Parris & Associates
Rheumatology
989 Lawrenceville Highway
Lawrenceville GA 30046
Telephone: (770) 962-1616 Fax: (770) 962-7977

WELCOME TO OUR OFFICE!

We would like to give you some information about our practice.

We work by appointments only. We give each patient the care needed and sometimes, due to emergencies and other medical needs, we may fall behind this schedule, but know that you will receive the same care when we see you.

We attempt to remind you of your appointment 48 hours in advance. Please be sure we have alternative phone numbers. Should you change or cancel your appointment, we request that you give us at least 24 hours notice. Phone: 770-962-1616. **If you do not give us 24 hours notice or do not show up for your scheduled appointment, you may be charged a no show fee of $50.00 for new patients and $25.00 for existing patients.**

****PLEASE BRING COMPLETED FORMS IN THIS PACKAGE WITH YOU TO YOUR APPOINTMENT!**

IF YOUR INSURANCE COMPANY REQUIRES A REFERRAL, YOU MUST HAVE IT IN HAND BEFORE YOU CAN BE SEEN.

******We **DO NOT** accept: **Kaiser**.
Please check with your insurance company prior to appointment to verify we are an in-network provider and to verify if you need a referral for your visit.

When you arrive for your visit, we will:

1. Collect any co-pay that is due. We accept cash, check, Visa, MasterCard, American Express and Discover. We also accept Visa and MasterCard DEBIT CARDS.
2. Review your medication. Be sure you have a complete list of medications including the strength and how often you take them.
3. If blood work is needed, it can be done here and the Lab will bill your insurance company. If your insurance requires a special lab, *please let us know so we can mark your file appropriately*.
4. If simple X-rays are needed, they will be done here.

Before you leave, we may give you orders for tests that need to be done at other facilities, prescriptions (30 day or 90 day supply), and make your follow up appointment. Test results may be available in 7-10 days. You will be advised how to get those results.

You may reach us by phone Monday thru Thursday 9:00 AM to 5:00 PM and Friday 9:00 AM to Noon. If you have an emergency after hours, an answering service is available, or if you feel you have a life threatening emergency; you should call 911 or proceed to the nearest emergency room.

Signature: _____ Date: _____

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DIRECTIONS TO 989 LAWRENCEVILLE HIGHWAY

FROM 1-85

Take Highway 316 east and travel approximately 2 miles and exit Sugar Loaf Parkway. Take a right off exit and travel approximately 2 miles to Lawrenceville Highway. Take a left turn onto Lawrenceville Highway and travel 1.5 miles. Parris and Associates will be on the left next to Gwinnett Library.

FROM ATHENS

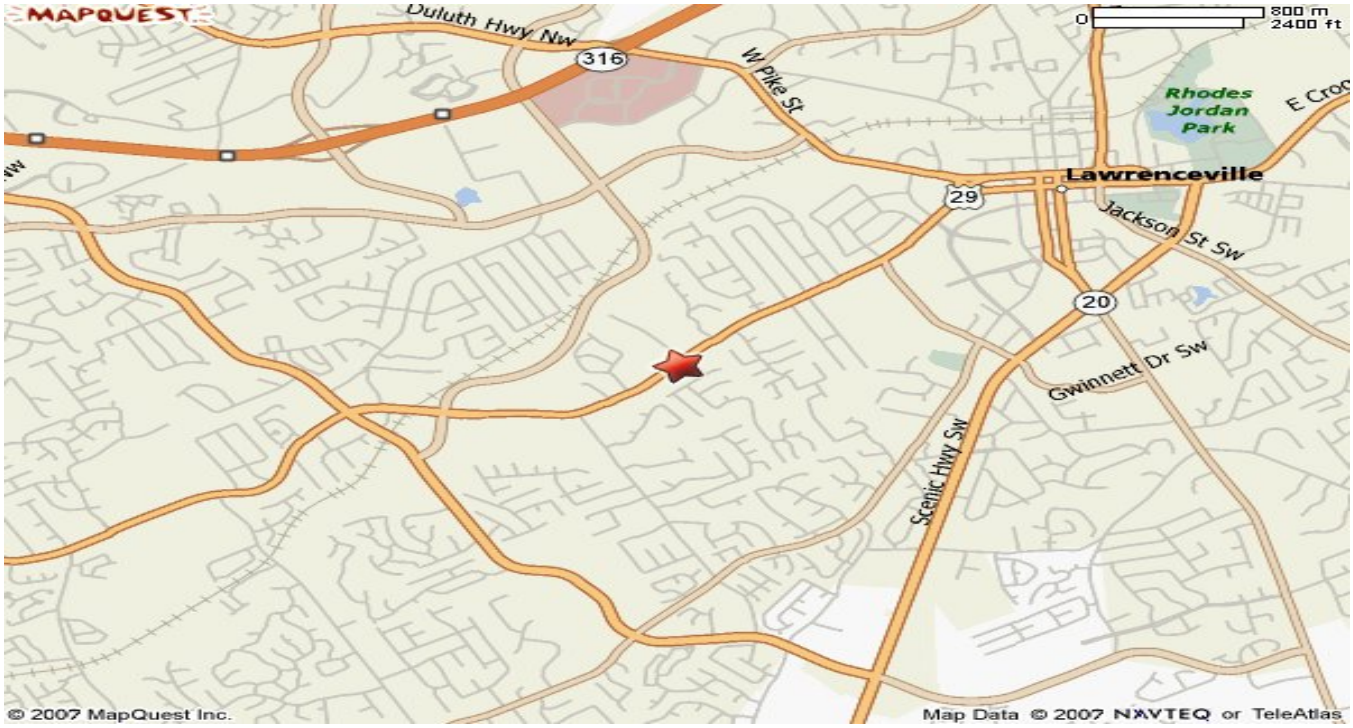
Take Highway 316 west and exit Duluth Highway 120. Take a right off exit and travel approximately l/4 mile to Lawrenceville/Suwannee Road, turn left on Lawrenceville Hwy and travel approximately I mile, Parris and Associates will be on the your left next to Gwinnett Library.

FROM SNELLVILLE/LOGANVILLE

Take Highway 124 North to sugarloaf Parkway. Turn left onto Sugarloaf Parkway keep on driving to you see Lawrenceville/Suwannee Rd. Turn right. Travel approximately 0.5 mile to you see Lawrenceville Highway, turn right travel approximately I mile, Parris and Associates will be on the left next to Gwinnett Library.

FROM GAINESVILLE

Take 85s to Suwannee Exit, Turn left and go straight until you reach Lawrenceville Highway (29) turn left and travel approximately 1 mile down on left. Parris & Associates will be next to the Gwinnett Library.



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REQUIRED DOCUMENTS

For first time visit or, if you have not been seen in this office for 3 years or longer, please bring with you the following;

- Valid Insurance card of official policy or document.
- Photo Identification (e.g. valid Driver's License).
- Referral, if required by your Health Plan.
- Current address and phone number.
- Business card from referring Physician (optional).

ASSIGNMENT AND RELEASE

I, the undersigned certify that I have insurance coverage with_____
Insurance Company Name

And assign directly to PARRIS & ASSOCIATES, DR. GLENN PARRIS, M.D. all insurance benefits, in any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize PARRIS & ASSOCIATES to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance company submissions.

RESPONSIBLE PARTY RELATIONSHIP DATE

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Parris & Associates

New Patient Consent to the Use and Disclosure of Health Information for
Treatment, **Payment**, or **Healthcare Operations**

I**, _____,** understand that as part of my healthcare **Parris & Associates** originates and maintains paper and/or electronic records describing my health history, symptoms, examination & test results, diagnoses, and treatment plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures.

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I understand **Parris & Associates** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken actions in reliance thereon. I also understand that by refusing to sign this consent or revoke this consent, this organization may refuse to treat me as permitted by *Section 164.506 of the Code of Federal Regulations*.

I further understand that **Parris & Associates** reserves the right to change their notice and practices and prior to implementation, in accordance with *Section 164.520 of the Code of Federal Regulation.* Should **Parris & Associates** change their notice, they will send a copy of any revised notice to the address I've provided (whether US Mail or, if I agree to Email.)

I agree that I will submit to a blood or urine test if requested to starting treatment in monitor therapy or determine toxicity of some of your medications.

I wish to have the following restrictions to the use of disclosure of my health information:

_____
_____
_____
_____

I understand that a part of this organization's treatment, payment, or healthcare operations may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and **Accept** or **Decline** the terms of this consent.

Patient's Name: _____ Date: _____

****

For Office Use:

Consent Received By: _____
Consent Refused by Patient and Treatment Refused as Permitted: _____
Consent Added to the Patient's Medical Record on: _____
Revised November 22, 2011

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PATIENT INFORMATION

NAME: _____ SS#: _____-_____-_____

ADDRESS: _____ HOME PHONE: _____-_____-_____

_____ CELL PHONE: _____-_____-_____

DOB: _____-_____-_____

MAY WE REMIND OF YOUR APPOINTMENTS BY TEXT MESSAGING: YES _ NO_____ MOBILE CARRIER? _____

E-MAIL ADDRESS (FOR NOTIFICATION OF APPOINTMENTS):_____

SEX: M____F____ AGE: _____ SINGLE, MARRIED, SEPARATED, DIVORCED, WIDOWDED

***IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED:** _____ **Phone:**_____

PRIMARY INSURANCE

PERSON RESPONSIBLE FOR BILL: SELF___ SPOUSE___ OTHER___ IF NOT YOU, GIVE US THE
NAME: _____ DOB:_____-_____-_____
ADDRESS IF DIFFERENT FROM YOU_____ SS#:
_____-_____-_____

EMPLOYER: _____ OCCUPATION: _____
EMPLOYER ADDRESS:_____
EMPLOYER PHONE: _____-_____-_____INSURANCE COMPANY:_____
GROUP#:_____ ID#: _____ SUBSCR1BER#: _____

SECONDARY INSURANCE

PERSON RESPONSIBLE FOR BILL: SELF___ SPOUSE___ OTHER___ IF NOT YOU, GIVE US THE
NAME: _____ DOB:_____-_____-_____
ADDRESS IF DIFFERENT FROM YOU_____ SS#:
_____-_____-_____

EMPLOYER: _____ OCCUPATION: _____
EMPLOYER ADDRESS:_____
EMPLOYER PHONE: _____-_____-_____INSURANCE COMPANY:_____
GROUP#:_____ ID#: _____ SUBSCR1BER#: _____

EMPLOYER: _____ OCCUPATION: _____
EMPLOYER ADDRESS: _____
EMPLOYER PHONE: _____/_____/_____X _____

PRIMARY CARE DOCTOR: _____ PHONE #: _____/_____/_____

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CORRESPONDENCE LIST

Date: / /

Please list individuals and Professionals to whom you would like your medical information released. If you wish your ***PHI** restricted to yourself and your insurance company per your contract, write "None" in the first empty box below. PARRIS & ASSOCIATES does not release PHI to mailing lists or registries other than those mandated by State and Federal regulation as covered entities without your expressed permission.
(***Be aware***: For parties other than Health Care Providers and appropriate Insurance companies, reproduction fees may apply). **(*Protected Health Information)**

Name, relationship/company	Address	Phone/Fax numbers

Signature

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RECORDS RELEASE FORM

I, _____ hereby request that you release my medical records, including all clinical information and other data related to my medical treatment while under the care of Dr. Glenn R. Parris @ Parris and Associates.

What are you requesting?

Please check one: ☐ Clinical Information ☐ Lab ☐ Radiology Reports ☐ Full Medical File

What time Frame?

Please check one: ☐ Past Year ☐ Past 5 years ☐ Specific Date: _____

The information may be faxed to (770) 962-7977

Patient's Signature: _____ Today's Date: _____

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

Patient's Address: _____

_____

***** In compliance with HIPPA Regulations, these medical records release forms are to be used only for patient's care.**

(Fill out if you want records to go somewhere)

SEND RECORDS TO: _____

_____

_____

(Fill out if you want records to be sent to Dr. Parris)

RECEIVED FROM: _____

_____

_____

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Date/Time of Appointment:

Patient Name: DOB: Referring Physician:

Reason for Rheumatology Evaluation: _____

_____

_____

Surgical History: _____

Do you have any records for review; Labs, X-rays, office notes or other reports?_____

Is your visit today workers compensation or personal injury related? Yes No

Is there any family history of Arthritis, Rheumatism or autoimmune disease?(Please specify)_____

_____

REVIEW OF SYSTEMS (Please circle symptoms you have suffered recently or often)

Constitutional: Fever; night sweats; insomnia; chronic fatigue; illness; wasting of muscle /weight gain

EYES: Pain; light sensitivity; dry eyes; red eyes; eye drainage; foreign body sensation; change of vision; swelling of the eyes or eyelids.

EARS: Ringing in the ears; dizziness; loss of balance; ear pain or drainage;

NOSE: Nasal lesions; Nose bleeds; frontal headaches; nasal discharge; sinus congestion; loss of sense of smell.

MOUTH: Dry mouth; mouth ulcers; bleeding gums; alteration of sense of taste.

THROAT: Sore throat; hoarseness; difficulty swallowing.

CARDIOVASCULAR: Chest pain; chest pressure; chest tenderness; skipped heart beats; high BP; shortness of breath; swelling of the feet or legs; abnormal heart exam or diagnostic test.

RESPIRATORY: Wheezing; coughing; shortness of breath; pain on respiration; heavy snoring; rib pain.

GASTROINTESTINAL: Nausea; vomiting; diarrhea; abdominal pain; bloody or black stool; dyspepsia; reflux symptoms.

URINARY: Urinary frequency; burning on urination; kidney stones; inability to empty your bladder; involuntary leaking of urine; bloody urine.

GENITOREPRODUCTIVE: (Please document gender appropriate history)

Female: Pregnancy; Miscarriage; vaginal dryness; sexually transmitted disease/lesions.

Male: prostate problems**,** testicular problems, swollen groin glands, sexually transmitted disease/lesions.

MUSCULOSKELETAL: Joint pain; joint swelling; morning stiffness; stiffness at night; gelling; muscle aches; neck pain; back pain; restricted joint motion; dislocations; weakness. Any neck, back, bone or joint fracture or injuries? _____ If so any surgery?_____

BREASTS: Masses; skin changes; surgery; nipple discharge; abnormal diagnostic test.

SKIN: Rashes; Raynaud's phenomena; nail changes; patchy hair loss; stiff, thickening of skin; skin nodules; psoriasis; hives; red or purple rash or outbreak, precancerous lesions.

NEUROLOGIC: Headaches; weakness; numbness or tingling; tremor; head injury; change in behavior; change in memory; seizure activity, stroke.

PSYCHIATRIC: Depression; anxiety or panic attacks; illicit drug or alcohol use; psychiatric hospitalization.

ENDOCRINE: Thyroid changes; diabetic changes; osteoporosis; cushingoid (Steroid) changes.

HEMATOLOGIC: Anemia; swollen lymph glands; bruising or bleeding; recent diagnosis cancer.

ALLERGIES: _____

General Family Medical History:

_____

SOCIAL HISTORY: Where were you born? _____ Occupation:_____

Do you have any children? Yes No Daughters: Sons: Living Situation:

Exercise habits: _____ Dietary Pattern:_____Education:_____ Disabled? Yes No When?

Alcohol consumption:____ (if so how much?) Tobacco use: ___ ___ (#of packs per day and #of years.)

Illicit drug use: _____ Pain management:_____ Psychiatric Care:_____

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MEDICATION LIST

DATE: _____

Please list your medications including over the counter (OTC) medications and Prescription medications.
Eg: Aspirin, Tylenol (OTC) or Celebrex, Codeine, Prednisone (Prescription)

Medication	Dose	Used for what condition?	How do you take each medicine?	Prescriber/OTC	Started/Stopped

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Original Date:	05/27/2008
Dates Revised:	12/06/2012
	OFFICE: 770-962-1616
	FAX: 770-962-7977

IN YOUR OWN WORDS

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**

WHAT IS YOUR MAIN CONCERN OR SYMPTOM FOR THIS VISIT? *"THE SYMPTOM"* may be a group of related problems! FEEL FREE TO USE "YOUR OWN WORDS" TO EXPRESS YOURSELF!!!

LOCATION:	☐ HEAD ☐ EYES/EARS/NOSE/THROAT ☐ CHEST ☐ ABDOMEN/PELVIS ☐ NECK/BACK ☐ HANDS ☐ ARMS ☐ LEGS ☐ FEET ☐ SKIN/HAIR/NAILS ☐ *CHANGE IN OVERALL SENSE OF WELL BEING(if above don't apply)*

HOW LONG HAS THIS SYMPTOM/PROBLEM BEEN WORRISOME TO YOU/FAMILY OR TO YOUR DOCTORS?

Describe in:	☐ minutes ☐ hours ☐ days ☐ weeks ☐ months ☐ years ☐ decades ☐***Recurring Episodes***

WHAT DOES THE SYMPTOM FEEL LIKE?

SEVERITY(How bad does you symptom get?):

DESCRIBE HOW YOUR SYMPTOM COMES ON AND CHANGES WHEN IT OCCURS?

WHAT RELIEVES THE SYMPTOM?

WHAT ELSE IS GOING ON WHEN SYMPTOM OCCURS? (Do you think they're connected somehow?):

HAS THERE EVER BEEN A MEDICAL INVESTIGATION (TESTS) OF THESE SYMPTOMS BEFORE?

ARE YOU DIABETIC? □ **yes** □ **no**

DO YOU HAVE NUMBNESS AND TINGLING IN YOUR ARMS OR LEGS? □ **yes** □ **no**

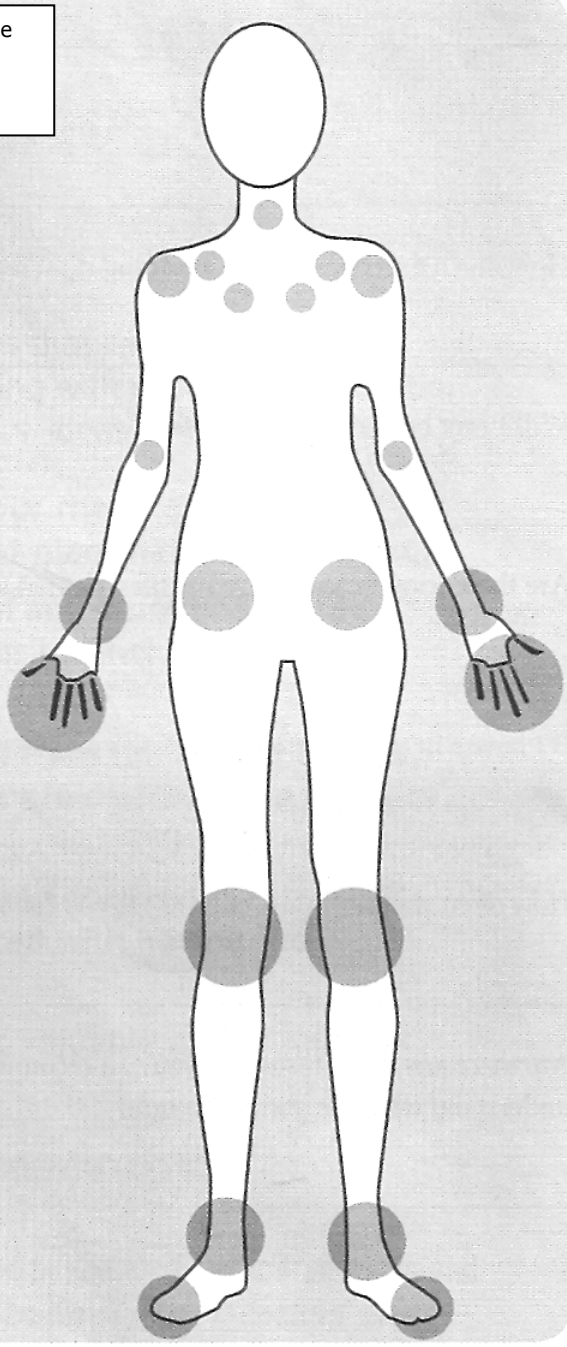
DO YOU HAVE SHOOTING PAIN IN YOUR ARMS OR LEGS? □ **yes** □ **no**

[You]& your doctor

Where Does it Hurt?

Draw "+" for Front and "X" for Back

Use this diagram when you talk with your doctor about the different areas in your body that can be affected by your illness (Frequently affected joints and muscle areas are marked by gray circles)



Notes: