Essential Rheumatology LLC
860-325-6908

Patient Intake Packet — Check-In Consent Forms

Patient Name: _____

Date of Birth: _____
MM / DD / YYYY

Authorization for Care

I voluntarily consent to and authorize Essential Rheumatology LLC and its licensed clinical providers to perform routine evaluations, diagnostic procedures, and medical treatments. I understand my care may include physical examinations, joint assessments, laboratory testing (including advanced autoantibody panels), and diagnostic imaging (such as X-rays or musculoskeletal ultrasound).

Specialized Rheumatologic Care

I understand that rheumatological conditions often require long-term management strategies. Treatment plans may include, but are not limited to, the administration or prescription of immunosuppressive medications, disease-modifying antirheumatic drugs (DMARDs), and biologic therapies.

Injections and Aspirations

I acknowledge that routine care in this practice may involve therapeutic joint or soft-tissue injections (such as corticosteroids or hyaluronic acid) and diagnostic joint fluid aspirations. I understand that the specific risks and benefits of these minor procedures will be explained to me by my provider prior to the procedure.

Right to Refuse

I understand that I have the right to discuss any proposed treatment plan, ask questions about alternative therapies, and refuse any specific test or treatment at any time.

Acknowledgment

☐ **I accept and authorize routine treatment.**

_____

Patient Name (Print) Patient Signature

_____

Date