Arizona Arthritis Clinic,PLLC
Dr. Amer Al-Khoudari, MD, FACR

Practice Policy

Dear Patients,

Arizona Arthritis Clinic is dedicated to excellence in research, education and most importantly, patient care. In our continuing efforts to provide the highest quality of care to all our patients we ask that you read the Arizona Arthritis Clinic as outlined below.

1. Please give us at least 24-hour notice if you are unable to come to your appointment. A 48-hour notice would allow us to fill the vacant time slot with another patient who urgently needs to be seen by one of our physicians. Repeated failure to give us a 24-hour notice may result in our inability to provide you with future appointments.

2. We ask that you arrive 30 minutes before your appointment time. For example, if your doctor's appointment is at 10:00 AM you should arrive at 9:30 AM. Arriving 20 minutes early would give you enough time to register at the front desk, complete health-related questionnaires and have your vital signs (e.g., blood pressure) taken.

3. We recommend that you register with our electronic medical record (EMR) system 14673.portal.athenahealth.com to access your test results online. On the day of your first visit, you will be asked for your email address so that we can send you an invitation to our patient portal.

4. If you are not registered with our EMR system we may leave test results that are within normal limits on your answering machine. Please let us know if you prefer an alternative method of notifying you of your test results that are within normal limits

5. You will be informed (via regular mail or phone call) of your laboratory test result after 5 business days, on the average.

6. Due to the large amount of requests for medication refills we ask that you give us 48 hours to address your refill request.

7. Given that most of the medications we prescribe have potentially serious side effects (although infrequent) we ask that you comply with our doctor's recommendation in getting your blood tests regularly to identify any medication-related toxicity.

8. To avoid interruption in getting your medications that require pre-authorization please provide us with your insurance information every time you change your insurance carrier.

9. After your initial visit, if we determine that you have fibromyalgia, we will provide your primary care provider treatment recommendations.

10. Only in very rare situations do our physicians prescribe strong pain medication (e.g., hydrocodone, oxycodone, etc.). For your own safety we ask that you get your pain medication from only one health care provider - your primary care provider.

Patient Signature: _____

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AUTHORIZAION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name: _____ DOB: _____ Phone #: _____

MAIL OR FAX THE RECORDS TO THE ADDRESS/NUMBER ABOVE TO THE ATTENTION OF: ARIELLE

Requesting Records From: _____

PLEASE RELEASE MEDICAL RECORDS PERTAINING TO THE FOLLOWING DIAGNOSIS INCLUDING BUT NOT LIMITED TO ANY TESTING, SURGERIS, TREATMENTS OR THERAPIES.

DIAGNOSIS:

_____

Reason for requesting records: Continued Care Consult

By signing this, I authorize the release of the above requested records and anything pertinent the physician feels will be beneficial in the pursuance of my overall healthcare including but not limited to any disclosure that may contain confidential HIV/AIDS related information, confidential communicable disease related information, confidential information related to mental health, drug and alcohol use, sexual history and that the records will be forwarded to the address/fax number on the letterhead.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already taken place. I hereby give my consent freely, voluntarily and without coercion or hesitation:

Patient signature: _____Date: _____

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HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit:

_____

FAVORITE PHARMACY: (please list phone number of pharmacy)**:**

_____

MEDICATION ALLERGIES:

List all medications you are allergic to and what kind of reaction you have.

1._____

2._____

3._____

MEDICATIONS:

Please list all prescription medications you are taking. Please include the dose and how often you take it.

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

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PAST MEDICAL HISTORY:

Please circle all that apply:

Anxiety Disorder
Arthritis
Asthma
Bleeding Disorder
Blood Clots (or DVT)
Cancer
Coronary Artery Disease
Claustrophobic
Diabetes - Insulin
Diabetes - Non-Insulin
Dialysis
Diverticulitis
Fibromyalgia
Gout
Has Pacemaker
Heart Attack
Heart Murmur
Hiatal Hernia or Reflux Disease
HIV or AIDS
High Cholesterol
High Blood Pressure
Overactive Thyroid
Kidney Disease
Kidney Stones
Leg/Foot Ulcers
Liver Disease
Osteoporosis
Polio
Pulmonary Embolism
Reflux or Ulcers
Stroke
Tuberculosis
Other: _____

PAST SURGICAL HISTORY:

1._____
2._____
3._____
4._____

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FAMILY HEALTH HISTORY:

Please list family members by maternal and paternal relation.

Rheumatoid Arthritis: _____

Psoriasis: _____

Psoriatic Arthritis: _____

Ankylosing Spondylitis: _____

Polymyalgia Rheumatica: _____

Vasculitis: _____

Osteoarthritis: _____

Osteoporosis: _____

SOCIAL HISTORY:

Smoking:----------Current smoker (# cigarettes/day)----------, ----------Previous smoker

ETOH:

Please add any other information about your health that you would like your provider to know here:

Patient Signature: _____ Date: _____