

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:

<i>Drug Name</i>	<i>Dose</i>	<i>Directions</i>

Preferred Pharmacy: Advanced Rx Other: _____

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

Reviewed by physician _____ Date _____

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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:

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

PATIENT RHEUMATOLIC HISTORY:

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Antiphospholipid (APS) | <input type="checkbox"/> Lupus | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Avascular necrosis | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Scleroderma |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Sjogren's syndrome |
| <input type="checkbox"/> Dermatomyositis | <input type="checkbox"/> Periph Nerve-carpal tunnel | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Periph Nerve-tarsal tunnel | <input type="checkbox"/> Vasculitis |
| <input type="checkbox"/> Fracture, vertebral | <input type="checkbox"/> Polymyalgia Rheumatica | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Fracture, other | <input type="checkbox"/> Polymyositis | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Pseudogout | |

Reviewed by physician _____ Date _____

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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					

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

Example:

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 _____

Quality: 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

Marital Status

Married Single
 Widowed Partner

Portal Email

Please provide email for patient portal access: _____

Consent to Text, Call and leave detailed voice messages

Do you give Advanced Pain Care permission to text you? Yes No

Do you give Advanced Pain Care permission to call you? Yes No

Consent for communication of medical information via voice message

Do you give Advanced Pain Care permission to leave a detailed voice message on your phone regarding your healthcare? This may include but is not limited to information about upcoming surgical procedures, appointment information, payment information, lab results, and other health-related information. Yes No

Patient Signature

Date

****** OFFICE USE ONLY ******
Staff initial below when completed

Race / Ethnicity / Language updated in Athena _____

Portal Registration: Y or N If no, did they decline and you printed portal URL? Y or N _____

ASSIGNMENT OF BENEFITS, RELEASE OF INFORMATION AND FINANCIAL AGREEMENT

Patient's Name: _____

Date of Birth: _____

Thank you for choosing **Advanced Pain Care and its sub-specialties, affiliated and related entities** 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.

A 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:

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 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 collection 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 Billing Information and Assignment of 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 and its sub-specialties, affiliated and related entities** 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 and sub-specialties, affiliated and related entities.***

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 Athena _____

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:

- | | | |
|--|--|--|
| <input type="checkbox"/> Regarding appointment, time & date | <input type="checkbox"/> Discuss Lab Results | <input type="checkbox"/> Discuss Imaging Results |
| <input type="checkbox"/> Discuss medical care, an issue or concern | <input type="checkbox"/> Pick up Prescriptions | <input type="checkbox"/> Pick up Forms |
| <input type="checkbox"/> Discuss Billing Information | | |

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. I understand that Advanced Pain Care will not condition treatment on whether I sign this authorization.*

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.*

This authorization will expire in 1 year from the date of signature unless another date is specified: _____

 Patient Signature

 Date

 Legally Authorized Representative

 Relationship to Patient

 Witness

 Date

RHEUMATOLOGY INFORMED CONSENT

Patient's Name: _____

Date of Birth: _____

PLEASE SIGN THE BOTTOM OF THE FORM 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 its 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.

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: _____

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.