Leaders in Rheumatology Care since 1955.

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Jennifer M. Richardson, M.D., FACR
Anupama Chauhan, M.D., FACR
Marc A. Antonchak, M.D.
Shannon Ghizzoni, 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 a.m. until 4:30 p.m. Should you need 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 had 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, 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. We ask that you bring these papers with you for your scheduled appointment:

- Financial Policy
- Map
- Patient Registration
- Preliminary History Form
- Notice of our Privacy Policies and your Rights as a Patient (These are required by the federal government and yours to keep)
- Acknowledgement of Your Receipt of the Notice (Must be signed and kept in our office in your personal record)

We ask that you arrive at our office at least 15 minutes before your scheduled appointment time. **Please bring your insurance card(s), your copay, a photo ID, all of the papers in this packet, and any results from recent lab work or x-rays.**

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 or Visa.
    - 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 finance charge will be added to any balance over 60 days at the rate of 1.5% per month or 18% per annum.
7.) A fee of $25.00 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.
8.) There is a fee of $25.00 on all returned checks.
9.) There is a fee to copy any and all medical records based on the number of pages copied, after a one time courtesy.
10)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. You may also ask our office for the procedure/diagnosis codes to verify that the procedure is a covered benefit.

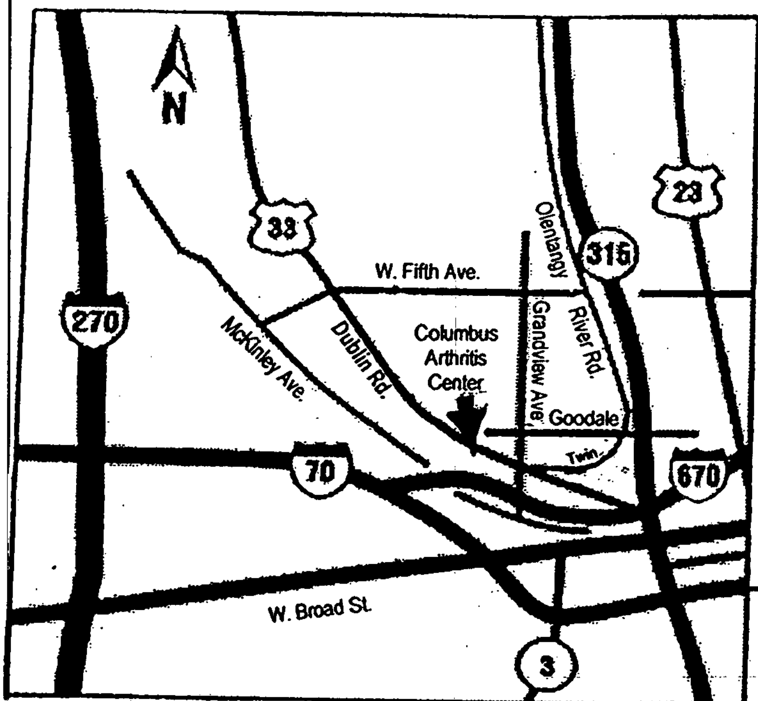
Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

By signing the detached paper, I certify that I will pay The Columbus Arthritis Center any co-payments, co-insurances, deductibles or non-covered services. I will immediately pay to The Columbus Arthritis Center any payment that I receive from my insurance company or reimbursement service for services provided to me. I will also be responsible for any amounts not paid by insurance due to not providing the appropriate insurance information for billing purposes.

DIRECTIONS

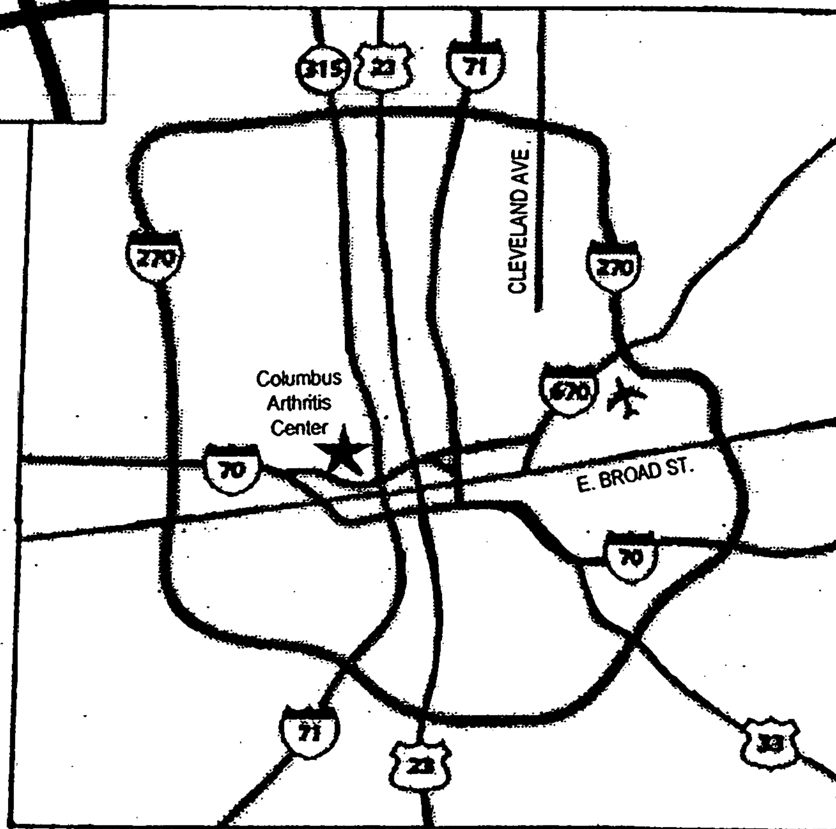
COLUMBUS ARTHRITIS CENTER

1211 Dublin Road
Columbus, Ohio 43215



From the North:
71 South to 670 West
Take the Grandview Ave. Exit
Turn right onto Grandview Ave.
Turn left onto Dublin Rd/US-33

From the East:
70 West to 315 North
Take the Dublin Rd/Long St. Exit
Take a left onto Dublin Rd/US-33
OR
Take W. Broad St.
Turn right on Souder Ave.
Turn left onto Dublin Rd/US-33.



From Marysville/Dublin:
Route 33 East to 270 South
Exit left on Fishinger Rd.
Turn Right on Riverside Dr.
Riverside Dr. becomes Dublin Rd.
after the 5th Ave. intersection.

From the West:
270 N to 70 East to 670 East
Take the Grandview Ave. Exit
Turn right onto Grandview Ave.
Take a left onto Dublin Rd/US-33
OR
Take Central Ave. North
Turn left onto McKinley Ave.
Turn left onto Grandview Ave.
Turn left onto Dublin Rd/US-33.

From the South:
23 North to 270 West to 71 North
Follow the 315 North Exit
Take the Dublin Rd/Long St. Exit
Turn left onto Dublin Rd./US-33

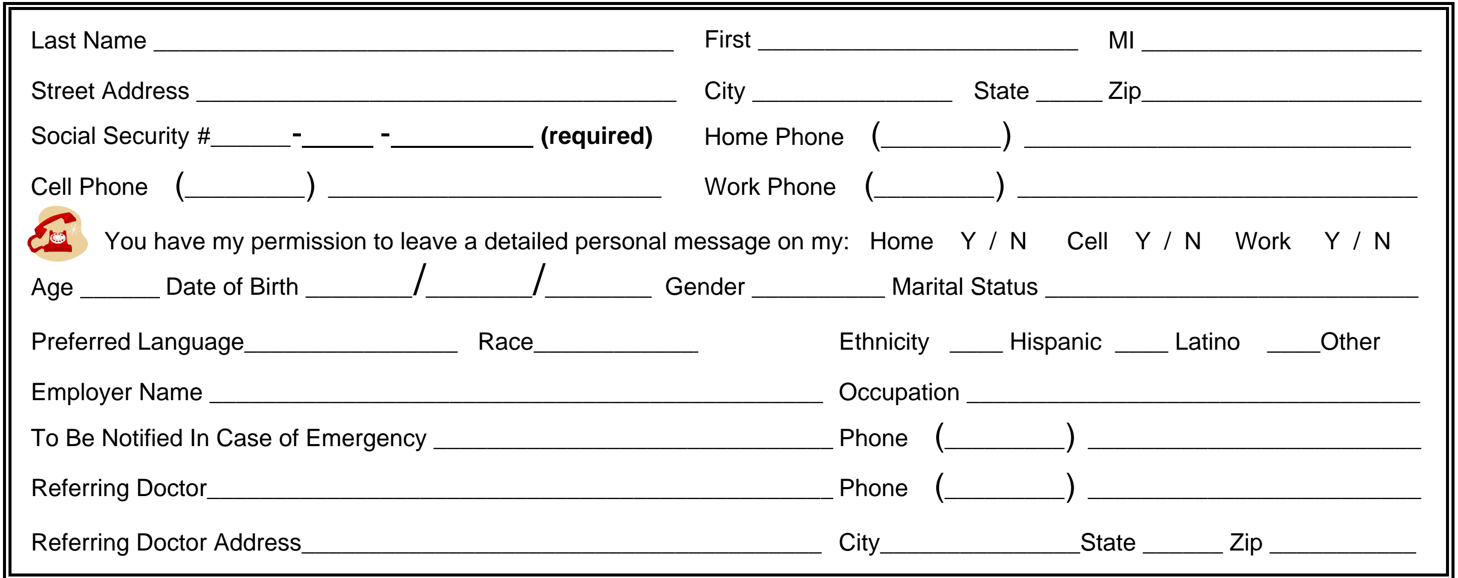
OR

270 West to 70 East to 670 East
Take the Grandview Ave. Exit
Turn right onto Grandview Ave.
Turn left onto Dublin Rd/US-33.

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 (________) ______________

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 ________

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

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 __	Other__________
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_________________	

Preliminary History Sheet

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

Medication	Dose	Instructions	Year started		Medication	Dose	Instructions	Year started

Do you take calcium and or vitamin D? ____ If so, how much? _____________

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:

Name	Yes/No	Year
Hepatitis B Vaccine		
Influenza Vaccine		
Shingles Vaccine		
BCG Vaccine		
TB Skin Test		
Pneumovac		
Chest X-ray		

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

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__

COLUMBUS ARTHRITIS CENTER, INC.

Patient Assessment

This Questionnaire includes information not available from blood tests, X-rays, or any soource other than you. Please try to answer each question, even if you do not think it is related to you at this time. There are no right or wrong answers. Please answer exactly as you think or feel. Thank you.

1.) Please check (✓) the ONE best answer for your abilities at this time:

OVER THE LAST WEEK, were you able to:	Without ANY Difficulty	With Some Difficulty	With MUCH Difficuty	UNABLE To Do
a. Dress yourself, including tying shoelaces and doing buttons?	____0	____1	____2	____3
b. Get in and out of bed?	____0	____1	____2	____3
c. Lift a full cup or glass to your mouth?	____0	____1	____2	____3
d. Walk outdoors on flat ground?	____0	____1	____2	____3
e. Wash and dry your entire body?	____0	____1	____2	____3
f. Bend down to pick up clothing from the floor?	____0	____1	____2	____3
g. Turn regular faucets on and off?	____0	____1	____2	____3
h. Get in and out of a car, bus, or airplane?	____0	____1	____2	____3
i. Walk two miles?	____0	____1	____2	____3
j. Participate in sports and games as desired?	____0	____1	____2	____3
k. Get a good nights sleep?	____0	____1	____2	____3
l. Deal with feelings of anxiety or being nervous?	____0	____1	____2	____3
m. Deal with feelings of depression or feeling blue?	____0	____1	____2	____3

2.) How much pain have you had because of your condition OVER THE PAST WEEK? Place a mark on the line below to indicate how severe your pain has been:

NO PAIN ____ PAIN AS BAD AS IT COULD BE

3.) How much of a problem has unusual fatigues or tiredness been for you OVER THE PAST WEEK? Place a mark on the line below:

FATIGUE IS NO ____ FATIGUE IS A MAJOR PROBLEM

4.) Consider all the ways in which illness and health conditions may affect you at this time, Please make a mark below to show how you are doing:

VERY WELL ____ VERY POORLY

Your Name ______________________ Today's Date ______________________ Time of Day __________

For Office Use Only

GL

PN

FN

1=0.33
2=0.67
3=1.0
4=1.33
5=1.67
6=2.0
7=2.33
8=2.67
9=3.0
10=3.33
11=3.67
12=4.0
13=4.33
14=4.67
15=5.0
16=5.33
17=5.67
18=6.0
19=6.33
20=6.67
21=7.0
22=7.33
23=7.67
24=8.0
25=8.33
26=8.67
27=9.0
28=9.33
29=9.67
30=10.0

Instructions for Office Staff

Activity Level Index Scoring: For FN (questions 1-10) add total points and convert using scale on right. For PS (questins 11-13), add total points

Visual Analog Sclaes:measure with metric ruler. Line is exactly 10 cm long. Scores should be recorded in cm.mm format.

Columbus Arthritis Center

NOTICE OF PRIVACY PRACTICES
As Required by the Privacy Regulations Created as a result of the Health Insurance Portability and Accountability Act of 1996
(HIPPA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU AS A PATIENT OF THIS PRACTICE MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI).

PLEASE REVIEW THIS NOTICE CAREFULLY.

Our commitment to your privacy
Our practice is dedicated to maintain the confidentiality of health information that identifies you. In conducting our business, we will create records regarding you and the treatment and services we provide you. We are required by law not only to maintain the confidentiality of your records but also to provide you with this notice of our legal duties and the privacy practices that we follow in our office.

The terms of this notice apply to all records containing your health information that are created and retained by our office. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and of your records that we may create or maintain in the future. Our practice will post a copy of our current notice and you may request a copy at any time.

WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

Treatment: Our practice may use or disclose your health information to a physician or other health care provider for purposes related to your treatment.

Payments: Our practice may use or disclose your health information to bill and collect payment for the services and items you may receive from us.

Health Care Operations: Our practice may use or disclose your health information to operate our business. For example, we may use your health information to evaluate the quality of care you received from us or to conduct business planning activities for our office.

Appointment Reminders: Our practice may use and disclose your health information to contact you and remind you of an appointment.

Treatment Options: Our practice may use and disclose your health information to inform you of potential treatment alternative options or alternatives.

Health-Related Benefits and Services: Our practice may use and disclosure your health information to inform you of health-related benefits or services that may be of interest to you.

Release of Information to Family/Friends: Our practice may release your health information to a friend or family member that is involved in your care or who assists in taking care of you, but only if you agree that we may do so.

Disclosures Required by Law: Our practice will use and disclose your health information when we are required to do so by federal, state, or local law.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES

Public Health Risks: Our practice may disclose your health information to public health authorities that are authorized by law to collect information for the purpose of reporting such things as abuse or neglect (including domestic violence), reporting potential exposure to a communicable disease.

Health Oversight Activities: Our practice may disclose your health information to a health oversight agency for activities authorized by law such as investigations, civil, administrative and criminal procedures, and other activities necessary for the government to monitor programs, compliance with civil rights laws and the health care system in general.

Lawsuits and Similar Proceedings: Our practice may use and disclose your health information in response to a court or administrative order, in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

Law Enforcement: We may release your health information if asked to do so by a law enforcement official in circumstances such as, criminal conduct in our offices or in emergency situations to report a crime.

Military: Our practice may disclose your health information if you are a member of U.S. or foreign military forces (including veterans) and if required by appropriate authorities.

National Security: Our practice may disclose your health information to federal officials for intelligence and national security activities authorized by law.

YOUR RIGHTS REGARDING YOUR PRIVATE HEALTH INFORMATION

Confidential Communications: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For example, you may ask that we contact you at home rather than work. You must make a written request. Our practice will accommodate reasonable request.

Requesting Restrictions: You have the right to request a restriction on our use or disclosure of your health information. We are not required to agree to these additional restrictions but, if we do, we will abide by our agreement, except in emergency. Request for additional restrictions must be made in writing.

Inspection and Copies: You have the right to inspect and obtain a copy of your health information. You must submit your request in writing. Our practice may charge a fee for the costs of the copying, mailing, labor and supplies associated with your request.

Amendment: You may ask us to amend your health information if you believe it is incorrect or incomplete. Your request must be made in writing and you must provide us with a reason that supports your request. We may deny your request if, in our opinion, the information is accurate and complete, if it is not part of the information kept by or for the practice, or not created by our practice.

Accounting of disclosures: All of our patients have a right to request a list of certain non-routine disclosures our practice has made of your health information for non-treatment or operations purposes. Use of your health information as part of routine patient care is not required to be documented. Requests must be submitted in writing and must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request is free of charge but our practice may charge you for additional lists within the same 12 month period.

Right to a paper copy of this notice: You are entitled to receive a paper copy of our notice of privacy practices.

Right to provide an authorization for other uses and disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services, Office of Civil Rights. You will not be penalized for filing a complaint. All complaints must be submitted in writing to:

Practice Administrator
Columbus Arthritis Center
1211 Dublin Road
Columbus, Ohio 43215

Office of Civil Rights – Regional Manager
Department of Health & Human Services
233 N. Michigan Avenue, Suite 240
Chicago, Illinois 60601

Columbus Arthritis Center

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Columbus Arthritis Center to use and disclose protected health information (PHI) about me to carry out **treatment, payment and healthcare operations (TPO)**. (Columbus Arthritis Center's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Columbus Arthritis Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Columbus Arthritis Center Privacy officer at **1211 Dublin Road Columbus, Ohio 43215**.

With this consent, Columbus Arthritis Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Columbus Arthritis Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Columbus Arthritis Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions. But if it does, it is bound by this agreement. By signing this form, I am consenting to Columbus Arthritis Center's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Columbus Arthritis Center may decline to provide treatment to me.

Signature of Patient/Legal Guardian___________________________________

Print Patient's Name____

Date____

PATIENT CONSENT FOR ASSIGNMENT OF BENEFITS

I hereby consent to assign all payments for services rendered by the physicians of Columbus Arthritis Center to the Columbus Arthritis Center. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by my contract with my insurance plan. I further understand that my contract with my insurance plan may or may not cover some services.

Signature______________________________________Date________________

Columbus Arthritis Center, Inc.

Disclosure of Physician Ownership

To Our Patients:

We wish to notify you that the physicians of the Columbus Arthritis Center are owners of the Radiology and Therapy services located at:

1211 Dublin Rd
Columbus, Ohio 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 the facility where they receive their care. If you would prefer to obtain your services at another facility, please notify the physician or his/her staff. We have identified additional facilities available to provide the services required:

Riverside Methodist Hospital
3535 Olentangy River Rd
Columbus, Ohio 43214-3998
(614) 566-5000
Scheduling: (614) 566-1111

Mount Carmel Health- West
793 West State Street
Columbus, Ohio 43222
(614) 234-5000
Scheduling: (614) 234-7400

Dublin Methodist Hospital
7500 Hospital Drive
Dublin, OH 43016
(614) 544-8000
Scheduling: (614) 566-1111

Adena Medical Center
272 Hospital Road
Chillicothe, OH 45601
(740) 779-7500
Scheduling: (800) 374-7711

Ohio State University Medical Center
410 W. 10th Ave
Columbus, Ohio 43210
(800) 293-5123

COLUMBUS ARTHRITIS CENTER

RECEIPT OF **NOTICE OF PRIVACY PRACTICES** AND **FINANCIAL POLICY**
WRITTEN ACKNOWLEDGEMENT FORM

I, ________________________________, have received a copy of the
(Print) Patient Name

COLUMBUS ARTHRITIS CENTER'S Notice of Privacy Practices and

Financial Policies.

______________________________________ ______________________
Signature of Patient Date