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# Patient Information

**PATIENT INFORMATION** (THE PERSON SEEING THE PHYSICIAN):

DATE_____ PRIMARY CARE PHYSICIAN (PCP)_____ REFERRING PHYSICIAN_____

NAME _____
FIRST M.I. LAST SUFFIX (Jr/Sr/II etc)

MAILING ADDRESS _____ CITY _____ STATE____ZIP____COUNTY____

PHYSICAL ADDRESS _____ CITY _____ STATE____ZIP____COUNTY____

HOME PHONE (___) _____ CELL PHONE (___) _____ SSN _____ DATE OF BIRTH _____

EMAIL ADDRESS _____

☐ MALE ☐ FEMALE **MARITAL STATUS** ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ OTHER

**RACE** ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ WHITE/CAUCASIAN ☐ OTHER

**ETHNICITY** ☐ HISPANIC/LATINO ☐ NOT HISPANIC/NOT LATINO ☐ OTHER **LANGUAGE** ☐ ENGLISH ☐ SPANISH ☐ OTHER

EMPLOYER _____ ☐ Full time ☐ Part time WORK PHONE (___) _____

EMPLOYER ADDRESS _____ CITY_____STATE_____ZIP____

PHARMACY_____ PHARMACY PHONE_____
CITY

**SPOUSE INFORMATION:**

NAME _____
FIRST M.I. LAST SUFFIX (Jr/Sr/II etc)

DATE OF BIRTH_____ SSN _____ CELL PHONE (___) _____

EMPLOYER _____ ☐ Full time ☐ Part time PHONE _____

ADDRESS _____

**EMERGENCY CONTACT (if other than spouse):**

NAME _____
FIRST M.I. LAST SUFFIX (Jr/Sr/II etc)

HOME PHONE (___) _____ CELL PHONE (___) _____ RELATIONSHIP TO PATIENT _____

**PRIMARY INSURED** (THE PERSON WHO CARRIES THE INSURANCE):

SUBSCRIBER_____
FIRST M.I. LAST

**INSURANCE INFORMATION**

**PRIMARY INSURANCE** (MUST HAVE COPY OF CARD):

INSURANCE NAME_____

GROUP# _____ POLICY/ ID# _____

EFFECTIVE DATE OF INSURANCE: _____

**DOES PRIMARY INSURANCE REQUIRE A REFERRAL? Y / N**

**SECONDARY INSURED**

SUBSCRIBER_____
FIRST M.I. LAST

**INSURANCE INFORMATION**

**SECONDARY INSURANCE** (MUST HAVE COPY OF CARD):

INSURANCE NAME_____

GROUP# _____ POLICY/ ID# _____

EFFECTIVE DATE OF INSURANCE: _____

**DOES SECONDARY INSURANCE REQUIRE A REFERRAL? Y / N**

Signature:_____ Date:_____

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# Authorizations & Consents

Leslie McCasland, M.D. Beata Filip-Majewski, M.D.

**ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE**

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____

Patient Signature

_____

Date

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# Authorizations & Consents

Date:_____ DOB:_____ MRN_____
*For Internal Use Only*

Patient Name: _____
First Middle Last

## Communications Regarding My Account

*Initial Here* _____ I agree that Arthritis & Rheumatism Associates or any other collection or servicing agency retained by Arthritis & Rheumatism Associates (together referred to hereafter as "collectors") to collect any money that I owe to the clinic, may contact me by telephone or text message at any number given by me or that is or becomes associated with me or my account from sources other than me, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the clinic or is otherwise associated with my account.

*Initial Here* _____ It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Arthritis & Rheumatism Associates there is a reasonable chance that a third party may be able to intercept those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

I consent to allow Arthritis & Rheumatism Associates to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Appointment Reminders
- Health Related Information
- Marketing Offers

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that message & data rates may apply. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

## General Consent to Treatment and Test

*Initial Here* _____ I am voluntarily seeking medical treatment. I consent to examination by the physician, nurse practitioner, nurse and other health care professionals at this clinic. I also consent to any medical procedures, x-ray, laboratory tests or other health care services ordered by the health care team. I understand that I may refuse specific treatments or procedures by informing the health care team.

_____ Date:_____
SIGNATURE OF PATIENT/PARENT/GUARDIAN/PERSON AUTHORIZED TO SIGN FOR PATIENT

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# Hipaa Privacy Notice Acknowledgement

Patient Name: _____
First Middle Last

Date of Birth ____/____/____ Social Security Number _____ MRN _____
*For Internal Use Only*

The signature below acknowledges a copy of this Notice was RECEIVED (not necessarily read).

_____ _____
Date Patient/Legal Representative Signature

_____
State Capacity, if Legal Representative

## AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

With whom may we share information about your health? Please list below.

**Note: In order for ARA to disclose your Private Health Information, the representative listed must be able to provide (2) two of the (3) three identifiers listed below:**

**1. Last 4 digits patient's social security number** **2. Patient's date of birth** **3. Patient's zip code**

| Name | Relationship to You | Telephone Number | May Discuss Diagnosis/Treatment | May Discuss Billing Info |
|---|---|---|---|---|
| _____ | _____ | _____ | ☐ Yes ☐ No | ☐ Yes ☐ No |
| _____ | _____ | _____ | ☐ Yes ☐ No | ☐ Yes ☐ No |
| _____ | _____ | _____ | ☐ Yes ☐ No | ☐ Yes ☐ No |
| _____ | _____ | _____ | ☐ Yes ☐ No | ☐ Yes ☐ No |

Do you have a legal document that states who will make decisions if you are unable? ☐ Yes ☐ No

If yes, Name_____ Relationship to Patient_____

Check one: ☐ Healthcare Proxy/Agent ☐ General Power of Attorney ☐ Healthcare Power of Attorney

I understand that it is my responsibility to update this list in order to keep accurate those authorized persons to discuss and use the patient's healthcare information.

Patient/Legal Representative Signature:_____ Date: _____

If legal representative, explain the capacity: _____

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**For internal use only**

**Lack of Patient Acknowledgement:**

| Date | Reason | Staff Signature |
|---|---|---|

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# ARMD-MDHAQ

Date:_____ DOB:_____ MRN:_____
*For Internal Use Only*

Patient Name: _____
First Middle Last

SEX: ☐ Female ☐ Male

ETHNIC: ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Other _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Other _____

YOUR DIAGNOSIS/CONDITION: _____

**1. Please check ( ) the ONE best answer for your abilities at this time:**

| **OVER THE LAST WEEK,** were you able to: | With **NO** Difficulty | With **SOME** Difficulty | With **MUCH** Difficulty | **UNABLE** to Do |
|---|---|---|---|---|
| a. Dress yourself, including tying shoelaces and doing buttons? | (0) _____ | (1) _____ | (2)_____ | (3)_____ |
| b. Get in and out of bed? | (0) _____ | (1) _____ | (2)_____ | (3)_____ |
| c. Lift a full cup or glass to your mouth? | (0) _____ | (1) _____ | (2)_____ | (3)_____ |
| d. Walk outdoors on flat ground? | (0) _____ | (1) _____ | (2)_____ | (3)_____ |
| e. Wash and dry your entire body? | (0) _____ | (1) _____ | (2)_____ | (3)_____ |
| f. Bend down to pick up clothing from the floor? | (0) _____ | (1) _____ | (2)_____ | (3)_____ |
| g. Turn regular faucets on and off? | (0) _____ | (1) _____ | (2)_____ | (3)_____ |
| h. Get in and out of a car, bus, train, or airplane? | (0) _____ | (1) _____ | (2)_____ | (3)_____ |
| i. Walk two miles? | (0) _____ | (1) _____ | (2)_____ | (3)_____ |
| j. Participate in recreational activities and sports as you would like, if you wish? | (0) _____ | (1) _____ | (2)_____ | (3)_____ |
| k. Get a good night sleep? | (0) _____ | (1) _____ | (2)_____ | (3)_____ |
| l. Deal with feelings of anxiety or being nervous? | (0) _____ | (1) _____ | (2)_____ | (3)_____ |
| m. Deal with feelings of depression or feeling blue? | (0) _____ | (1) _____ | (2)_____ | (3)_____ |

**2. How much pain have you had because of your condition OVER THE LAST WEEK?**
**Please indicate below how severe your pain has been:**

NO PAIN 0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10 PAIN AS BAD AS COULD BE

**3. When you awoke in the morning OVER THE LAST WEEK, did you feel stiff?** ☐ Yes ☐ No

If "Yes," please indicate the number of minutes _____, or hours _____ it lasted.

ATTENTION INFUSION PATIENTS

IT IS **VERY IMPORTANT** TO NOTIFY THE FRONT OFFICE IF YOUR INSURANCE HAS CHANGED

PLEASE NOTE
OUR OFFICE HOURS ARE **MONDAY-THURSDAY**
PHYSICIANS & NURSES WILL NOT BE HERE ON FRIDAYS

**PATIENTS WITH RHEUMATOID ARTHRITIS PLEASE FILL OUT BACK OF SHEET**

## DISEASE ACTIVITY SCORE FOR RHEUMATOID ARTHRITIS: DAS 28

Date of assessment:_____ MRN_____
*For Internal Use Only*

Patient Name: _____
First Middle Last

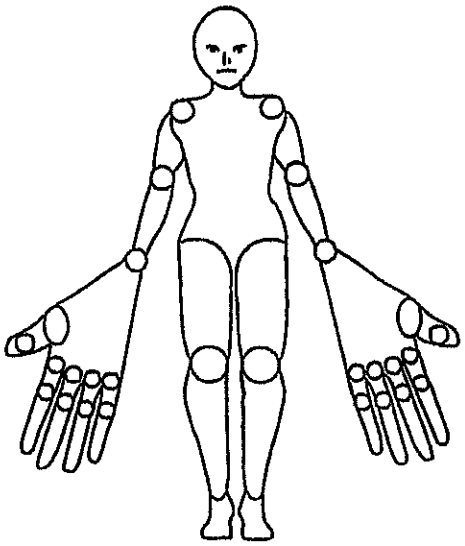
ESR taken? Y or N

Patient assessment: To be **completed by patient by placing a vertical mark through the line**

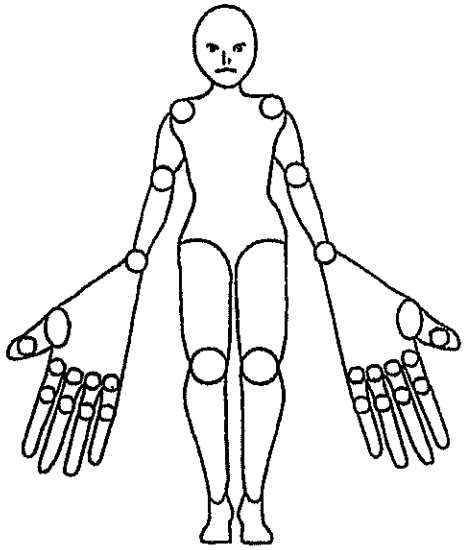
On this line, where would you rate the affect your arthritis has on you today?

0 None _____ 10 Max

Shade Tender Joints



Shade Swollen Joints



Formula: DAS28(4) = $0.56*\sqrt{(t28)} + 0.28*\sqrt{(sw28)} + 0.70*Ln(ESR) + 0.014*GH$

http://www.das-score.nl/a/en/

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# Med List / History

Date:_____ DOB:_____ MRN:_____
*For Internal Use Only*

Patient Name: _____
First Middle Last

Current Medications:

| Drug Taken | Dosage | How many times per day? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Allergies: _____

_____

Past Medical History (check all that apply)

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Arthritis | | Heart Disease | | Liver Disease | | Rheumatic Fever | | Tuberculosis |
| | Cancer | | Hypertension | | Pneumonia | | Rheumatoid Arthritis | | |
| | Diabetes | | Jaundice | | Renal Disease | | Thyroid Disease | | |

Family Medical History (check under each family member diagnosed with listed disease)

| DIAGNOSIS | Maternal Grandparent | Paternal Grandparent | Mother | Father | Brother | Sister | Son | Daughter |
|---|---|---|---|---|---|---|---|---|
| Arthritis | | | | | | | | |
| Cancer | | | | | | | | |
| Diabetes | | | | | | | | |
| Heart Disease | | | | | | | | |
| Hypertension | | | | | | | | |
| Lupus | | | | | | | | |
| Tuberculosis | | | | | | | | |

Past Surgical History

| TYPE OF SURGERY | Approximate Date |
|---|---|
| | |
| | |
| | |
| | |

Social History (Please circle one)

| Marital Status: | Single | Married | Widowed | Divorced |
|---|---|---|---|---|
| Do you smoke? | NO YES | If yes, how many years? _____ | How many packs per day? _____ | |
| Other tobacco use? | NO YES | | | |
| Alcohol use? | NO YES | | | |
| Drug use? | NO YES | | | |