

Arthritis & Rheumatology of Metairie, 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

Arthritis & Rheumatology of Metairie, APMC
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PATIENT INFORMATION FORM

LAST NAME: _____
FIRST NAME: _____
ADDRESS: _____
CITY: _____
STATE: _____ ZIP CODE: _____
GENDER: _____ Date of Birth: _____

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

PRIMARY INSURANCE CARRIER: _____

HOME PHONE () _____
CELL PHONE: () _____
EMAIL: _____

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

PREFERRED CONTACT METHOD: (circle one)
HOME CELL EMAIL WORK

SECONDARY INSURANCE CARRIER: _____

EMERGENCY CONTACT
NAME: _____
RELATIONSHIP _____
PHONE: () _____

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

MARITAL STATUS: (circle one)
MARRIED SINGLE
EMPLOYED: YES NO
EMPLOYMENT STATUS: _____
EMPLOYER: _____

PREFERRED PHARMACY: _____
PHARMACY #: () _____

WORK PHONE: () _____

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 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 & Rheumatology of Metairie, 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:

For new patients:

- 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

For established patients:

- 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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Please check any of the following items which have significantly affected you over THE LAST WEEK:

Name: _____

Today's Date: _____

Date of Birth: _____

- | | | |
|--|--|---|
| Constitutional:
<input type="checkbox"/> Chills/Rigors
<input type="checkbox"/> Fatigue
<input type="checkbox"/> Fever
<input type="checkbox"/> Night sweats
<input type="checkbox"/> Weight changes, if so gain or loss? How much? Time frame? _____ | <input type="checkbox"/> Raynaud's
Gastrointestinal:
<input type="checkbox"/> Abdominal cramping
<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Bloating
<input type="checkbox"/> Bright red blood in stool
<input type="checkbox"/> Constipation
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Heartburn
<input type="checkbox"/> Loss of appetite
<input type="checkbox"/> Nausea
<input type="checkbox"/> Vomiting | Psychiatric:
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Depression
<input type="checkbox"/> Emotionally labile
<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Insomnia
<input type="checkbox"/> Suicidal thoughts |
| Head/Eyes/Ears/Nose/Throat:
<input type="checkbox"/> Visual loss
<input type="checkbox"/> Blurry vision
<input type="checkbox"/> Double vision
<input type="checkbox"/> Dry mouth
<input type="checkbox"/> Dry eyes
<input type="checkbox"/> Problems swallowing
<input type="checkbox"/> Frequent nose bleeds
<input type="checkbox"/> Eye Pain
<input type="checkbox"/> Facial pain
<input type="checkbox"/> Hearing loss
<input type="checkbox"/> Hoarse voice
<input type="checkbox"/> Nasal drainage
<input type="checkbox"/> Sores in mouth
<input type="checkbox"/> Eye Redness
<input type="checkbox"/> Frequent sinusitis
<input type="checkbox"/> Sore throat
<input type="checkbox"/> Ringing | Genitourinary:
<input type="checkbox"/> Pain on urination
<input type="checkbox"/> Genital lesions/ulcers
<input type="checkbox"/> Bloody urine
<input type="checkbox"/> Frequent urination at night
<input type="checkbox"/> Pain in sex organs
<input type="checkbox"/> Increased urination
<input type="checkbox"/> Urinary incontinence | Immunology:
<input type="checkbox"/> Seasonal allergies
<input type="checkbox"/> Frequent infections |
| Respiratory:
<input type="checkbox"/> Cough
<input type="checkbox"/> Coughing up blood
<input type="checkbox"/> Breathing problems when lying flat
<input type="checkbox"/> Pain with breathing
<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Wheezing | Metabolic/endocrine:
<input type="checkbox"/> Cold intolerance
<input type="checkbox"/> New hair loss
<input type="checkbox"/> Heat intolerance
<input type="checkbox"/> Increased facial hair
<input type="checkbox"/> Hot flashes
<input type="checkbox"/> Excessive thirst | Dermatologic:
<input type="checkbox"/> Acne
<input type="checkbox"/> Hives
<input type="checkbox"/> Itchy skin
<input type="checkbox"/> Nail changes
<input type="checkbox"/> Sunlight sensitivity
<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Rash |
| Cardiovascular:
<input type="checkbox"/> Chest pain
<input type="checkbox"/> Pain in calves with walking
<input type="checkbox"/> Leg/feet swelling
<input type="checkbox"/> Irregular heart beat | Neurological:
<input type="checkbox"/> Confusion/disorientation
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Numbness in hands/feet
<input type="checkbox"/> Weakness of hands/feet
<input type="checkbox"/> New gait disturbance
<input type="checkbox"/> Headache
<input type="checkbox"/> Memory loss
<input type="checkbox"/> Seizures
<input type="checkbox"/> Fainting
<input type="checkbox"/> Tingling of hands/feet
<input type="checkbox"/> Tremors | Musculoskeletal:
<input type="checkbox"/> Back pain
<input type="checkbox"/> Joint pain
<input type="checkbox"/> Joint swelling
<input type="checkbox"/> Muscle cramping
<input type="checkbox"/> Muscle weakness
<input type="checkbox"/> Muscle pain
<input type="checkbox"/> Neck pain |
| | | Hematological:
<input type="checkbox"/> Easy bleeding
<input type="checkbox"/> Easy bruising
<input type="checkbox"/> Enlarged lymph nodes
<input type="checkbox"/> Hx of blood clots?
Any other symptoms not addressed? Explain.

_____ |

Arthritis and Rheumatology of Metairie | Notice of Privacy Practices

4315 Houma Blvd., Suite 303 | 504-889-5242

Last Updated: 02/09/2026

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.

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.

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.
- If we intend to use or disclose your substance use disorder records (subject to 42 CFR Part 2) for fundraising purposes, you have the right to elect not to receive such communications before we send them.

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

STATE LAW AND SENSITIVE INFORMATION

- In some cases, state laws or other federal laws provide greater privacy protections for specific types of "sensitive" health information than the general HIPAA rules. This may include information related to reproductive health (including abortion and contraception), HIV/AIDS, mental health, or genetic testing. When these stricter laws apply, we will follow the law that provides you with the most protection before sharing that information with others.

SUBSTANCE USE DISORDER RECORDS (42 CFR PART 2)

- We may use and disclose your substance use disorder records subject to 42 CFR Part 2 for treatment, payment, and health care operations as permitted by law.
- **Prohibition on Use in Legal Proceedings:** We are prohibited from using or disclosing your substance use disorder records subject to 42 CFR Part 2 in any civil, criminal, administrative, or legislative proceedings against you without your specific written consent or a court order.

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/noticeapp.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.

FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS ARE VIOLATED

- You can complain if you feel we have violated your rights by contacting the Privacy Officer 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.