ADVANCED 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 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 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*

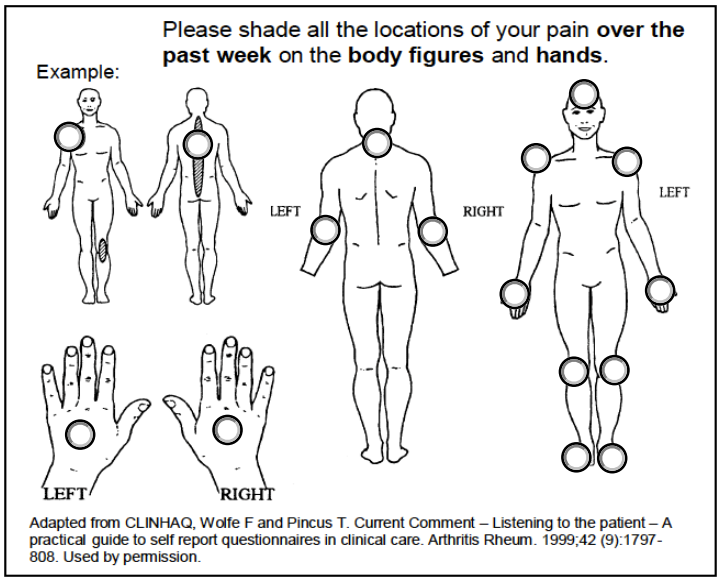
	Y	N		Y	N		Y	N
GENERAL			**GENITAL/URINARY TRACK**			**NERVOUS SYSTEM**		
Chills			Discharge			Bowel/bladder control		
Fatigue/tiredness			Painful urination			Headache		
Fevers			Frequency			Numbness/tingling		
Night sweats			Genital ulcer			Other		
Sleep disturbances			Blood in urine			**OB/GYN**		
Weight 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 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

ASSIGNMENT OF BENEFITS (AOB), RELEASE OF INFORMATION (ROI) 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. Office visit no shows without 24-hour notice, are subject to a $25.00 charge.
7. Paperwork requiring completion by a provider will incur a $75.00 charge. Including but limited to disability, FMLA, etc.
8. 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 about any such problems so that we can assist you in the management of your account.

Procedure No Show, Cancellations & Reschedules within 72 hours:
At the time of scheduling, a credit card will be obtained and securely placed on file. Failure to show on the scheduled day, or cancellation or rescheduling made within 72 hours of the procedure, will incur a $75 fee.

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 _____

Mark Malone MD PA includes Advanced Pain Care and sub-specialties, affiliated and related entities.

ADVANCED RHEUMATOLOGY

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 _____

ADVANCED RHEUMATOLOGY

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

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:

Failure to designate any limitations on the release of PHI below shall result in authorization to release all medical records.

- ☐ 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. 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

ADVANCED RHEUMATOLOGY

INFORMED CONSENT - RHEUMATOLOGY

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.

ARTIFICIAL INTELLIGENCE (AI) DOCUMENTATION NOTICE: Our practice uses artificial intelligence (AI) technology within our electronic health record (EHR) system to assist with administrative and clinical documentation, including the dictation and transcription of office visits.

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

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 _____

ADVANCED RHEUMATOLOGY

Patient's Name: _____ **Date of Birth:** _____

Notice Informing Individuals About Nondiscrimination and Accessibility

Discrimination is Against the Law

Advanced Pain Care/Advanced Surgical/Advanced Pharmacies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)) [optional: (or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Advanced Pain Care/Advanced Surgical/Advanced Pharmacies does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Advanced Pain Care/Advanced Surgical/Advanced Pharmacies:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Michael Jensen, Compliance Officer and Civil Rights Coordinator.

If you believe that Advanced Pain Care/Advanced Surgical/Advanced Pharmacies has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Michael Jensen, Compliance Officer and Civil Rights Coordinator, 101 Louis Henna Blvd., Ste 300, Austin, TX 78278, Tel: 512-244-4272, Fax: 512-244-2895, or at compliance@advancedpaincare.us.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Michael Jensen, Compliance Officer and Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at Advanced Pain Care's website: https://austinpaindoctor.com

By signing below, I acknowledge that I have been given this notice.

Patient Signature: _____ **Date:** _____