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:

_____
_____
_____
_____
_____
_____
_____

(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.
_____
_____
_____
_____

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. You can get an electronic or paper copy of your medical record:

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information. We may charge a reasonable, cost-based fee.

ASK US TO CORRECT YOUR MEDICAL RECORD

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days

REQUEST CONFIDENTIAL COMMUNICATIONS

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

ASK US TO LIMIT WHAT WE USE OR SHARE

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

GET A LIST OF THOSE WITH WHOM WE'VE SHARED INFORMATION

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

GET A COPY OF THIS PRIVACY NOTICE

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

CHOOSE SOMEONE TO ACT FOR YOU

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS ARE VIOLATED

- You can complain if you feel we have violated your rights by contacting us at 504-889-5242.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

HOW DO WE TYPICALLY USE OR SHARE YOUR HEALTH INFORMATION?

We typically use or share your health information in the following ways:

TREAT YOU

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

RUN OUR ORGANIZATION

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

BILL FOR YOUR SERVICES

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

HELP WITH PUBLIC HEALTH AND SAFETY ISSUES

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

DO RESEARCH

We can use or share your information for health research.

COMPLY WITH THE LAW

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

RESPOND TO ORGAN AND TISSUE DONATION REQUESTS

We can share health information about you with organ procurement organizations.

WORK WITH A MEDICAL EXAMINER OR FUNERAL DIRECTOR

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

ADDRESS WORKERS' COMPENSATION, LAW ENFORCEMENT, AND OTHER GOVERNMENT REQUESTS

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

RESPOND TO LAWSUITS AND LEGAL ACTIONS

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

FOR MORE INFORMATION SEE:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.