Coastal Rheumatology Associates

Patient Information

Last Name	First Name	Middle Initial
Street Address	Apt/Lot#	
City	State	Zip
Social Security #	Date of Birth	□ Mr. □ Mrs. □ Ms. □ Dr.
Home Phone #	Alternate Phone #	
Email	Employment □ Full Time □ Part-Time □ Retired □ Disabled	
Sex □ Male □ Female	Marital Status □ S □ M □ W □ D	Student □ Yes □ No □ Full Time □ Part-Time
Referring Physician	Phone #	
Primary Care Physician	Phone #	
Spouse	Phone #	
Emergency Contact	Phone #	
Primary Insurance Name		
Policy Holder Name	D.O.B.	
Policy #	Group #	Group Name
Secondary Insurance Name		
Policy Holder Name	D.O.B.	
Policy #	Group #	Group Name

Consent for Treatment, Payment, and Acknowledgement of Receipt of Notice of Privacy Practices: I request that payment under the medical insurance program be made payable to Articularis Healthcare Group, Inc. for services rendered. I understand that I am financially responsible for all charges incurred at Articularis Healthcare Group, Inc. I authorize disclosure of my personal health information to carry out treatment, payment, or health care procedures. I have received the privacy policy and Notice of Information Practices that provides a more complete description of information uses and disclosures. I agree to pay any and all charges that exceed or not paid/covered by my insurance. In the event my account is turned over to a collection agency, I will be billed the additional collection fees.

Patient/Guardian: _____ Date: _____
Signature

HOW DID YOU HEAR ABOUT US? _____

REASON FOR TODAY'S VISIT_____

_____

APPROXIMATE DATE SYMPTOMS BEGAN? _____

RHEUMATOLOGIC HISTORY - Have you ever been diagnosed with any of the following diseases?

Rheumatoid arthritis	▢ Yes	▢ No	List any other rheumatologic diagnosis:
Psoriasis	▢ Yes	▢ No	
Osteoarthritis	▢ Yes	▢ No	
Gout	▢ Yes	▢ No	
Lupus	▢ Yes	▢ No	
Fibromyalgia	▢ Yes	▢ No	
Osteoporosis	▢ Yes	▢ No	
Vasculitis	▢ Yes	▢ No	
Ankylosing spondylitis	▢ Yes	▢ No	

OTHER HISTORY - Have you been diagnosed with any of the following?

Cancer (type) _____	▢ Yes	▢ No	Eye problems (type)	▢ Yes	▢ No
ADHD	▢ Yes	▢ No	GERD (or heartburn)	▢ Yes	▢ No
Anxiety	▢ Yes	▢ No	Hypertension	▢ Yes	▢ No
Depression	▢ Yes	▢ No	Hyperlipidemia (high cholesterol)	▢ Yes	▢ No
Asthma	▢ Yes	▢ No	Kidney disease	▢ Yes	▢ No
Back Pain	▢ Yes	▢ No	Liver disease	▢ Yes	▢ No
Bipolar Disorder	▢ Yes	▢ No	Lung disease	▢ Yes	▢ No
Anemia	▢ Yes	▢ No	Migraine headaches	▢ Yes	▢ No
Heart Disease	▢ Yes	▢ No	Bleeding Disorder	▢ Yes	▢ No
COPD	▢ Yes	▢ No	Stroke	▢ Yes	▢ No
Diabetes	▢ Yes	▢ No	Hepatitis B	▢ Yes	▢ No
Diverticulitis	▢ Yes	▢ No	Hepatitis C	▢ Yes	▢ No
Epilepsy/Seizure Disorder	▢ Yes	▢ No	Tuberculosis	▢ Yes	▢ No
Skin Disease	▢ Yes	▢ No	Allergies	▢ Yes	▢ No
Thyroid Disorder	▢ Yes	▢ No	Multiple Sclerosis	▢ Yes	▢ No
Rash (type)	▢ Yes	▢ No			
Other:					

Please list all physicians that you currently use:

Physician	Type of MD *(Ex: Orthopedic)*

PAST SURGICAL HISTORY

Procedure/Surgery	Performing Doctor	Year

SOCIAL HISTORY

Do you now or have you ever smoked? ▢ Yes ▢ No If Yes, how much per day and for how long? _____

Do you drink alcohol? ▢ Yes ▢ No If Yes, how many drinks per week? _____

Do you use now or have a history of illegal/illicit drug use? ▢ Yes ▢ No If Yes, what type? _____

FAMILY HISTORY

Do any of your close ***family members*** have any of the following?

Disease	Yes	No	Relationship to you
Rheumatoid Arthritis	▢ Yes	▢ No	
Osteoarthritis	▢ Yes	▢ No	
Osteoporosis	▢ Yes	▢ No	
Lupus	▢ Yes	▢ No	
Heart Disease	▢ Yes	▢ No	
Hypertension	▢ Yes	▢ No	
Gout	▢ Yes	▢ No	
Diabetes	▢ Yes	▢ No	
Vasculitis	▢ Yes	▢ No	
Cancer (what type?) _____	▢ Yes	▢ No	
Other:			

DRUG ALLERGIES:

Drug Name	Reaction

CURRENT MEDICATIONS

Medication Name	Dose/Strength	How Often per Day	Prescribing MD

Have you tried ANY of the following medications?

Medication	Did it help?	Describe any side effects or problems
Ibuprofen	▢ Yes ▢ No	
Naproxen	▢ Yes ▢ No	
NSAIDS (ex: Celebrex; Mobic)	▢ Yes ▢ No	
Methotrexate	▢ Yes ▢ No	
Sulfasalazine	▢ Yes ▢ No	
Plaquenil (hydroxychloroquine)	▢ Yes ▢ No	
Arava (leflunomide)	▢ Yes ▢ No	
Enbrel	▢ Yes ▢ No	
Humira	▢ Yes ▢ No	
Cimzia	▢ Yes ▢ No	
Actemra	▢ Yes ▢ No	
Orencia	▢ Yes ▢ No	
Simponi	▢ Yes ▢ No	
Xeljanz	▢ Yes ▢ No	
Stelara	▢ Yes ▢ No	
Otezla	▢ Yes ▢ No	
Infusion Medications (list name):		
Other:		

AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS

COASTAL
RHEUMATOLOGY ASSOCIATES

5400 Waters Avenue
Savannah, GA 31404
Tel 912.349.4227
Fax 912.349.4457
coastalrheumatology.com

Patient Name _____ Date of Birth _____/_____/_____

Previous Name (if applicable) _____ Social Security # _____/_____/_____

This authorization expires <u>One Year</u> from the date of Signature

METHOD OF DISCLOSURE:

- ▢ I authorize Coastal Rheumatology Associates to RELEASE my medical records to:

  NAME: _____

  FAX #: _____

- ▢ I authorize Coastal Rheumatology Associates to OBTAIN my medical records from:

  NAME: _____

  FAX #: _____

HEALTH INFORMATION TO DISCLOSE:

- ▢ ALL health information
- ▢ Healthcare information relating to the following:
  Treatment, condition, or dates:

  _____

I understand I have the right to refuse to sign this form and that I may revoke my authorization at any time. When my information is disclosed, the federal HIPAA privacy rule may no longer protect it. This authorization will automatically expire ONE year from the date of this request.

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

COASTAL RHEUMATOLOGY ASSOCIATES, LLC
5400 Waters Avenue, Savannah, GA 31404

NOTICE OF PRIVACY PRACTICES

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.

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, usually within 30 days of your request. 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 using the information found at the top of this page. • 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 • Contact you for fundraising efforts *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.

NOTE: We do not create or maintain a hospital directory or psychotherapy notes at this practice.

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.hss.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.

Effective 7/16/2018
5400 Waters Avenue
Savannah, GA 31404
Privacy Officer
Telephone: 912/349-4227

FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ▢ an emergency existed and a signature was not possible at the time.
- ▢ the individual refused to sign.
- ▢ a copy was mailed with a request for a signature by return mail.
- ▢ unable to communicate with the patient for the following reason:

  _____
- ▢ other _____

Prepared by _____ Signature _____Date _____

PATIENT RIGHTS AND RESPONSIBILITIES

RIGHTS

Patients of Coastal Rheumatology Associates have the right to:

1) quality care and treatment.
2) know the names of those treating you.
3) respectful, safe care and treatment free from abuse and harassment.
4) participate in decisions concerning care and treatment.
5) fully informed regarding your condition.
6) confidentiality of records and communications, and access to them.
7) information privacy regarding your diagnosis, treatment options, and the potential outcomes of treatment.
8) refuse a treatment, as permitted by law. You can refuse treatment and still receive alternate care.
9) detailed information regarding service fees and charges.
10) express spiritual and cultural beliefs.
11) redress a grievance.
12) appropriate assessment and management of pain.
13) know practice rules that will affect your treatment.

RESPONSIBILITIES

Patients of Coastal Rheumatology Associates are responsible for:

1) providing accurate/complete information related to their health, for reporting perceived risks in their care, and for reporting unexpected changes in their health.
2) notifying the office when unable to keep a scheduled appointment.
3) providing their health care insurance information to the practice.
4) their actions, if they refuse treatment, or fail to follow their practitioner's instructions.
5) being respectful and considerate of other patients and organizational personnel.
6) asking questions when they don't understand about their care or what they are supposed to do.

These rights and responsibilities outline the basic concepts of service here at Coastal Rheumatology Associates, LLC. If you believe that, at any time, one or more of the statements above has not been met during your care here, please ask to speak to the Office Manager or Physician. We will make every attempt to understand your complaint/concern. We will correct the issue you have if it is within our control, and you will receive a written response.

MEDICAL INFORMATION RELEASE FORM

5400 Waters Avenue
Savannah, GA 31404
Tel 912.349.4227
Fax 912.349.4457
coastalrheumatology.com

I understand that Coastal Rheumatology Associates maintains my personal records, medical history, symptoms, examinations, and test results as part of my healthcare. This information is not to be given to any other person without my permission. Therefore, this is a written consent to authorize release of my medical information.

RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records, laboratory values, prescribed medications, treatment plan, examination rendered, and claims information. This information may be released to:

▢ Spouse: _____ Phone #: ( ) _____

▢ Child(ren): _____ Phone #: ( ) _____

▢ Other: _____ Phone #: ( ) _____

▢ Information is NOT to be released to anyone

▢ check if okay to leave detailed health information on voicemail

PATIENT SIGNATURE _____ DATE _____

WITNESS SIGNATURE _____ DATE _____

COASTAL RHEUMATOLOGY ASSOCIATES PATIENT SCHEDULING POLICY

We are committed to providing our patients with the best possible medical care while also minimizing administrative costs. This scheduling policy has been established with these objectives in mind to avoid any misunderstanding or disagreement concerning payment for professional services.

New Patients:

- due to an increased number of no shows and cancellations of new patient appointments, we are now charging a $25.00 fee for all appointments that have not been cancelled 24 hours prior to the scheduled appointment date. A payment of $25.00 will be required to schedule and secure ALL new patient appointments. This payment will be taken over the phone when scheduling the appointment and can be applied to your account for usage of a co-payment upon checkout.
- Any new patient that no shows their first appointment will not be rescheduled with either provider.
- If you are unable to keep your appointment, kindly call our office at least 24 hours prior to your appointment time. We will work with you to reschedule you to a more convenient time. The $25.00 fee will be applied and charged to all appointments cancelled and NOT rescheduled 24 hours prior to the appointment date. If you fail to cancel your appointment within 24 hours, your $25.00 deposit will be forfeited.
- Cash payments and co-payments must be paid at the time of service. If requested, the $25.00 deposit can be applied to your account for usage of a co-payment upon checkout.
- We do NOT accept Medicaid as a secondary insurance. If Medicaid is secondary, you will be required to sign an agreement understanding that Medicaid will not be accepted.
- Our office does not accept non-established self-pay patients.
- A physician will review the medical records of all Medicaid and self-referral patients before being scheduled.

Follow-up Appointments:

- Established self-pay patients are required to bring $100.00 to each visit and will be collected prior to being seen by the physician. Any remaining balance will be billed to the patient's address on file.
- Established patients with a balance greater than $100.00 must clear the outstanding balance with the billing department before scheduling any future appointments. Payment plans can be arranged if necessary.
- Any patient who cancels three (3) appointments without giving 24 hours of notice will be discharged from the practice.
- Any patient who no-shows two (2) appointments in a calendar year will be discharged from the practice.
- It is the patient's responsibility to keep up with their appointment times. We send automated calls as a courtesy.
- It is the patient's responsibility to obtain any insurance referrals required for their office visit.

Our practice firmly believes that a good physician-patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the medical practice. We are here to help you.

PATIENT SIGNATURE _____DATE _____

COASTAL RHEUMATOLOGY ASSOCIATES PATIENT FINANCIAL POLICY

We are committed to providing our patients with the best possible medical care while also minimizing administrative costs. This scheduling policy has been established with these objectives in mind to avoid any misunderstanding or disagreement concerning payment for professional services.

- As the owner of your insurance policy, you are solely responsible for the policies regarding your plan.
- Our practice participates with numerous insurance companies. For patients who are beneficiaries of one of these insurance companies, our billing office will submit a claim for services rendered. All necessary insurance information, including any forms, must be completed by the patient prior to leaving the office.
- If a patient has insurance in which we do not participate, our office is happy to file the claim upon request; however, payment in full is expected at the time of service.
- There is a mandatory deposit of $100.00 for all existing non-insured patients. This deposit will be applied to all charges incurred during your visit. If you are unable to make a deposit, your visit may be rescheduled.
- It is the patient's responsibility to pay any deductible, copayment, or any portion of the charges as specified by plan at the time of visit. Payments for medical service not covered by an individual's insurance plan are the patient's responsibility and payment in full is due at the time of the visit.
- Payment for professional services can be made with cash, check, credit or debit card.
- It is the patient's responsibility to ensure that any required referrals or precertification for treatment are provided to the practice prior to the visit. Visits may be rescheduled, or the patient may be financially responsible due to lack of referral or authorization from their insurance company.
- It is the patient's responsibility to provide us with current insurance information and bring his/her insurance card to each visit.
- Any patient who cancels two (2) appointments without giving a 24-hour notice cannot be rescheduled with a $50.00 deposit by credit/debit card. Make sure we have proper documentation in the notes screen.
- Our staff is happy to help with insurance questions relating to how a claim was filed or regarding any additional information the payer might need to process the claim. Specific coverage issues, however, can only be addressed by the insurance company member services department.
- If your insurance company requests additional information from you, it is important to reply with their requests in a timely manner considering that the balance of your claim and bill is ultimately the patient's responsibility whether your insurance company pays your claim or not. If the insurance company does not pay your claim in 45 days, the balance is billed to and becomes the responsibility of the patient.
- It is the patient's responsibility to notify our office with any changes to insurance coverage and to make sure Coastal Rheumatology Associates has the proper insurance information. If we do not have the correct insurance information, the patient is responsible for the total bill.

Our practice firmly believes that a good physician-patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to the medical practice. We are here to help you.

PATIENT SIGNATURE: _____ DATE: _____

COASTAL RHEUMATOLOGY ASSOCIATES PATIENT REFILL POLICY

We are committed to providing our patients with the best possible medical care while also minimizing administrative costs. This scheduling policy has been established with these objectives in mind to avoid any misunderstanding or disagreement concerning payment for professional services.

Refill request will only be accepted if the following appropriate criteria have been met:

- Physicians will not accept refill requests after hours or on weekends.
- Refill requests will be submitted to your pharmacy. Please allow 24 hours for this process. You may call our office only after you have spoken with your pharmacy.
- For all controlled substances, refill requests will take 48 hours to process. You may pick up your prescription at our office no sooner than 48 hours after it was called in.
- Your prescriptions can only be discussed with a physician, nurse or medical assistant.
- Our office is closed on Fridays. No prescription request will be taken Friday, Saturday, or Sunday.
- The requested medication has been ordered previously by a Coastal Rheumatology Associates physician.
- The patient has been seen by the physician in the last six (6) months or it is documented that the physician has ordered a one (1) year follow-up.
- The patient has kept the last scheduled appointment or has been rescheduled for a date within the next four (4) weeks.
- The patient requesting DMARDs must have had the required bloodwork within the last 6-8 weeks. The nurse may arrange for the patient to get bloodwork completed if necessary.
- All prescriptions will be written for periods no longer than your next scheduled appointment.
- If a patient misses their appointment and calls in for a prescription, the nurse may only authorize enough medication to meet the patient's dosing requirement until the next scheduled appointment.
- No further refills can be authorized unless the next scheduled appointment is kept.

Our practice firmly believes that a good physician-patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to the medical practice. We are here to help you.

PATIENT SIGNATURE: _____ DATE: _____