ARTHRITIS & RHEUMATOLOGY CENTER, PC
Phone: (770) 284 3150 | Fax: (770) 284 3170 | Email: info@arcenterpc.com

Patient Intake Form

Patients Information

Last Name	First Name	Middle Initial	Preferred name		
Street Address	Appt#	City	State	Zip	
Home Phone	Cell Phone	SSN#	Date of Birth	Sex	Marital status
Employed by			Spouse's Name		
Employer's Address			Spouse Employed by		
Occupation	Business Phone & Ext		Spouse's Occupation	Spouse's Business Phone & Ext	
Nearest friend or relative NOT living with you			Relationship to Insured	Spouse's Phone#	

Policy Holder's Insurance Information

Primary

Last Name	First Name	Relationship to Patient
Insurance provider's name	Policy/Subscriber ID:	Group#
Insurance Providers complete mailing address (See back of the card)		Insurance Providers Phone#

Secondary

Insurance provider's name	Policy/Subscriber ID:	Group#
Insurance Providers complete mailing address (See back of the card)		Insurance Providers Phone#

Referring and Primary Provider's Information

Referring Provider's Name		Phone#
Address		
Primary Care Provider's Name		Phone#
Address		
Referral Source (Doctors office, Insurance network, Family Member, Internet, etc.) Please list below.		

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Receipt of Notice of Privacy Practices

This is to acknowledge that I have reviewed and/or have access to a copy of Arthritis and Rheumatology Center, PC's Notice of Privacy Practices. This information is located at the front office or on Arthritis and Rheumatology Center PC's website, www.arcenterpc.com

Medicare Insurance Records Authorization

I REQUEST THAT PAYMENT OF AUTHORIZED benefits be made to Arthritis and Rheumatology Center, PC. I authorize any holder of medical information about me to release to the Center of Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable to related services in reference to Medicare. (NOTE: This office does not accept MEDICAID.)

Out of Network Insurance Notification

This office is out-of-network for these Insurance Plans:

Amerigroup, Wellcare, Peachstate, Humana-X, unless considered state health benefits plan, GA Medicaid or any other type of Medicaid (Other insurances may also apply. Please contact your insurance company to find out.)

I hereby authorize the release of any medical information, including information related to psychiatric care, drug & alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any healthcare related utilization, review or quality assurance activities or any healthcare professional requiring this information.

I hereby assign and authorize payment to, of all medical and/or surgical benefits, including major medical policies, to which i am entitled to under any insurance policy or policies, under any self-insurance program, or under any benefit plan.

I understand and acknowledge that this assignment of benefits does not releive me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including but not limited to payment of those fees and charges not directly reimbursed to by any insurance policy, self-insurance program or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Person providing the authorization (Print Name): ____

Relationship to patient if not the Patient: ____

Patient Portal Information

I ☐ Do ☐ Do Not want to be signed up for the Patient Portal. If you choose to be signed up for, then an email shall be automatically sent to you after your appointment is made.

Email ID (required to join Patient Portal): ____

I have read and understood all the about policies and agree to abide by its terms.

Date: Signature:

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General Office Policies

Please read carefully. A copy can be provided to you upon request.

1. We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. Arthritis & Rheumatology Center, PC participates in most major insurance plans. For a complete list of insurance participants at this practice please call the practice main line. We will file your insurance for you if we are participating provider of your plan.
2. All Co-Payments and Deductibles are due at the time of service. Please remember to bring your insurance card (HMO, CMO, PPO, etc.) with you to each appointment
3. On your first visit the physician may order labs and or x-rays. These tests must be performed before your next visit in order to prevent delays in your potential treatment.
4. There is a $50 No-Show fees for appointments not canceled or rescheduled within 24 hours
5. We have reserved your appointment time exclusively for you, if you are more than 10 minutes late to your appointment, it may need to reschedule.
6. Lab, X-rays and all diagnostic test results are NOT given over the phone but rather at your next visit. If there is an abnormal result that warrants immediate attention, the office will contact you asap.
7. All patients must present their insurance card at each visit. If you do not update us regarding new insurance or additional insurance, this could affect medical claims and delay authorization for medications.
8. Please advise our front office staff if you have a new phone number, address or email
9. Referrals will be processed within 72 business hours from the receipt of request. Referral request received on Fridays will be processed the following week. If you have change to pharmacies, you will need to update us at the time of the refill request. If you have not kept up with your follow-up visits, your prescriptions may not be refilled.
10. This practice Does Not participate in filling out disability claims forms. This includes short-term disability claim forms. If a case warrants an exception to this policy, it is left to the discretion of the physician.
11. Medical records can be printed at the patient's request with fee of $1 per page, ($25 max) and $10 for CD's. There are no charges for sending medical records to other physician. This process can take up to 2 weeks.
12. FMLA forms can be completed under the discretion of the physician with $25 fees. This office does not fill out long-term or short-term disability forms. Any exception to this policy is at the discretion of the provider(s).
13. Telephone messages left for our staff after 3.00 p.m. will be returned the next business day.
14. Arthritis and Rheumatology Center PC does not allow patients to switch physicians once seen by original provider. All our physicians are excellent in their field and have your best interest as their priority.

I have read and understood all the about policies and agree to abide by its terms.

Date: Signature:

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Pain / Narcotic Medication Policy

Please read carefully. A copy can be provided to you upon request.

1. I agree to take narcotic medication exactly as instructed. I am NOT allowed to change the dosage, amount or alter the time schedule of taking the medication without first talking to my prescribing physician.
2. Narcotics will NOT be phoned in after business hours or on weekends
3. Only ONE pharmacy will be used for filling narcotic prescription
4. The following are the conditions for immediate termination from the practice.
    a. Obtaining narcotics from any other physician while under our care without our knowledge
    b. Altering or forging of a prescription is a felony and will be reported.
    c. Testing positive for illegal drugs while taking controlled substance prescribed by a physician at Arthritis and Rheumatology Center PC
5. Patients may be terminated from the practice with 30 days' notice for non-compliance.
6. We will NOT refill prescription that have been lost or misplaced. Please be responsible in keeping up with your narcotic prescription
7. Stolen medication can be replaced ONE TIME ONLY, if you have a valid police report
8. In the case of intolerance or ineffective narcotic medication, a different prescription may be given, provided the unused portion of the previously prescribed medication was returned
9. I have been informed about the use of narcotic adverse side effects such as development of intolerance, dependence, addiction, withdrawal, constipation, nausea, itching, harmful effects to an unborn child, urinary retention, impairment of reasoning & judgement and depression of breathing.
10. I will not combine any narcotic medication with the consumption of alcohol and / or illegal drugs.
11. I will not give, trade or sell pain medication
12. I will allow 24 hours for a prescription refill to be authorized. I also understand that request received after 2 p.m. are handled on the next business day.
13. I understand that at any given time I may be tested by urine or blood for drug use and that a positive test will result in refusal of narcotic medication and possibly subject me to termination from the practice

I have read and understood all the above policies and agree to abide by its terms.

Date: Signature:

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Financial Policies

Please read carefully. A copy can be provided to you upon request.

- We understand how helpful it can be to know in advance how payment arrangements are handled visit to the doctor's office is necessary. Outlined below are the Arthritis & Rheumatology Center PC's basic Financial policy
- Arthritis and Rheumatology Center PC, requires you to provide a copy of your insurance card, co-payment and/or deductibles at the time of check-in. As our office often performs many procedures in house, it is your responsibility as a patient, to become familiar with your individual insurance benefits prior to accepting.
- If we participate in your insurance plan, we will file your charges with your insurance company on your behalf. if we do not participate in your insurance plan, payment for services rendered is collected at the time of service.
- Failure to provide updated insurance information in a timely manner may cause Insurance denials and non-coverage for procedures including in-office infusion therapy. Any claims denied due to the lack of updated insurance information will then become the responsibility of the patient. If new insurance information is provided, we will file the claim under that plan if the effective date falls within the range of the date of service. If the claim is denied by the health insurance plan for timely filing, the patient will be responsible for payment of the claim.
- After we file the claim with your insurance, we will wait 60 days for payment from your insurance company. If payment has not been received within 60 days, we will turn the account over to patient responsibility. We ask that you follow up with your insurance company to make sure your claims are processed in a timely manner. Please communicate your findings to us so that we may remain on sound financial footing. If for any reason we are not provided notification of a new insurance plan you are on and the claim is denied for timely filing, the balance will become the responsibility of the patient.
- Although we are reluctant to do so, we utilize a collection agency for accounts not paid within 90 days. Once an account has been sent to the collection agency, it cannot be retrieved. Prompt payment of any balances remaining after insurance has paid will keep your account in good standing.
- Charges for Lab Services performed outside of our office are billed separately and are not typically included with the Physicians bill.
- Our charges for copying medical records are based on the charge set forth by the Georgia office of Planning and Budget pursuant to O.C.G.A 31-33-3. In order to comply with the HIPAA regulations, a signed, written request for medical records must be received along with the payments before records can be released. Varying fees are charged for forms and letters that may be requested.
- Please let us know at least 24 hours prior do your scheduled appointment time if you will not be able to keep your appointment. Appointments not canceled in a timely manner will be assessed a No-show fee off $50. we accept Visa, MasterCard, American Express and Discover as well as cash and personal checks drawn on a local bank with pre-printed name, address and phone number.
- Personal checks returned for insufficient funds are assessed a $35 fee. Checks that are returned by the bank as non-paid are assessed a $35 bad check fee. The amount of the non-paid check plus the $35 bad check fee are due within 10 days. We reserve the right to require payment of the non-paid check and the bad check fee by a method other than check (cash, credit/debit, money order). Failure to rectify the situation within 10 days, will result in the account being sent to our collection agency

I have read and understood all the above policies and agree to abide by its terms.

Date: Signature:

Ways to Help us to help you

We are committed to high-quality healthcare for you and your family. We have compiled a list of information that will assist us in providing you with the highest level of patient care and customer service. Please familiarize yourself with this information so you would know what to expect in the event you should need our assistance.

Pharmacy Prescription Refills:

You are encouraged to have prescription refills addressed at the time of your visit with your provider. Should you need a refill during the interim, please have your pharmacy fax your request to our fax line at 770-284-3170 or send electronically. This will help expedite the refill process. Please remember that your provider reviews all prescription refill requests and must approve the refill. The review could take up to 72 hours. Contact your Pharmacy prior to calling our office to confirm whether your prescription refill has been approved.

Labs, X-Rays and Diagnostic Testing Results:

Labs, X-rays and all Diagnostic test results are NOT given over the phone but rather at your next visit. If there is an abnormal test result that warrants immediate attention, the office will contact you. It is most important that we have your current phone number on file so you can receive your results.

Insurance:

Please bring your insurance card with you to every visit. We will need to review it and scan the card. This will assist us in filing your claim for payment. In the event your coverage has lapsed ore expired on the date the services are rendered, all charges will be your responsibility and payable that same day. Any Coinsurance, Deductible or Co-payments are collected upfront at the time of service.

Phones:

To better serve you, if someone does not answer your call at our office, please leave a voicemail message. Messages left before 3p.m. will be returned to the same day. Please do not leave multiple messages as this delays our response time to your original message.

We are very pleased that you have chosen our office for your care. If you have any special needs or questions, please let our staff know or feel free to call the Office Manager at 770-284-3150. Thank you for your confidence in us

I have read and understood all the above policies and agree to abide by its terms.

Date: Signature:

ARTHRITIS & RHEUMATOLOGY — CENTER PC —

ARTHRITIS & RHEUMATOLOGY CENTER, PC

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No Show Policy

- When an appointment is missed without a call from someone to cancel or reschedule your appointment, it is considered a NO-SHOW. When a patient does not appear for their appointment, the time is lost not only for the physician, but also for the patient we might have been able to schedule at that time.

- The NO-SHOW rate has steadily increased over time. Almost every day there is someone that we are not able to see because we have no remaining available appointments. Even though we try to accommodate as many of our patients as possible, there is a limit to how many patients we can book as we assume that everyone will keep that appointment. Therefore, after much consideration, and in fairness to all our patients who do keep their appointments or call at least 24 hours in advance to reschedule, we feel it is necessary to implement a NO-SHOW policy as follows

    - Patient who miss their appointments without calling at least 24 hours in advance to cancel, will receive a charge of $50 on their account for missed appointment. At the time of the third missed appointment the patient will be advised that another no-show may result in discharge/termination from the practice.

- We value you as a patient and recognize the difficulties you face in trying to coordinate all the demands made up on your time. We know that unavoidable emergencies occur sometimes. We hope that you understand about the need to implement this policy in our attempt to accommodate all of our patient's time constraints. Thank you for your understanding and support.

Please sign below indicating that you have reviewed the NO-SHOW policy

I have read and understood all the above policies and agree to abide by its terms.

Date: Signature:

Authorization for Release of Health Information

Please read carefully. A copy can be provided to you upon request.

Note: If the form is not complete, signed and dated, it becomes Invalid and cannot be accepted.

Patients Name: ____ DOB: _________________________

Consent to release your medical record information:

In an event, Arthritis and Rheumatology Center PC may need to contact you regarding your Medical Records or Appointment. For such events, please list the phone numbers and email at which you may be reached:

Home: ____ Cell: ____

Work: ____ Email: ____

In the event you are not available or not reachable:

Do you give permission for Arthritis and Rheumatology Center PC to leave a Voice Message on a voice messaging device?

☐ Yes, I give permission for HOME / CELL / WORK (please circle all that apply)

☐ No, I do not give permission

Do you give permission for Arthritis and Rheumatology Center PC to release information verbally regarding your medical records, test results, appointment details or additional information to person(s) listed below?

☐ Yes, I give permission for ☐ No, I do not give my permission

List the person(s) to release information to:

1) ____
Name | Relationship | Contact number

2) ____
Name | Relationship | Contact number

3) ____
Name | Relationship | Contact number

List of Person(s) to restrict from receiving information:

X) ____
Name

By signing the form you verify that the information listed above is correct. If you wish to remove or add additional person(s) to this form you will need to fill out a new form and submit it to the front office.

Patient's Signature: Date:

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Authorization for use or Disclosure of Protected Health Information

What is this? This form gives our practice authorization to pull as well as send your medical records from/to other healthcare institutions and/or practices to be reviewed by our/other physician(s) respectively.

Patients Info				
Last Name		First Name		Middle Initial
Full Address				
Home Phone	Cell Phone	SSN#	Date of Birth	Sex

☐ I authorize Arthritis and Rheumatology Center PC to use or disclose my protected health information as indicated

Print above the name of entity to receive this information

Print above the full address of the entity to receive this information

☐ I Authorize (Print Entity name) ____

to release my protected health information to Arthritis and Rheumatology Center PC as indicated below

	Information to be released		Purpose of Disclosure
☐	From & to dates:	☐	Changing Physicians
☐	History and Physical exam	☐	Continue care
☐	Office notes	☐	At patients request
☐	X-ray reports	☐	Second opinion
☐	Lab reports	☐	Legal
☐	Hospital records (OP notes, discharge summary)	☐	Insurance/ Workers Compensation
☐	Medication records	☐	School
☐	Others:	☐	Others:

I understand that this authorization will expire on ____
(Expiration date or Defined event)

I understand that I may revoke this authorization at any time by notifying Arthritis & Rheumatology Center PC in writing. This authorization will cease to be effective on the date notified except to the extent that the practice has acted in trust upon this authorization.

Date: Signature:

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Initial Patient health Survey

Last name: _______________________________ First name: _______________________________ Date:__________________

DOB: ______________________ Age: __________, Sex: Male / Female, Height: ___________inch, Weight: _____________lbs.

Race: Hispanic | Asian | African American | White | Refuse to report | Others: _________________________

Language: English | Spanish | Indian | Korean | Russian | Refuse to report | Others: _________________

Primary care physician: Name ____, Phone: __________________________________

Address: ____

Preferred Pharmacy: Name ____, Phone: __________________________________

Address: ____

New Patient Questionnaire

Reason for your visit (Chief Complaint): ____

____

Medications: Are you taking any medications (including alternative, herbal and over the counter) now? Yes / No

If yes, please list name and dosage

Name of Medication	Dosage	Name of medication	Dosage

Allergies:

Do you have any allergic or adverse reaction to any medications or substance? Yes / No

Allergic Medication/Substance	Reaction to it		Allergic Medication/Substance	Reaction to it

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Full Name: ____DOB: ________________________________Date:_____________________

Review of systems:

(Please check if you recently have had any of the following signs and symptoms)

Constitutional:
- [ ] Sleep Problems
- [ ] Change in appetite
- [ ] Fatigue
- [ ] Fever
- [ ] Weight gain/loss

Ophthalmologic:
- [ ] Visual changes
- [ ] Eye inflammation
- [ ] Red eyes
- [ ] Blurred vision
- [ ] Dry eyes
- [ ] Itchy eyes

Ear/Nose/ Mouth/Throat:
- [ ] Difficulty in hearing
- [ ] Runny nose
- [ ] Nose ulcers
- [ ] Mouth sore/ulcers
- [ ] Gum bleeding
- [ ] Hoarseness
- [ ] Sinus problem
- [ ] Difficulty swallowing
- [ ] Ear pain
- [ ] Ringing in ears
- [ ] Sinus pain
- [ ] Sore throat
- [ ] Swollen glands

Endocrine:
- [ ] Thyroid problems
- [ ] Frequent thirst
- [ ] Lack of sexual desire
- [ ] Excessive sweating
- [ ] Heat intolerance

Respiratory:
- [ ] Shortness of breath
- [ ] Difficulty breathing
- [ ] Asthma
- [ ] Cough
- [ ] Heavy snoring
- [ ] Shortness of breath with exertion
- [ ] Wheezing

Breasts:
- [ ] Breast lumps
- [ ] Breast pain
- [ ] Breast swelling
- [ ] Nipple discharge

Hematologic/Lymphatic
- [ ] Bleeding tendencies
- [ ] Easy bruising
- [ ] Swollen lymph nodes

Cardiovascular:
- [ ] Heart murmur
- [ ] Heart attack/problems
- [ ] Leg pain while walking
- [ ] Leg swelling
- [ ] Varicosities (big leg vein)
- [ ] High blood pressure
- [ ] Chest pain
- [ ] Chest pressure
- [ ] Irregular heartbeat

Psychiatric:
- [ ] Anxiety
- [ ] Feeling depressed
- [ ] Mood swings
- [ ] Decreased interest in doing normal activities

Gastrointestinal:
- [ ] Intolerance to NSAIDS (anti-inflammatory medications)
- [ ] Bloating/belching
- [ ] Black tarry stools
- [ ] GERD (Gastro Esophageal Reflux Disease)
- [ ] Abdominal pain
- [ ] Blood in stools
- [ ] Changes to bowel habits
- [ ] Constipation
- [ ] Decreased appetite
- [ ] Diarrhea
- [ ] Difficulty swallowing
- [ ] Nausea
- [ ] Vomiting

Genitourinary:
- [ ] Blood in urine
- [ ] Frequent urination
- [ ] Pain during urination
- [ ] Hesitancy
- [ ] Incontinence (trouble holding urine)
- [ ] Awake at night to urinate
- [ ] Menstrual problems
- [ ] Cervicitis
- [ ] Vaginal ulcers
- [ ] Abnormal vaginal discharge
- [ ] Problems with erection / impotence
- [ ] Prostate problems

Musculoskeletal:
- [ ] Morning stiffness
- [ ] Limitation of daily activities
- [ ] Low back pain
- [ ] Neck pain
- [ ] Jaw pain
- [ ] Achilles tendinitis
- [ ] Knee pain
- [ ] Wrist pain
- [ ] Hand pain
- [ ] Elbow pain
- [ ] Ankle pain
- [ ] Leg pain
- [ ] Feet pain
- [ ] Hip pain
- [ ] Carpal tunnel
- [ ] Joint stiffness
- [ ] Leg cramps
- [ ] Muscle aches
- [ ] Shoulder pain
- [ ] Joint pain
- [ ] Sciatica
- [ ] Joint swelling
- [ ] Weakness

Neurologic:
- [ ] Sciatica pain
- [ ] Balance difficulty
- [ ] Coordination
- [ ] Dizziness
- [ ] Fainting
- [ ] Headache
- [ ] Loss of strength
- [ ] Seizures
- [ ] Tingling/ numbness
- [ ] Tremors

Integumentary/Skin
- [ ] Erythema (redness
- [ ] Petechial (small purple spots)
- [ ] Ulcers
- [ ] Psoriasis
- [ ] Hair loss
- [ ] Cold sensitivity
- [ ] Sun sensitivity
- [ ] Blistering of skin
- [ ] Dry skin
- [ ] Eczema
- [ ] Itching
- [ ] Skin nodules
- [ ] Rashes
- [ ] Raynaud's phenomenon
- [ ] Skin lesions

Others:
Please specify below

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Full Name: ____DOB: ______________________________Date:_____________________

Past Medical History:

Please check if you suffer from, or have been treated for any of the following medical conditions: (Please Circle)

Arthritis	YES	NO		Colitis	YES	NO		Diabetes	YES	NO
Psoriasis	YES	NO		Raynaud's	YES	NO		Heart disease	YES	NO
Uveitis	YES	NO		Cancer	YES	NO		Stroke	YES	NO
Iritis	YES	NO		Osteoporosis	YES	NO		Seizures	YES	NO
Kidney stones	YES	NO		Hypertension	YES	NO		Glaucoma	YES	NO

If yes, please explain: ____

Do you suffer from Anxiety/Depression Yes / No

Drug/Alcohol Addiction Yes / No

Other known conditions: ____

Past Surgical history: Please list any surgeries you have had in the past:

Type of Surgeries	Year		Type of Surgeries	Year

Have you been admitted to a hospital during the past five years? Yes / No

If yes, please list the name of hospital, reason for admission and year of admission

Hospital Name	Reason for admission	Year		Hospital Name	Reason for admission	Year

Family History: Please circle if your family suffers from, or have been treated for any of the following medical conditions:

Arthritis	YES	NO		Colitis	YES	NO		Diabetes	YES	NO
Psoriasis	YES	NO		Raynaud's	YES	NO		Heart disease	YES	NO
Uveitis	YES	NO		Cancer	YES	NO		Stroke	YES	NO
Iritis	YES	NO		Osteoporosis	YES	NO		Seizures	YES	NO
Kidney stones	YES	NO		Hypertension	YES	NO		Glaucoma	YES	NO

If yes, please explain: ____

Do your family suffer from Anxiety/Depression Yes / No and/or Drug/Alcohol Addiction Yes / No

Other known conditions: ____

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Full Name: ____DOB: ___________________________Date:____________________

Social History:

Do you smoke? Yes / No if yes, how often? _________________________________

Ex-smoker / Quit Date: ______________________

Do you drink Alcohol? Yes / No if yes, how often? _________________________________

Do you use any illicit (street) drugs? Yes / No if yes, how often? _______________________________

What is your occupation? ____

Marital Status (Please circle one): Married Single Widowed Divorced

Number of children's? _________________

Sexual History:

Are you sexually active? Yes / No

Method of Birth control? None Others: _______________________________________

History of Sexually transmitted diseases? Yes / No if yes, please explain _________________________

(For Women's only)

Are you pregnant? Yes / No If yes, how many months? ________

Nursing? Yes / No

Total births: __________ Total miscarriages: _________ Last menstrual period: ________

Prolong or abnormal bleeding? Yes / No

Pelvic pain Yes / No

I understand the above information is necessary to provide me with surgical / Medical Care in a safe and efficient manner. I have answered all questions to the best of my knowledge. should further information be needed, you have my permission to ask the respect to healthcare provider or agency, who made release such information to you. I will notify the doctor of any change in my health or medications.

Patient / Guardian Signature: ______________________________________ Date: ____________________________________

I have reviewed the form and discussed it with the patient:

Physicians Signature: ____ Date: ____________________________________

Physician's Assistant Signature: ___________________________________ Date: ____________________________________