ADVANCED PAIN CARE Rheumatology

Rheumatology New Patient Intake

Patient Name: _____ **DOB:** _____

Reason for Visit / Chief Complaint: _____

Were you referred to our office? Yes | No If yes, by who? _____

Primary Care: _____

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Widower ☐ Separated ☐ Divorced ☐ Life partner

Current Occupation: _____

____ Unemployed ☐ Sedentary ____ Moderate activity ☐ Laborer

Past Occupation: _____ Notes: _____

Lifestyle/Habits: ___ Alcohol Use ____ IV drug use ____ Other drug use ☐ Tattoos

____ History of blood transfusion ____ Tobacco Use: ☐ packs/day for ____ years

List Allergies: _____

Past Surgical History: _____

_____

Imaging: _____

Date: __/____/____ Where? _____

CURRENT MEDICATIONS:

Drug Name	*Dose*	*Directions*

Preferred Pharmacy: ☐ Advanced Rx ☐ Other: _____

Advanced Rx pick up or mail next day available (Shipping and Handling included).

Reviewed by physician _____ Date _____

ADVANCED PAIN CARE Rheumatology

Rheumatology New Patient Intake

Patient Name: _____ **DOB:** _____

RHEUMATOLOGY/ARTHRITIS FAMILY HISTORY (Name the conditions if known)

___ Mother _____ ____ Father _____

____ Sister _____ ☐ Brother_____

____ Other _____

PAST MEDICAL HISTORY

✔***CHECK****, if your doctor diagnosed you with any of the following conditions:*

- ☐ Acid Reflux/GERD
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Bowel disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ DVT (blood clots in the legs)
- ☐ Emphysema
- ☐ Headaches/migraines
- ☐ Heart attack, heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Miscarriage
- ☐ PE (blood clots in the lungs)
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Seizure
- ☐ Sinusitis
- ☐ Sleep problems/sleep apnea
- ☐ Stomach ulcers/bleeding
- ☐ Stroke/mini-stroke
- ☐ Thyroid disease
- ☐ Tuberculosis

PATIENT RHEUMATOLIC HISTORY:

✔***CHECK****, any of the following rheumatologic diseases that you have been diagnosed with in the past:*

- ☐ Antiphospholipid (APS)
- ☐ Avascular necrosis
- ☐ Bursitis
- ☐ Dermatomyositis
- ☐ Fibromyalgia
- ☐ Fracture, vertebral
- ☐ Fracture, other
- ☐ Gout
- ☐ Lupus
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Periph Nerve-carpal tunnel
- ☐ Periph Nerve-tarsal tunnel
- ☐ Polymyalgia Rheumatica
- ☐ Polymyositis
- ☐ Pseudogout
- ☐ Rheumatoid Arthritis
- ☐ Scleroderma
- ☐ Sjogren's syndrome
- ☐ Tendonitis
- ☐ Vasculitis
- ☐ Other: _____
- ☐ **NONE**

Reviewed by physician _____ Date _____

ADVANCED PAIN CARE Rheumatology

Rheumatology New Patient Intake

Patient Name: _____ **DOB:** _____

REVIEW OF SYSTEMS:
Do you have problems with any of the symptoms listed below? ✔***CHECK*** *yes or no*

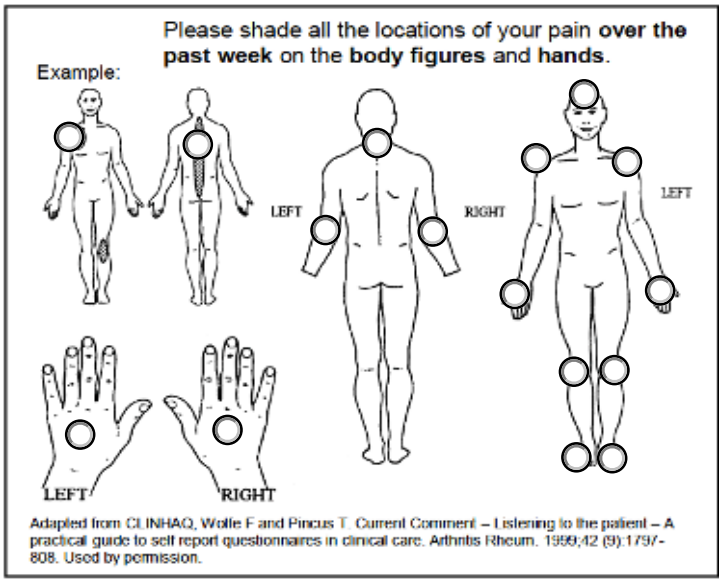
	Y	N		Y	N		Y	N
GENERAL			**GENITAL/URINARY TRACK**			**NERVOUS SYSTEM**		
Chills			Discharge			Bowel/bladder control		
Fatigue/tiredness			Painful urination			Headache		
Fevers			Frequency			Numbness/tingling		
Night sweats			Genital ulcer			Other		
Sleep disturbances			Blood in urine			**OB/GYN**		
Weight gain			Testicular pain			Abnormal menses		
Weight loss			Other			Menopause		
Other			**EYES/EARS/NOSE/THROAT**			Other		
ALLERGY			Diminished vision			**LUNGS**		
Seasonal			Eye pain			Cough		
Other			Dry eyes			Coughing blood		
HEART			Red eyes			Shortness of breath		
Chest pain			TMJ symptoms			Other		
Leg swelling			Dry mouth			**SKIN**		
Palpitation			Oral ulcers			Hair loss		
Other			Parotid gland swelling			Bruising		
HORMONE PROBLEMS			Imbalance			Sun-sensitive skin rash		
Thyroid			Hearing loss			Rash		
Other			Other			Raynaud's		
STOMACH/BOWEL			**BLOOD DISORDERS**			Skin ulcer		
Anorexia			Bleeding problems			Other		
Bloody/tarry stools			Blood transfusion history			**PSYCHIATRIC**		
Constipation			Other			Depression		
Diarrhea			**MUSCULOSKELETAL**			Anxiety		
Heartburn			Joint pain			Other		
Jaundice			Joint swelling			**NOTES:**		
Stomach upset			Muscle weakness					
Nausea			Morning stiffness > 1 hour (If "Y" ____ hrs: ____ mins)					
Vomiting			Muscle pain					
Other			Other					

Reviewed by physician _____ Date _____

ADVANCED PAIN CARE Rheumatology

Rheumatology New Patient Intake

Patient Name: _____ **DOB:** _____



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.

PE:	N	A
GEN		
HEENT		
RESP		
CVS		
ABD		
MSK		
Gait		
Shoulder		
Elbow		
Wrist		
Hand		
Hips		
Knee		
Ankles		
Feet		
Spine		

Assessment:

Plan:

Reviewed by physician _____ Date _____

ADVANCED RHEUMATOLOGY

RHEUMATOLOGY INFORMED CONSENT

Patient's Name: Date of Birth:

PLEASE INITIAL EACH PARAGRAPH SIGNIFYING CONSENT AND UNDERSTANDING

_____ I voluntarily request and intend to receive diagnostic and clinical rheumatologic medical services and related treatment from Advanced Pain Care and its sub-specialties; its licensed and unlicensed staff. I understand that Advanced Pain Care and its sub-specialties provides care to assist or enable me to remedy or recover from an ailment. I understand, however, that Advanced Pain Care and its sub-specialties cannot guarantee any specific outcome from this provision of care. I also understand and agree that my acceptance of care is voluntary. Advanced Pain Care and its sub-specialties may make treatment recommendations (including medical procedures), but I ultimately have the choice to accept and/or participate in such treatment. Accordingly, I understand that I may withdraw my consent for treatment at any time.

_____ I give Advanced Pain Care and its sub-specialties the permission and authority to perform (or order) labs, x-rays and/or other diagnostic studies. I understand that these clinical procedures are usually beneficial, but they can sometimes cause harm. I also understand that, in rare cases, underlying physical deformity or pathology may render me susceptible to injury. Advanced Pain Care and its sub-specialties will inform me if they are unable to treat me, but it is my responsibility to make known any pathological illnesses or deformities of which I am aware, and of which Advanced Pain Care and it's sub-specialties would otherwise be unaware. Advanced Pain Care and its sub-specialties provides rheumatologic care, which cannot and does not encompass every medical specialty; I understand and agree that I must consult with the correct specialist for proper diagnostic and clinical procedures for non-rheumatologic care.

_____ I understand that Advanced Pain Care and its sub-specialties may prescribe medication(s) as needed. I understand that all medications have the potential for side effects and that medications prescribed for rheumatologic conditions can have serious potential side effects such as an increased risk for serious infections. I agree to review any literature provided by Advanced Pain Care and its sub-specialties before starting my medication and I agree to accept the risks that accompany the medication I'm prescribed. I agree not to change my dose or discontinue that medication without the knowledge and guidance of Advanced Pain Care and its sub-specialties or, when applicable, another licensed healthcare provider.

_____ I understand that Advanced Pain Care and its sub-specialties may prescribe, perform, or recommend medical procedures such as injections, infusions and aspirations of joints or soft tissues. I understand that these medical procedures have the potential for side effects. Though typically safe, it is possible to have a negative reaction to the medication or procedure itself including infection, bleeding, pain, skin discoloration/scarring, and the risk that the procedure/medication is not effective. Regardless, I am willing to accept these risks and, by either asking or permitting Advanced Pain Care and its sub-specialties to perform these procedures, I am doubly confirming my acceptance of the risks associated with these procedures.

ADVANCED RHEUMATOLOGY

RHEUMATOLOGY INFORMED CONSENT

Patients Name: Date or Birth:

Continued:

_____ Although my participation is voluntary, I understand that achievement of the best possible results for my care will require that I adhere Advanced Pain Care and its sub-specialty's treatment recommendations and treatment plan which includes keeping regularly scheduled appointments. I further understand that other treatments may exist in addition to Advanced Pain Care and its sub-specialties recommendations.

_____ During the course of your physician/patient relationship with Advanced Pain Care and its sub-specialties, you may be prescribed medication that can be filled at Advanced Rx Pharmacy. The address of the Pharmacy is 2000 South Mays Street Suite 200, Round Rock, TX 78664. You are hereby advised that Advanced Pain Care and its sub-specialties have an investment interest in the Pharmacy. This information is being provided to help you make an informed decision about your health care. You have the right to choose your pharmacy. You have the option of obtaining the prescription ordered by your physician at Advanced Rx Pharmacy or at any other pharmacy you select. You will not be treated differently by your physician, Advanced Pain Care or Advanced Rx Pharmacy if you choose to use a different facility.

_____ After reading the above, I hereby request that Advanced Pain Care and its sub-specialties provide me treatment, and I hereby accept the risk of any unknown side effects associated with the treatment or medication prescribed.

Patient Signature:_____Date:_____

Witness Signature:_____Date:_____

ADVANCED RHEUMATOLOGY

ASSIGNMENT OF INSURANCE BENEFITS, CONSENT FOR TREATMENT, GUARENTEE AND STATEMENT OF SERVICE

Patient's Name: Date of Birth:

I hereby assign and authorize payment made directly to **Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center** of all of my covered health insurance benefits including Medicare, Medicaid, Medigap, HSA, commercial, all third party payors, or private managed care plans and insurance whether payable directly to me by any or all third party payors.

I UNDERSTAND my health insurance plan or third party payors may not cover part or all of the medical services rendered. *I fully understand I am financially responsible for and agree to pay all charges not paid by my health insurance plans or payors, including deductibles and co-insurance regardless of reason given for non-payment. I agree to immediately forward all payments, explanations of benefits, and correspondence sent directly to me from any and all third party payors related to care rendered by Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center and agree that failure to do so will make me responsible for the entire billed charge.* My assignment of benefits covers Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center physicians and surgical center for all services now rendered and to be rendered in the future until this assignment is revoked. This assignment of benefits *supersedes* any previous assignments or agreements I made with my insurance company, including Blue Cross Blue Shield and their related companies or any other third party payor to pay me directly. A copy of this form shall be considered as valid as the original. I have received a copy of Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center's patient information brochure.

I UNDERSTAND Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center , is a licensed surgical center and multi-specialty clinic and files claims on my behalf as a courtesy. I agree that I am financially responsible for any facility fees, laboratory test charges, and x-ray charges incurred on my behalf for care rendered. These charges will be in addition to charges for the care that the physicians at Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center . I further understand I may receive separate bills for each of these services, and that I am financially responsible for any services not covered by third party payors, including but not limited to my health insurance and/or managed care plans. I acknowledge *some or all of my care*, including surgical center facility fees, laboratory testing, x-rays, CT, DEXA, MRI, and physician services may be provided by out-of-network providers, and that I am financially responsible for any increased co-pays, deductibles, and non-covered services provided on an out-of-network basis.

I HAVE DISCLOSED the names of all my health insurance plans and third party payors, including secondary plans, and I represent such health care coverage is in full force and effect at this time. I also agree to promptly notify Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center , of any change in my health insurance plan and/or coverage as well as any changes in my address and phone number. I understand that my failure to do so may make me fully responsible for the *entire* bill. In consideration of the services furnished to me, I hereby agree to pay any balance due *within thirty (30) days* from presentation of my bill. If my account should become delinquent, and collection efforts become necessary, I agree to pay 1% per month delinquency charges and any reasonable collection and/or attorney fees incurred. I further agree that *TRAVIS COUNTY, TX* will be the venue for any collection efforts including small claims court and for any and all other litigation required to collect amounts due.

I UNDERSTAND it is ultimately my responsibility to obtain all required referral authorizations and/or precertifications for medical services that are required by my health insurance plan and/or third party payors. I acknowledge that this is *not* the responsibility of Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center

I ALSO ACKNOWLEDGE no guarantees have been made by any employee of Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center or any other party about: (1) my treatment; (2) whether it will be paid for by any third party payor(s) or health insurance plans; or (3) whether any care rendered by Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center including but not limited to physician services, radiology services, and surgical center fees are in or out of network with my insurance plans.

I AGREE to fully cooperate with Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center to assist in their efforts to get claims paid on my behalf but understand that ultimately I am financially responsible for, and agree to pay, and unconditionally guaranty payment, of all charges not paid by my health insurance plan or third party payors.

Patient Signature: _____ Date: _____

ADVANCED RHEUMATOLOGY

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: Date of Birth:

- I authorize Advanced Pain Care and it's sub-specialties to release information from my Medical Record as described in this form.
- Many of our patients allow family members to call and discuss medical information, request prescription refills, medical records, and results of tests, pick up forms, etc. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have any of your medical information released to family members you must sign this form. Signing this form will only give consent to release said information to the individuals indicated below.

Name	Relationship	Phone Number
Name	Relationship	Phone Number

Check all that apply to the above names:

___Regarding appointment, time & date
___Discuss medical care, an issue or concern
Discuss Billing Information
___Discuss Lab Results
Pick up Prescriptions
___Discuss Imaging Results
___Pick up Forms

RIGHT TO REVOKE: *I understand that I can withdraw at any time by giving written notice stating my intent to TERMINATE this authorization to* ***Advanced Pain Care 2000 S. Mays St., Suite 201 Round Rock, TX 78664****. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my Medical Record will not be affected.*

SIGNATURE AUTHORIZATION: *I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop release of Medical Record that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code 181.154(c) and/or 45 C.F.R. 164.502(a)(1). I understand that information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.*

Patient Signature	Date
Legally Authorized Representative	Relationship to Patient
Witness	Date

FINANCIAL POLICY

Patient's Name: Date of Birth:

Thank you for choosing **Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center** as your health care provider. The following is our Financial Policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask our business office personnel. We ask that all patients read and sign our Financial Policy prior to seeing a medical care provider.

Patient's portion of payment, including co-pay, deductible, and/or balance on account is due at the time services are rendered unless prior arrangements have been made with the Billing Department.

We accept assignment with most major insurance companies and participating provider plans. However, you must understand that:
(Please initial all lines below)

_____1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance carrier. We verify your benefits as a courtesy and do not guarantee of coverage or payment.

_____2. All charges are your responsibility whether your insurance company pays or not.

_____3. Fees for services, along with unpaid deductibles and co-payments, are due at the time of treatment.

_____4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to request prompt payment. Please inform our office of the carrier's response.

_____5. Returned checks will be subject to a $25.00 collection charge. If the check is not picked up within 10 days, the check may be turned over to law enforcement.

_____6. No show or cancellations without 24 hour notice are subject to a $25.00 charge.

_____7. Unpaid balances over 90 days may be subject to collections via small claims court, attorney, and/or collection agency with applicable collection fees. All collection fees are the responsibility of the patient.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Authorization to Release and Assign Insurance Benefits: I authorize release of **ANY** medical information, including substance abuse, mental health, and HIV/AIDS records, required to act on **ANY** medical insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to **Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center** the medical and/or surgical benefits I am entitled from my insurance company(s) and/or Medicare and Medicaid. This authorization is in effect for all future claims, until I choose to revoke it in writing.

I, the undersigned, understand and agree to the above Financial Policy. I understand that I am financially responsible for all charges incurred for my medical treatment. I have had the opportunity to ask and have my questions answered to my satisfaction.

Patient Signature_____ Date: _____

Relationship to patient if not patient _____ Authorized Witness:_____

***Mark Malone MD PA includes* Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center.**

ADVANCED RHEUMATOLOGY

ADVANCED SURGICAL CENTER

NOTICE OF PRIVACY PRACTICES AND PATIENT CONSENT

FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient name: *Date of Birth:*

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain PATIENT RIGHTS regarding my protected health information.

I understand that Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center may use or disclose my protected health information for treatment, payment, or health care operations- which means for: providing health care to me, the patient; handling billing and payment; and taking care of other health care operations. Unless required by law, there will be no other uses or disclosures of this information without my authorization.

I authorize Advanced Pain Care and it's sub-specialties, and Advanced Surgical Center to communicate with my **PCP** *(Primary Care Physician)* **: Dr.**
Phone #: ( )

Advanced Pain Care , it's sub-specialties, and Advanced Surgical Center has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the ***'Notice of Privacy Practices'*** before signing this agreement. If I ask, Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center will provide me with most current ***'Notice of Privacy Practices'.***

My signature below indicates that I have been given the chance to review such copy of the ***'Notice of Privacy Practices'.*** My signature means that I agree to allow Advanced Pain Care , it's sub-specialties, and Advanced Surgical Center to use and disclose my protected health information to carry out treatment, payment and health care operations. I have the right to revoke the consent in writing at any time, except to the extent that Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center has taken action relying on

this consent.

_____ _____

Patient Signature ***Date***

_____ _____

Relationship to Patient if signed by another party ***Date***

You may obtain a copy of our ***'Notice of Privacy Practices'*** including any revisions to our ***'Notice of Privacy Practices'*** at any time by contacting: Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center at 2000 S. Mays St, Round Rock Texas 78664 or (512) 244-4272.

****** OFFICE USE ONLY ******

Staff initial below when completed

Consent dates have been updated in Centricity _____

Meaningful Use: Demographics

Patient Name: **DOB:**

Language

English

Spanish

Other:_____

Race

American Indian or Alaskan Native

Asian

Chinese

Filipino

Japanese

Black or African American

White or Caucasian

Native Hawaiian

Multi-Racial

Other:_____

Ethnicity

Hispanic or Latino

Non-Hispanic or Latino

Portal Email

Please provide email for patient portal access: _____

_____ _____

Patient Signature *Date*

**** OFFICE USE ONLY ****

Staff initial below when completed

Race / Ethnicity / Language updated in Centricity _____

Portal Registration: Y or N If No, did you print portal letter? Y or N _____

ADVANCED RHEUMATOLOGY

PATIENT CANCELLATION AND NO-SHOW AGREEMENT

To better serve our patients and provide excellent care, Advanced Pain Care (APC) will enforce a new cancellation, no-show, and/or late arrival policy, effective August 1, 2022. In order to provide you with high quality health care, it is important for you to keep your scheduled appointment with the medical provider. Valuable time has been reserved for you or your family member. A missed appointment or late cancellation of an appointment results in lost time which could have been given to another patient awaiting to receive care.

APC will try to remind you of your appointment (via your preferred method of communication). However, it is your responsibility to keep a record of your appointment and to arrive on time. If you need to cancel or reschedule your appointment, please call or text 24 hours in advance (between the hours of 8:00 AM and 5:00 PM). We realize that an emergency may occur, and you may not be able to notify us. We will discuss such situations with you if such emergencies occur.

APC classifies a late arrival as more than 40 minutes past your allotted appointment time. After more than three (3) no-shows, cancellations, and/or late arrivals within a six (6) month period, APC will suspend your scheduling privileges and request that you see your referring physician for a referral back to APC.

A no-show will be fined $25, and this must be paid before scheduling another appointment.

Thank you for working with us to ensure that services are provided to all our patients in the best possible way.

Patient Signature: _____

Date: _____

ADVANCED RHEUMATOLOGY

Authorization to Release Medical Records

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the release of your Medical Records.

Patient Name: DOB:

Phone Number: Email Address:

RELEASE INFO TO:

Name:_____

Address:_____

City, State:_____ Zip:_____

Phone: _____

Fax: _____

OBTAIN INFO FROM:

Name:_____

Address:_____

City, State:_____ Zip:_____

Phone: _____

Fax: _____

Reason for Disclosure (Please circle one):

Treatment/Continuing Care	Personal Use	Billing/Claims
Insurance	Legal Purposes	Disability Determination
School	Unemployment	Other: _____

What information can be disclosed? *Complete the following by indicating those ıs that you want disclosed. If entire Medical Record is to be released, then check only the first line.*

___**Entire Record**	___History/Physical Exam	___Past/Present Medication	___Lab Results
___Physicians Orders	___Patient Allergies	___Operation Reports	___Consultations
___Progress Notes	___Diagnostic Test Reports	___Billing Information	___Radiology

Your initials are required to <u>NOT</u> release the following information:

___Mental Health Records (Excluding Psychotherapy Notes)

___Drug, Alcohol, or Substance Abuse Records

___Genetic Information/results

___ HIV/AIDS test results/treatment

RIGHT TO REVOKE: *I understand that I can withdraw at any time by giving written notice stating my intent to TERMINATE this authorization to **<u>Advanced Pain Care 2000 S. Mays St., Suite 201 Round Rock, TX 78664</u>**. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my Medical Record will not be affected.*

SIGNATURE AUTHORIZATION: *I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop release of Medical Record that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code 181.154(c) and/or 45 C.F.R. 164.502(a)(1). I understand that information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.*

_____ _____

Patient Signature Date

_____ _____

Legally Authorized Representative Relationship to Patient

_____ _____

Witness Signature Date

ADVANCED RHEUMATOLOGY

Pharmacy Letter

Patient's Name:_____ Date of Birth: _____

Dear Valued Patients:

Due to new government regulations, it will be much harder to get pain medications approved through your pharmacy starting, January 1, 2019.

Your pharmacist will be required to call your doctor and discuss your prescription(s). In many cases, this could take days. Also, your insurance company will have increased preauthorization requirements that may delay prescriptions.

We strongly urge you to use our pharmacy to avoid this red tape nightmare. Our pharmacists have access to our electronic medical records and can quickly and seamlessly confirm, communicate and obtain authorization for our prescriptions.

There will be no waiting. Your prescriptions will be ready to be picked-up the next day or mailed to your door within 1-2 days. We will have them in stock.

Another regulation is no pharmacy can fill only controlled substances. We ask that for every controlled prescription, you also fill at least one other non-controlled prescription. Your medications can be transferred with a simple call from our pharmacists. We can also fill medications for your family and pets for your convenience.

Your follow-up appointments will be scheduled about two days before running out of medication, giving your doctor and pharmacist time to satisfy all the new requirements.

☐ If you would like Advanced Rx to become your pharmacy, please check the box.

Please sign below stating that you have read and have been informed about the new government mandated rules for prescribers and pharmacists regarding controlled medication refills going into effect January 2019.

Feel free to speak with me, your provider or any staff member should you need more information.

Sincerely,

Mark T. Malone, M.D.

Patient Name: _____ Signature: _____

Date: _____

Advanced Pain Care and Dr. Malone have a vested interest in Advanced Rx Pharmacy.

All patients have a right to receive a copy of their prescription and have it filled wherever they choose.