Arthritis & **R**heumatology of **M**etairie, APMC
4315 Houma Blvd, Suite 303 Metairie, LA 70006
phone: 504-889-5242 fax: 504-780-9251

Enclosed you will find the Patient Information Form and others that will require your signature and agreement. These forms need to be filled out prior to scheduling your appointment with our office.

Also, if you are being referred by a Physician/Physician Assistant please note we do **require** the following before we can schedule you: Referral, Last clinic Notes from your referring Physician, and pertinent recent Labs and/or X-Rays.

We will take a copy of your insurance card and picture when you arrive. Please be aware of your insurance benefits before coming into the office and present your insurance cards for check-in prior to all appointments. We will collect any co-pays, co-insurance and deductibles at the time of service. In the event that you do not have your insurance information prior to appointment, you may pay a $330 visit charge which we will refund after we obtain insurance payment.

Please be sure to bring an up-to-date list of all your medications, even over the counter supplements, substances.

If you are unable to keep your appointment, please call us as we do charge a NO SHOW AND SAME DAY CANCELLATION FEE.

As of January 1, 2022 there is a convenience fee of 2.95% added to all transactions using credit cards and debit cards. We accept Visa/Mastercard, American Express, Discover, Cash and Check as a form of payment.

Thank you,

Nancy Bordelon
Office Manager

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PATIENT INFORMATION FORM

LAST NAME:_____
FIRST NAME: _____
ADDRESS: _____
CITY:_____
STATE:_____ ZIP CODE: _____
GENDER:____ Date of Birth:_____
SOCIAL SECURITY #: _____

HOME PHONE (____)_____
CELL PHONE:_(____)_____
EMAIL:_____
PREFERRED CONTACT METHOD: (circle one)
HOME CELL EMAIL WORK

EMERGENCY CONTACT
NAME: _____
RELATIONSHIP_____
PHONE: (____)_____

MARITAL STATUS: (circle one)
MARRIED SINGLE

EMPLOYED: YES NO
EMPLOYMENT STATUS:_____
EMPLOYER:_____
WORK PHONE:(____)_____

PRIMARY CARE PHYSICIAN NAME:
_____
PHONE:(____)_____
FAX:(____)_____

PRIMARY INSURANCE CARRIER:
_____

INSURED BY: (circle one)
SELF PARENT SPOUSE OTHER
LAST NAME:_____
FIRST NAME: _____
DATE OF BIRTH::_____
POLICY ID NUMBER #:_____
GROUP #:_____

SECONDARY INSURANCE CARRIER:
_____

POLICY HOLDER:_____
DATE OF BIRTH:_____
POLICY ID NUMBER #:_____
GROUP #:_____

PREFERRED PHARMACY:_____
PHARMACY #: (____)_____

DO YOU HAVE A LIVING WILL? (circle one) YES NO

ACKNOWLEDGMENT: ALL OFFICE VISIT FEES ARE DUE AND PAYABLE AT TIME OF SERVICE. WE WILL BILL YOUR INSURANCE COMPANY AS A COURTESY. HOWEVER, IF PAYMENT IS NOT RECEIVED IN A TIMELY MANNER YOU ARE RESPONSIBLE FOR FOR THE FEES INCURRED.

I DO HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY DIRECTLY TO MY DOCTOR ALL MEDICAL BENEFITS FOR SERVICES RENDERED. Initials: _____ Date:___/____/_____

I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO PROCESS CLAIMS.
Initials: _____ Date:___/____/_____

I UNDERSTAND THE ABOVE OFFICE POLICY AND ALSO UNDERSTAND THERE IS A NO SHOW CHARGE OF $80.00.
Initials: _____ Date:___/____/_____

I UNDERSTAND THE ABOVE OFFICE POLICY AND ALSO UNDERSTAND THERE IS A SAME DAY CANCELLATION CHARGE FOR NEW PATIENT OF $100.00. INITIALS: _____ Date:___/____/_____

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I, Individually or on behalf of the patient, authorize Arthritis & Rheumatology of Metairie, APMC to use and disclose my health information as required for treatment, payment and healthcare operations as described in Arthritis & Rheumatology of Metairie Notice of Privacy Practice. I hereby acknowledge I was given or offered a copy of Arthritis & Rheumatology of Metairie Notice of Privacy Practices on the date written below.

Notice of Privacy Policy available at office when you check-in

PRINT NAME DATE

SIGNATURE DATE OF BIRTH

If signed by personal representative Relationship to the patient

May we leave information for you on your VOICEMAIL? YES NO

If Arthritis & Rheumatology of Metairie, APMC is unable to obtain acknowledgement of receipt of NOTICE of PRIVACY PRACTICE, please explain why:

YOU MAY DISCUSS MY MEDICAL CARE WITH THE FOLLOWING PEOPLE:

ACKNOWLEDGEMENT: To best protect your information, we suggest that you return all paperwork to us via fax, mail or drop off as our email address is not encrypted.
If you still prefer to email it back please initial here _____

1. **Preferred Language** (circle): English Spanish Unknown Refuse/Decline
2. **Ethnicity** (circle): Hispanic or Latino Not Hispanic or Latino Unknown
3. **Race** (circle):
   Am Indian/Alaska Native Asian Black/African-American Caucasian/White
   Native Hawaiian or Other Pacific Islander Multiracial Unknown Refused/Declin

Arthritis & **R**heumatology of **M**etairie, APMC

LATE APPOINTMENT/MISSED APPOINTMENT/NO-SHOW POLICY

We would sincerely like for everyone to understand that *missed appointments present problems for both our office and also for you as the patient.* For you, a missed appointment causes a delay in evaluation and treatment that was recommended to help improve your health. For our office, a missed appointment prevents us from scheduling another patient that could benefit from that evaluation and treatment. We schedule individual time for each patient in order to allow us to deliver the quality, personal care which we believe every patient deserves.

The definition of a missed appointment is when a patient does not show up for a scheduled appointment without *sufficient* notification to the office, or without notification at all. In other words, if we do not have a reasonable amount of time to fill that empty slot, it will be considered a missed appointment. **We ask for notification 24 hours in advance if you know that you will not be able to make your appointment.** We are *very understanding* about certain situations. Some notification is always better than none, and we are usually willing to take that into consideration.

In order to keep our physicians and our patients running on time, we ask that our patients **show up early for their pre-appointment check-in screen.** We expect/ask that returning patients show up 20 minutes ahead of appointment time and new patients arrive at least 30 minutes prior to their appointment time. This is to give sufficient time to fill out paperwork, verify insurance, pay copays, go over medications, and have vital signs checked prior to seeing the doctor. **It should also be noted that if a patient is more than 15 minutes late for an appointment, it will be considered a missed appointment and the appropriate action will be taken.**

Our Late, Missed, No-Show Appointment Policy is as follows:

<u>For new patients:</u>

- 1st missed appointment- **$100 charge** (must be paid before scheduling any further appointments)
- 2nd missed appointment-**$150 charge** (must be paid before scheduling any further appointments)
- 3rd missed appointment- **No further appointments will be scheduled**

<u>For established patients:</u>

- 1st missed appointment within the period of one year- **No Charge** (we know things happen)
- 2nd missed appointment within the period of one year-**$80 charge** with a warning
- 3rd missed appointment within the period of one year- **Discharged from our practice**

We will provide a confirmation call 1-2 days before your appointment as a reminder. **This is a courtesy call and does not release you from your appointment obligation.** If we are unable to reach you to confirm your appointment or we are unable to make that call for some reason, you will still be responsible for your appointment and the above action will still be taken.

If you would like to reschedule your appointment, or have any other questions or issues, please feel free to contact us at any time at 504-889-5242. If you ever need to notify us after hours that you will not be able to make a scheduled appointment, we do have an answering service available 24/7 that will be happy to take your message.

Please signify your complete understanding of this policy with your signature below:

_____

Patient Signature Date Date of birth

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CLINICAL INFORMATION FORM

Name: _____ Today's Date: _____
Date of birth: _____ Name of Practitioner referring You:
Reason for appointment: _____ _____
Reason for Referral: Phone: _____
_____ Fax:_____

Past Medical/Surgical History: Please include any conditions for which you have ever taken medications, been hospitalized, or have needed to seek medical attention.

Past Medical History: Date:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Past Surgical History: Date:

_____
_____
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_____

(Continue on back if need more space)

Family History: (Please include relation and disease)
Has anyone in your family been diagnosed with any autoimmune disease, such as lupus (SLE), rheumatoid arthritis (RA), vasculitis, ankylosing spondylitis, or other?

_____
Any relative suffered from psoriasis (skin rash) or inflammatory bowel disease (UC or Crohn's)?

_____
Please list medical history of your parents and siblings: Include hypertension, diabetes, heart disease, stroke, and cancer (including type of cancer).
Mother: _____ Brother: _____
Father_____ Sister: _____

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Name:_____ Today's Date:_____
Date of Birth: _____

Social History: What is your occupation? Full or part? (If retired or disabled, include date of retirement/disability and prior occupation.)

_____

Former occupations? (include any occupational hazards if applicable)

_____

Tobacco use (cigarettes, cigars, pipe, chewing)? If not, have you ever? When did you quit? (Please include how much per day and for how long.)

_____

Do you exercise? (If so, what type and how often per week?)

_____

Consume alcohol? (If so, what type? How much? And how often?)

_____

Do you consume caffeine products including coffee, tea, or soda? (If so, what type ,how many cups/day?)

_____

Current marital status (single, married, divorced, or widowed)? Any children (include # of sons and # of daughters)?

_____

If a woman, any history of miscarriages? If so, how many and at what week of pregnancy?

_____

Have you ever used illegal IV drugs even once in the past?

_____

Have you received any blood product transfusions ever in the past?

_____

Have you ever been treated for a sexually transmitted disease (STD)? Any high risk sexual behavior?

_____

Any recent travel outside of the USA? Where?

_____

Any exposure to TB (tuberculosis) that you are aware of? If so, when and were you treated?

_____

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Name:_____ Today's Date:_____
Date of Birth: _____

Preferred Pharmacy: _____ Pharmacy Street Address:_____
Pharmacy Phone: _____ City: _____
Pharmacy Fax: _____ Zip: _____

Medication Allergies:
(Please include the reaction you had and the approximate date of reaction.)

_____
_____
_____
_____

Current Medications and OTC Include dosage, frequency, indication and Prescriber

_____
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Please check any of the following items which have significantly affected you over THE LAST WEEK:
Name:_____ Today's Date:_____
Date of Birth: _____

Constitutional:
__ Chills/Rigors
__ Fatigue
__ Fever
__ Night sweats
__ Weight changes, if so gain or loss? How much? Time frame?_____

Head/Eyes/Ears/Nose/Throat:
__ Visual loss
__ Blurry vision
__ Double vision
__ Dry mouth
__ Dry eyes
__ Problems swallowing
__ Frequent nose bleeds
__ Eye Pain
__ Facial pain
__ Hearing loss
__ Hoarse voice
__ Nasal drainage
__ Sores in mouth
__ Eye Redness
__ Frequent sinusitis
__ Sore throat
__ Ringing

Respiratory:
__ Cough
__ Coughing up blood
__ Breathing problems when lying flat
__ Pain with breathing
__ Shortness of breath
__ Wheezing

Cardiovascular:
__ Chest pain
__ Pain in calves with walking
__ Leg/feet swelling
__ Irregular heart beat
__ Raynaud's

Gastrointestinal:
__ Abdominal cramping
__ Abdominal pain
__ Bloating
__ Bright red blood in stool
__ Constipation
__ Diarrhea
__ Heartburn
__ Loss of appetite
__ Nausea
__ Vomiting

Genitourinary:
__ Pain on urination
__ Genital lesions/ulcers
__ Bloody urine
__ Frequent urination at night
__ Pain in sex organs
__ Increased urination
__ Urinary incontinence

Metabolic/endocrine:
__ Cold intolerance
__ New hair loss
__ Heat intolerance
__ Increased facial hair
__ Hot flashes
__ Excessive thirst

Neurological:
__ Confusion/disorientation
__ Dizziness
__ Numbness in hands/feet
__ Weakness of hands/feet
__ New gait disturbance
__ Headache
__ Memory loss
__ Seizures
__ Fainting
__ Tingling of hands/feet
__ Tremors

Psychiatric:
__ Anxiety
__ Depression
__ Emotionally labile
__ Hallucinations
__ Insomnia
__ Suicidal thoughts

Immunology:
__ Seasonal allergies
__ Frequent infections

Dermatologic:
__ Acne
__ Hives
__ Itchy skin
__ Nail changes
__ Sunlight sensitivity
__ Psoriasis
__ Rash

Musculoskeletal:
__ Back pain
__ Joint pain
__ Joint swelling
__ Muscle cramping
__ Muscle weakness
__ Muscle pain
__ Neck pain

Hematological:
__ Easy bleeding
__ Easy bruising
__ Enlarged lymph nodes
__ Hx of blood clots?

Any other symptoms not addressed? Explain.
_____
_____
_____
_____

Arthritis & **R**heumatology of **M**etairie, APMC
NOTICE OF PRIVACY POLICY
PLEASE REVIEW IT CAREFULLY

Purpose: Arthritis & Rheumatology of Metairie, APMC is dedicated to maintaining the privacy of your individually identifiable health information. Arthritis & Rheumatology of Metairie, APMC maintains your health information in records that are kept in a confidential manner, as required by law. We must use and disclose or share your health information as necessary for treatment, payment, and health care operations to provide you with quality care.

Use and Release of Your Health Information for Treatment, Payment, and Health Care Operations: Arthritis & Rheumatology of Metairie, APMC has to use and release some of your health information to conduct its business. In these cases we are permitted to use and release health information without authorization from you. Treatment includes sharing information among health care providers involved in your care. For example, your health care provider may share information about your conditions with radiologists or other consultants to make a diagnosis. Arthritis & Rheumatology of Metairie, APMC may use your health information as required by your insurer to determine eligibility or to obtain payment for your treatment. In addition, we may use and disclose your health information to improve the quality of your care.

How Will Arthritis & Rheumatology of Metairie, APMC Use and Disclose My Health Information? Your health information may be used for the following purposes unless you ask for restrictions of a specific use or disclosure.

Note: You will have the opportunity to refuse some of these communications about your health information, indicated by (*).

- Family members or close friends, specified by your, involved in your care or payment for treatment (*)
- Disaster relief agency if you are involved in a disaster relief effort (*).
- Appointment Reminders (*)
- Public health activities, including disease prevention, injury or disability, reporting births and deaths; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect, or domestic violence.
- Health oversight activities, such as audits, inspections, investigations, and licensure.
- Law enforcement, as required by federal, state or local law.
- Lawsuit and disputes, in response to a court or administrative order, subpoena, discover request or other lawful request.
- Coroners, medical examiners, and funeral directors.
- Organ and tissue donations.
- To prevent a serious threat to health or safety.
- To military command authorities if you are a member of the armed forces or a member of a foreign military authority.
- National security and intelligence activities to authorized persons to conduct special investigations.
- Workers' Compensation. Your medical information regarding benefits for work-related injuries and illnesses may be released as appropriate.
- To carry out health care treatment, payment, and operations functions through business associates, such as to install a new computer system or electronic medical record system.
- The minimum necessary information required to serve the purpose of the use or disclosure will be used or disclosed.

Your Authorization is Required for Other Disclosures. Your authorization will be required for most uses and disclosure of psychotherapy notes, uses and disclosure for marketing purposes, and disclosures that constitute a sale of protected health information. Except as described above, we will not use or disclose your medical information, unless you allow Arthritis & Rheumatology of Metairie, APMC in writing to do so. You may withdraw or revoke your permission, which will be effective from the date your written withdrawal is received.

Alcohol and drug abuse information has special privacy protections. Arthritis & Rheumatology of Metairie, APMC will not disclose any information identifying an individual as being a patient or provide any health information relating to the patient's substance abuse treatment unless the patient authorizes in writing; to carry out treatment,p payment, and operations; or, as required by law.

You Have Rights Regarding Your Health Information. You have the following rights regarding your medical information, if requested on the form (s) provided by Arthritis & Rheumatology of Metairie, APMC:

- **Right to request restriction.** You may request limitations on your health information that we use or disclose for healthcare treatment, payment, or operations, although we are not required to comply with your request, we will attempt to comply. For example, you may ask us not to disclose that you have had a particular procedure. We will release the information if necessary for emergency treatment. We will notify you in writing whether we honor your request or not. We will always attempt to comply with reasonable requests.
- **Right to confidential communications.** You may request communications of your health information in a certain way or at a certain location, but you must tell us how or where you wish to be contacted.
- **Right to inspect and copy.** You have the right to review and obtain a copy of your medical or health record. We may charge a fee for copying, mailing, and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed health care professional chosen by Arthritis & Rheumatology of Metairie, APMC. Arthritis & Rheumatology of Metairie, APMC will comply with the outcome of the review.
- **Right to request amendment.** If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment on the form provided by Arthritis & Rheumatology of Metairie, APMC. Arthritis & Rheumatology of Metairie, APMC is not required to accept the amendment but will comply whenever we feel it is appropriate and possible.
- **Right to accounting of disclosures.** You may request a list of the disclosures of your health information that have been made to persons or entities during the past (6) years prior to the request, except for disclosure for health care treatment, payment and operations, and disclosures based on patient authorization, or as required by law. After the first request, there may be a charge.
- **Right to restrict certain disclosures to a Health Plan.** You may request a restriction of certain disclosures of your protected health information to a health plan if you have paid out of pocket in full for the health care item or service. You will need to notify us specifically which disclosures are to be restricted by submitting the appropriate form provided by Arthritis & Rheumatology of Metairie, APMC and with the understanding that we cannot be held in violation for any disclosures made prior to the request for restriction.
- **Right to copy of this Notice.** You may request a new paper copy of this Notice at any time.

Requirements Regarding This Notice. Arthritis & Rheumatology of Metairie, APMC is required by law to provide you with this Notice. We will comply with this Notice for as long as it is in effect. Arthritis & Rheumatology of Metairie, APMC may change this Notice, and these changes will be effective for health information we have about you, as well as any information we receive in the future. You have the right to be provided with updated Notices.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with:

Arthritis & Rheumatology of Metairie, APMC
Attn: Privacy Officer
4315 Houma Blvd #303
Metairie, LA 70006 (504) 889-5242

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509 F, HHH Building
WAshington, D.C. 20201

Contact Arthritis & Rheumatology of Metairie, APMC's Privacy Officer at (504) 889-5242, option 3 if:

- You have any questions about this Notice or any privacy issues or concerns
- You wish to request restrictions on uses and disclosures for health care treatment, payment, or operations; or
- You wish to obtain a form to exercise your individual rights