Ankylosing Spondylitis
Arthritis due to Hep C
Arthritis related to Crohn's Disease
Autoinflammatory Diseases
Dermatomyositis
Ehler's Danlos
Felty's Syndrome
Gout and all Crystals
Henoch-Schonlen Purpura
Lupus (SLE)
Marfans
Osteoarthritis
Osteoporosis
Polymyalgia Rheumatica
Polymyositis
Psoriasis
Psoriatic Arthritis
Reiterr's Syndrome
Relapsing Polychondritis
Rheumatoid Arthritis
Sarcoidosis
Scleroderma
Sjogren's Syndrome
Stills Disease
Temporal Arteritis
Ulcerative Colitis
Vasculitis Wegener's

Medical Orthopedics
Bursitis/Tendonitis
Carpal Tunnel
Elbow Pain Hand/Wrist Pain Heel Spurs
Hip and Back Pain Knee Pain
Shoulder Pain Spinal Stenosis Tennis Elbow
Trigger Finger

Infusion Center
Actemra
Benlysta
Cytoxan
IVIG
Krystexxa
Orencia
Reclast
Remicade
Rituxan
Simponi Aria
Solu-medrol

Visco Supplementation
Euflexxa
Hyalgan
Ortho- Visc
Supartz
Synvisc

On Site
DXA
EMG NCS
Fluoroscopy
Ultrasound
X-ray

STEPHEN SOLOWAY
MD | FACP | FACR | CCD

MATTHEW R. ARKEBAUER
DO|MS

LYNDY M. TANIMAE
PA-C

ARTHRITIS AND RHEUMATOLOGY ASSOCIATES OF SOUTH JERSEY, P.C.

Main Office
2848 S. Delsea Drive, Building 2C
Vineland, New Jersey 08360

Telephone: (856) 794-9090
Fax: (856) 794-3058
Website: www.drsoloway.com

524 Williamstown Road, Suite A
Sicklerville, New Jersey 08081

Date: _____

Dear _____

We would like to welcome you to Arthritis & Rheumatology Associates of South Jersey, P.C. Enclosed please find our New Patient Forms packet. Please fill out all attached forms in blue or black ink only, and bring them with you on your first visit to our office, scheduled on:

The check-in process will be completed much faster by having the attached forms completed upon arrival. We will also need you to bring your co-pay, photo ID, insurance cards and your referral, if you need one.

Please be advised that we are a very busy practice and your wait time may be several hours depending on that the doctor orders for you. You may wish to bring reading materials with you. We also have wi-fi available if you would like to bring your tablet or laptop.

Our president and founder, Dr. Stephen Soloway is recognized as a "Top Doctor" in the region by Philadelphia Magazine, Inside Jersey Magazine and as reported by US News and World Report. You may also visit us on our website at www.drsoloway.com to learn more about our practice and the services we provide. Please 'Like' us on Facebook at www.facebook.com/DrSoloway for medical information, tips and updates on our practice.

We look forward to seeing you on your first visit.

Sincerely,

Dr. Stephen Soloway
Arthritis & Rheumatology Associates of South Jersey, P.C.

Directions to:
Arthritis & Rheumatology Associates of S.J., P.C.
2848 S. Delsea Dr., Ste 2C, Vineland, NJ 08360

From Philadelphia & surrounding area - Via I-76 (Schuykill Expy) over the Walt Whitman Bridge. (Approx. 30 mins.)

- Once into New Jersey, I-76 merges into Route 42 South.
- Take Exit 13 - Route 55 South towards Glassboro/Vineland.
- Take Exit 29 - County Road 552 towards Bridgeton/Vineland.
- Turn right onto County Road 552/W Sherman Ave.
- Make a right onto Route 47/S Delsea Dr. (Wawa on the corner)
- After the Wawa on the right, make a right into 2848 S Delsea Dr. Building 2C is straight ahead.

From Berlin/Sicklerville/Williamstown – Via Route 555/Malaga Rd/Main Rd (Approx. 30 mins.)
(Note: Do not take Route 55 or Route 47, this route is more direct.)

- Starting from Geet's Diner on Route 42/Black Horse Pike, head east.
- Continue onto Route 322/Black Horse Pike and make a right onto Malaga Rd/County Road 659.
- There will be a fork in the road, make the left onto County Road 555/Main Rd.
- Make a right onto Sherman Avenue (there is a traffic light at this intersection).
- Cross over the railroad tracks and at the following traffic light make a left onto Route 47/S Delsea Drive.
- After the Wawa on the right, make a right into 2848 S Delsea Dr. Building 2C is straight ahead.

From Hammonton – Via Route 54/Lincoln Ave (Approx. 25 mins.)

- Head south on Route 54/12th Street.
- Cross over Route 40/Harding Hwy onto County Rd 619/Wheat Rd.
- Make the next left onto Lincoln Avenue toward Vineland.
- Turn right onto County Rd 552/E Sherman Ave.
- Cross over the railroad tracks and at the following traffic light make a left onto Route 47/S Delsea Drive.
- After the Wawa on the right, make a right into 2848 S Delsea Dr. Building 2C is straight ahead.

From Mays Landing/Egg Harbor Twp/Atlantic City – Via Route 40/Bears Head Rd. (Approx. 25 – 50 mins.)

- From Atlantic City/Egg Harbor Twp, take Route 322/Black Horse Pike to Route 40 West/Harding Hwy towards Mays Landing.
- Once through the main town of Mays Landing make a left hand turn onto County Rd 552/Millville Mays Landing Rd/Bears Head Rd at the traffic light.
- Make a right hand turn onto County Rd 552/Sherman Avenue toward Vineland.
- Cross over the railroad tracks and at the following traffic light make a left onto Route 47/S Delsea Drive.
- After the Wawa on the right, make a right into 2848 S Delsea Dr. Building 2C is straight ahead.

From Cape May County – Via County Rd 347/Route 55 (Approx. 30 – 50 mins.)

- From Cape May Court House and south take Route 9/Main St/Shore Rd north. Turn left onto County Hwy 657/S Dennisville Rd.
- The road splits into Route 47/N Delsea Dr and County Rd 347/New Stage Rd, stay right and continue onto County Rd 347/E Creek Mill Rd/New Stage Rd towards Port Elizabeth.
- Continue onto Route 47/Delsea Dr when County Rd 347 ends.
- Take the ramp onto Route 55 North toward Millville/Vineland.
- Take exit 27 and merge onto Route 47/N 2nd St, the road then becomes Route 47/Delsea Dr.
- Turn left into the driveway just before the Wawa at the intersection of Delsea and Sherman. Building 2C is straight ahead.

Arthritis & Rheumatology Associates of SJ, P.C.

2848 S. Delsea Drive, Ste 2C, Vineland, NJ 08360
Phone (856) 794-9090 Fax (856) 794-3058

Patient History Form

Date of first appointment: ____/____/____ (MONTH DAY YEAR) Time of appointment: _____ Birthplace: _____

Name: _____ (LAST FIRST MIDDLE INITIAL MAIDEN) Birthdate: ____/____/____ (MONTH DAY YEAR)

Address: _____ (STREET APT#) Age: _____ Sex: ☐ F ☐ M

_____ (CITY STATE ZIP) Telephone: Home (____) _____ Work (____) _____

MARITAL STATUS: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse/Significant Other: ☐ Alive/Age _____ ☐ Deceased/Age _____

EDUCATION (circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of hours worked/average per week _____

Referred here by: (check one) ☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Other Health Professional

Name of physician making referral: _____

The name of the physician providing your primary medical care: _____

Do you have an orthopedic surgeon? ☐ Yes ☐ No If yes, Name: _____

Describe briefly your present symptoms: _____

_____

_____

_____

Date symptoms began (approximate): _____

Diagnosis: _____

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later)

_____

_____

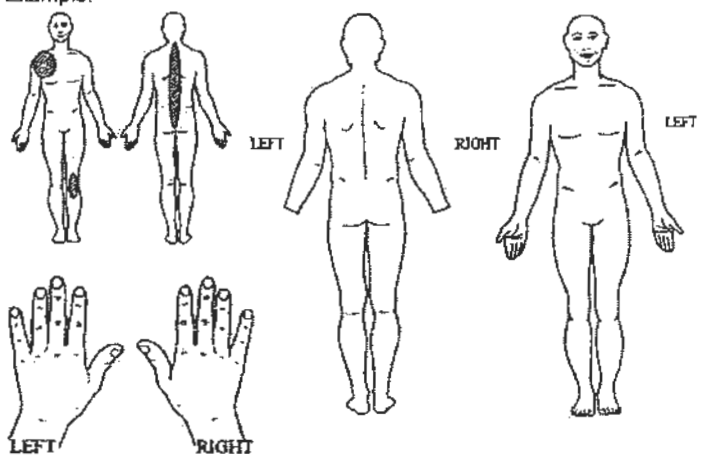
_____

Please list the names of other practitioners you have seen for this problem:

_____

_____

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	

Other arthritis conditions: _____

SYSTEMS REVIEW

As you review the following list, please check any of those problems, which have significantly affected you.

Date of last mammogram ____/____/____ Date of last eye exam ____/____/____ Date of last chest x-ray ____/____/____

Date of last Tuberculosis Test ____/____/____ Date of last bone densitometry ____/____/____

Constitutional

- ❑ Recent weight gain
  amount _____
- ❑ Recent weight loss
  amount _____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever

Eyes

- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

Ears-Nose-Mouth-Throat

- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness in nose
- ❑ Runny nose
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Loss of taste
- ❑ Dryness of mouth
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing

Cardiovascular

- ❑ Pain in chest
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ High blood pressure
- ❑ Heart murmurs

Respiratory

- ❑ Shortness of breath
- ❑ Difficulty in breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting of blood or coffee ground material
- ❑ Stomach pain relieved by food or milk
- ❑ Jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Heartburn

Genitourinary

- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, "smoky" urine
- ❑ Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties
- ❑ Prostate trouble

For Women Only:

Age when periods began:_____

Periods regular? ❑ Yes ❑ No

How many days apart? _____

Date of last period? ____/____/____/

Date of last pap?____/____/____

Bleeding after menopause? ❑ Yes ❑ No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal

- ❑ Morning stiffness
  Lasting how long?
  _____ Minutes _____ Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Joint swelling

List joints affected in the last 6 mos.

_____

_____

_____

_____

_____

Integumentary (skin and/or breast)

- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive (sun allergy)
- ❑ Tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold

Neurological System

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Loss of consciousness
- ❑ Sensitivity or pain of hands and/or feet
- ❑ Memory loss
- ❑ Night sweats

Psychiatric

- ❑ Excessive worries
- ❑ Anxiety
- ❑ Easily losing temper
- ❑ Depression
- ❑ Agitation
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

Endocrine

- ❑ Excessive thirst

Hematologic/Lymphatic

- ❑ Swollen glands
- ❑ Tender glands
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Transfusion/when _____

Allergic/Immunologic

- ❑ Frequent sneezing
- ❑ Increased susceptibility to infection

SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day? _____

Do you smoke? ❑ Yes ❑ No ❑ Past -- How long ago? _____

Do you drink alcohol? ❑ Yes ❑ No Number per week _____

Has anyone ever told you to cut down on your drinking?

❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ Yes ❑ No
If yes, please list: _____

_____

Do you exercise regularly? ❑ Yes ❑ No

Type _____

Amount per week _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No

PAST MEDICAL HISTORY

Do you now or have you ever had: *(check if "yes")*

❑ Cancer	❑ Heart problems	❑ Asthma
❑ Goiter	❑ Leukemia	❑ Stroke
❑ Cataracts	❑ Diabetes	❑ Epilepsy
❑ Nervous breakdown	❑ Stomach ulcers	❑ Rheumatic fever
❑ Bad headaches	❑ Jaundice	❑ Colitis
❑ Kidney disease	❑ Pneumonia	❑ Psoriasis
❑ Anemia	❑ HIV/AIDS	❑ High Blood Pressur
❑ Emphysema	❑ Glaucoma	❑ Tuberculosis

Other significant illness (please list) _____

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

Previous Operations

Type	*Year*	*Reason*
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ❑ No ❑ Yes Describe: _____

Any other serious injuries? ❑ No ❑ Yes Describe: _____

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number deceased _____

Number of children _____ Number living _____ Number deceased _____ List ages of each _____

Health of children: _____

_____

Do you know of any blood relative who has or had: (check and give relationship)

❑ Cancer _____	❑ Heart disease _____	❑ Rheumatic fever _____	❑ Tuberculosis _____
❑ Leukemia _____	❑ High blood pressure _____	❑ Epilepsy _____	❑ Diabetes _____
❑ Stroke _____	❑ Bleeding tendency _____	❑ Asthma _____	❑ Goiter _____
❑ Colitis _____	❑ Alcoholism _____	❑ Psoriasis _____	

Patient's Name _____ Date _____ Physician Initials _____

MEDICATIONS

Drug allergies: ☐ No ☐ Yes If yes, please list: _____

_____

Type of reaction: _____

PRESENT MEDICATIONS *(List any medications you are taking. Include items such as aspirin, vitamins, laxatives, calcium and other supplements, etc)*

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Helped a lot	Helped some	Helped not at all
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

PAST MEDICATIONS *Please review this list of "orthritis" medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the results of taking the medication and list any reactions you may have had.*

Drug names/Dose	Length of time	Helped a lot	Helped some	Helped not at all	Reactions
<u>Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)</u>					
Flurbiprofen					
Diclofenac + misoprostill					
Aspirin (including coated aspirin)					
Celecoxib					
Sulindac					
Oxaprozin					
Salsalate					
Diflunisal					
Piroxicam					
Indomethacin					
Etodolac					
Meclofenamate					
Ibuprofen					
Fenoprofen					
Naproxen					
Ketoprofen					
Tolmetin					
Cholinemagnesium trisalcylate					
Diclofenac					

Drug names/Dose	Length of time	Helped A lot	Helped Some	Helped Not At All	Reactions
Pain Relievers					
Acetaminophen					
Codeine					
Propoxyphene					
Biologic DMARDs					
Orencia (abatacept)					
Humira (adalimumab)					
Kineret (anakinra)					
Cimzia (certolizumab)					
Enbrel (etanercept)					
Ereizi (etanercept -szzs)					
Simponi Aria (golimumab)					
Remicade (infliximab)					
Inflectra (infliximab)					
Renflexis (infliximab)					
Rituxan (rituximab)					
Actemra (tocilizumab)					
Benlysta (belimumab)					
Cosentyx (secukinumab)					
Ilaris (canakinumab)					
Stelara (ustekinumab)					
Taltz (ixekizumab)					
Kevzara (sarilumab)					
Jak Inhibitor					
Olumiant (baricitinib)					
Xeljanz (tofacitinib)					
Ofev (nintedanib)					
Jakafi/Jakavi (ruxolitinib)					
Smyraf (peficitinib)					
Rinvoq (upadacitinib)					
Osteoporosis Meds					
Fosamax (alendronate)					
Boniva (Ibandronate)					
Zometa/Reclast (zoledronic acid)					
Evista (raloxifene)					
Prolia (denosumab)					
Atelvia/Actonel (risedronate)					
Forteo (teriparatide)					
Miacalcin (calcitonin injection or nasal)					

Drug names/Dose	Length of time	Helped A lot	Helped Some	Helped Not At All	Reactions
IVIG					
Privigen					
Gammagard					
Gammar - IV					
Gamimune - N					
Iveegam					
Polygam S/D					
Sandoglobulin					
Venoglobulin - I					
Venoglobulin - S					
Carimune - Panglobulin					
Gamunex					
Kiovig					
Gout					
Krystexxa (pegloticase)					
Lupus					
Benlysta (belimumab)					

Please list supplements:

_____

_____

Have you participated in any clinical trials for medications? ☐ Yes ☐ No

If yes, please list

_____

_____

_____

_____

_____

_____

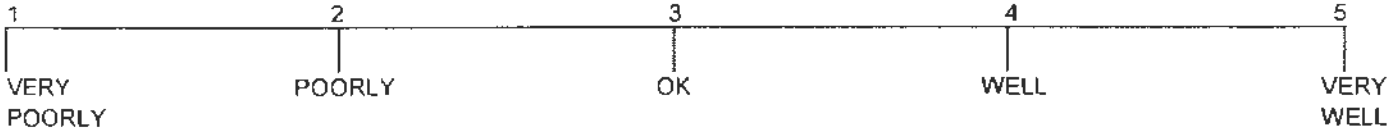
ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ❑ Yes ❑ No If yes, how many? _____

How many people in household? _____ Relationship and age of each _____

Who does most of the housework? _____ Who does most of the shopping? _____ Who does most of the yard work? _____

On the scale below, circle a number which best describes your situation; *Most of the time, I function…*



Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)	❑	❑	❑
Walking?	❑	❑	❑
Climbing stairs?	❑	❑	❑
Descending stairs?	❑	❑	❑
Sitting down?	❑	❑	❑
Getting up from chair?	❑	❑	❑
Touching your feet while seated?	❑	❑	❑
Reaching behind your back?	❑	❑	❑
Reaching behind your head?	❑	❑	❑
Dressing yourself?	❑	❑	❑
Going to sleep?	❑	❑	❑
Staying asleep due to pain?	❑	❑	❑
Obtaining restful sleep?	❑	❑	❑
Bathing?	❑	❑	❑
Eating?	❑	❑	❑
Working?	❑	❑	❑
Getting along with family members?	❑	❑	❑
In your sexual relationship?	❑	❑	❑
Engaging in leisure time activities?	❑	❑	❑
With morning stiffness?	❑	❑	❑
Do you use a cane, crutches, as walker or a wheelchair? (circle one)	❑	❑	❑

What is the hardest thing for you to do? _____

Are you receiving disability? Yes ❑ No ❑

Are you applying for disability? Yes ❑ No ❑

Do you have a medically related lawsuit pending? Yes ❑ No ❑

Patient's Name _____ Date _____ Physician Initials _____

Arthritis & Rheumatology Associates of South Jersey

Last Name _____ Date of Birth _____
First Name _____ MI _____ Gender: Male ____ Female ____
Mailing Address _____ Marital Status _____
_____ Social Security # _____
City, State, ZIP _____ Employer Name _____
Home Phone _____ Title _____
Work Phone _____ Ext. _____ Employment Status _____
Cell Phone _____ (FT, PT, retired, unemployed, disabled)
Email address _____ Student Status (FT, PT) _____

Additional Information

Name of Pharmacy _____ Pharmacy Phone # _____
Location of Pharmacy _____

Responsible Party

Last Name _____
First Name _____ MI _____
Date of Birth _____
Social Security # _____
Gender: Male ____ Female ____
Relation _____
Home Phone _____
Work Phone _____
Cell Phone _____
Email address _____

Emergency Contact: [redacted]

Last Name _____
First Name _____ MI _____
Relation _____
Address _____
_____
City, State, ZIP _____
Home Phone _____
Work Phone _____ Ext. _____
Cell Phone _____
Email address _____

Insurance

Primary Insurance _____
Insurance Address _____
_____
City, State, Zip _____
Phone Number _____
Subscriber/Member # _____
Group Number _____
Co-pay Amount _____
Insured Name _____
Insured's SSN _____
Insured's DOB _____
Relationship _____

Secondary Insurance _____
Insurance Address _____
_____
City, State, Zip _____
Phone Number _____
Subscriber/Member # _____
Group Number _____
Co-pay Amount _____
Insured Name _____
Insured's SSN _____
Insured's DOB _____
Relationship _____

Arthritis & Rheumatology Associates of SJ, P.C.

2848 S. Delsea Drive, Ste. 2C, Vineland, NJ 08360
Phone: (856) 794-9090 Fax: (856) 794-3058

Name: _____ DOB: _____

Phone number: (_____) _____ - _____

_____ I acknowledge that I have received a copy of *"Notice of Privacy Practices"* & office policies from Arthritis & Rheumatology Assoc. of SJ

I hereby grant my permission for disclosure of my personal health information to:

1. _____ Relationship_____
2. _____ Relationship_____
3. _____ Relationship_____

Check Choice below:

___ I hereby give my permission for Arthritis & Rheumatology Assoc. of SJ staff to leave information on my answering machine/voice mail in reference to appointments & and medical instructions.

___I refuse disclosure of my personal health information to anyone other than myself.

Do you have a Living Will or Advanced Directive? Yes: ____ No: ____

Arthritis & Rheumatology Assoc. of SJ photographs patients and places the photo inside of the patient's chart. We do this to help to document medical conditions, prevent medical errors and identity theft.

Do you consent to be photographed? Yes: ____ No: ____

Do you have a language, cultural and/or religious custom which may impact our provider's ability to provide medical care?

What type? ☐ Language ☐ Cultural Custom ☐ Religious Custom ☐ None

Note: **All co-pays are due at the time of service. A $30 fee may be assessed for "no-show" appointments. All balances are due in 30 days unless special arrangements are made. We do not routinely call for delinquent acconnts. Accounts that are greater than 90 days past due are sent for collections unless payment arrangements have been made and are current. You will be responsible for any balances due to lack of coverage and pre-existing conditions not covered under your plan.**

Patient/Guarantor Signature: _____ Date: _____

Arthritis & Rheumatology Associates of South Jersey
Financial Policy

Your complete understanding of your financial responsibility is essential. Your insurance is a contract between you, your employer and the insurance company. **We are not part of that contract.**

Appointment Cancellations: Please notify our office of any appointment cancellations at least 24 hours in advance by calling the office or the answering service. We reserve the right to charge you (not your insurance company) for a missed appointment. This is a $35.00 fee (fee amount is subject to change without prior notice).

Laboratory, Radiology and other diagnostic service bills: Please check with your insurance company to verify what your insurance benefits allow for. The doctor may order tests during your visit. These services are billed separately by the laboratory or diagnostic facility that performs these tests and are not covered by payments that you make to us.

Medical Record Fees: There will be a fee for copying medical records of $1.00 per page up to $100.00. There is an additional search fee of $10.00 and postage fees. You must fill out a medical records request form to obtain a copy of your medical records. Please allow up to 30 days for processing of your copy of medical records.

Payment Responsibility: I hereby authorize payment directly to **Artbritis & Rheumatology Associates of South Jersey, P.C.** of the physician's attendance benefits otherwise payable to me but not to exceed the charges as stated. I understand that I am financially responsible to **Arthritis & Rheumatology Associates of South Jersey, P.C.** for the charges not covered by this authorization. I also understand and agree that if my account is delinquent and incurs collections fees or legal fees that I am responsible for payment of those fees as well as the full balance of my account.

I have read and fully understand the financial policy set forth by Arthritis & Rheumatology Associates of South Jersey, P.C. I understand and agree to the terms of this policy. I also understand and agree that the terms of this financial policy may be amended by Arthritis & Rheumatology Associates of South Jersey, P.C. at any time without prior notification to me.

_____ _____

Signature of patient or responsible party Date

_____ _____

Printed name of patient or responsible party Date

_____ _____

Office Employee Date

Arthritis & Rheumatology Associates of South Jersey, P.C.
2848 S. Delsea Drive, Ste 2C
Vineland, NJ 08360
856-794-9090

Form Effective: October 17, 2014