may communicate with office.

I hereby declare that the information provided is true and correct.

Patient signature: _____ **Date:** _____

Witness Signature:_____ **Date:** _____

Main Office:
12955 Southern Blvd,
Bld 8 Ste 203
Loxahatchee, FL, 33470

Satellite Office:
210 Jupiter Lakes Blvd,
Bld 5000, Ste 203
Jupiter, FL 33458

Contact:
Phone: 561-899-0762
Fax: 833-217-6176
DrDRheumatology.com

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Office Policy

I understand that all questions concerning fees should be asked prior to service. I authorize my insurance company to make payment for all medical services directly to Keivan Dehghanpisheh MD, PA/AARA.
I agree that any balances will be paid by me.

__ *I also agree that if I do not pay my balance within 90 days, my account will go to a collection agency. I will be responsible for all collection fees and will be charged an* ***additional processing fee of $25.00 and 1.5% interest per month on my collection balance until the balance is paid in full.***

With regards to transfer of medical information, I authorize Keivan Dehghanpisheh MD, PA to release any information necessary to secure payment for all services provided, or to further my medical care. I authorize Keivan Dehghanpishegh MD, PA to view/receive my medical records, including but not limited to any medical history

__ I will notify the office of any changes to my address or phone number. I will notify the office of any change in insurance ***prior*** to my appointment otherwise I will be responsible for the full payment of the visit. Just as a friendly reminder, we bill your insurance company as a courtesy.

This office operates by appointment only. We reserve time with the Physician, just for you.
24-hour notice of rescheduling or cancellation is ***required*** to avoid a cancellation fee.
Monday appointments ***must*** *be rescheduled or cancelled by* ***noon*** *on the previous Friday.*

I understand that the office policy for ***Tardiness, No Show*** or ***Day of Visit Cancellation*** is:
__ Pt will arrive within 15 mins of visit time, or Pt will be considered a No show and fee will be charged.
__ The charge will be $75.00 for follow-up, infusion and injection visits. $150 for New Patient consults.
__ I understand that repeated cancellations and no shows will result in dismissal from the practice.

Prescription management is done at the time of your office visit. Prescriptions will not be managed after hours by the on-call provider.
__I understand it is my responsibility to request refills at the time of the office visit.

NOTICE: Rude, Inappropriate or abusive language and behavior will result in dismissal from the practice.

I, _____ have read the above and agree.

Patient signature_____ Date_____

Witness _____ Date _____

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please reviewed carefully. Below is a summary. If you would prefer the full notice, it will be provided at your request.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for health care services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, addressed, phone, etc.), that may identify you and relates to your past, present, or future physical or mental health condition and related health care services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This notice describes your right to access and control your PHI. It also describes how we follow applicable rules and use and disclosure your PHI to provide you treatment, obtained payment for service you receive, manage or healthcare operations and for other purposes that are permitted or required by law.

I, _____ acknowledge that I have read the above and given the opportunity to receive the full notice.

Patient Signature _____ Date _____

Witness _____ Date _____

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