CARONDELET RHEUMATOLOGY

Patient Registration

Name: _____ Email: _____

Address: _____

Primary Phone: _____

Birthdate: _____ Gender: ___ Female ___ Male Marital Status: _____

Primary Language: _____ SS#: _____

Ethnicity: ____ Hispanic or Latino ____Non-Hispanic or Latino ____Unknown ____ Declined

Employer/School: _____ Employer/School Phone: _____

Address: _____

Occupation: _____ By Whom were you referred: _____

Other physicians involved in your care: _____

In Case of Emergency:

Name: _____ Relationship: _____

Phone: _____ Alternate Phone: _____

Health Insurance Information:

Primary Insurance Name: _____

ID #: _____ Group #: _____ Policy Owner Name: _____

Policy Owner DOB and Relationship to Patient: _____

Secondary Insurance Name: _____

ID #: _____ Group #: _____ Policy Owner Name: _____

Policy Owner DOB and Relationship to Patient: _____

I authorize Carondelet Rheumatology to release medical information necessary for insurance reimbursement. I authorize and assign payment directly to Carondelet Rheumatology for insurance benefits herein specified and otherwise payable to me. I understand that I am financially responsible to Carondelet Rheumatology for all charges incurred regardless of potential insurance benefits.

Signed: _____ Date: _____

PAYMENT POLICIES
SIGNATURE MEDICAL GROUP

We accept cash, check, debit, Visa, MasterCard and most health plans/insurance programs. You may consent to pay by automated payment card by signing a separate authorization.

If the patient is covered by insurance, the following apply:

1. **The patient/responsible party or guarantor signing below ("you") must provide us with the patient's current and correct medical coverage/insurance/health plan ("health plan") or other responsible third-party payor.**
2. **You must follow the rules of the health plan such as providing a valid referral form and precertification of testing and/or surgery when required by the health plan for payment. We will assist with this process, but if claims are denied because of your failure to comply with coverage/payment rules, you will be responsible for paying the denied claim(s).**
3. **You are responsible for paying any deductibles and co-payments in the amount specified by the health plan as well as non-covered services or other costs not covered by the health plan.**
4. **Co-payments, non-covered services and other point of service payments must be paid at the time of service including amounts due for a child regardless of who has the legal obligation, or payment obligation under parental custody, divorce or separation terms.**
5. **WORK RELATED INJURIES:**
    a. **If the patient's employer has approved treatment, you will not be charged or billed.**
    b. **If the patient's employer does not approve treatment and <u>YOU SELECT US FOR YOUR TREATMENT</u>, you may be billed and you may be responsible for payment of services not approved by the employer.**
6. **If the patient is involved in a claim or lawsuit that affects the payment of our services, we hold you responsible for payment of our regular fees.**
7. **We file group health plan claims and by law, must file Medicare claims.**
8. **If you think your bill contains an error or if you need more information about an item on your bill, contact us at the address or telephone number on your statement.**

We expect payment in full at time of service for all charges which are not covered by the patient's health plan. It is your responsibility to contact us in the event of a need for an alternative payment plan or to apply for a discount if you do not have insurance.

In the event of non-payment, you will be responsible for any legal and collections fees. Legal and collection fees will be added to the outstanding balance on the account should the account be referred to an outside agency for collection.

I have read and agree to the above terms and hereby assume full responsibility for paying any medical service charges and collection fees according to these terms.

Print Patient Name: _____/Date of Birth: _____

Print Guarantor Name & Relationship to Patient: _____

Signed: _____/Date: _____
Patient or Guarantor/Responsible Party, if other than Patient

(Witness to Signature, if applicable): _____

PATIENT REGISTRATION CONSENT & ACKNOWLEDGMENTS

CONSENT TO TREAT

I consent to Signature Medical Group (SMG) physicians, practitioners, and other providers ("Provider"), their assistants and staff to provide medical and/or surgical treatment, testing, supplies, medications, services, equipment and other items deemed necessary for the patient named below. I have been informed of the nature and purpose of the proposed treatment, common side effects, risks, benefits, alternatives and estimated duration of treatment as applicable. I understand that I may withdraw consent to treatment and will inform the attending Provider of any decision to terminate treatment. I agree to provide at least 24 hours notice prior to cancelling an appointment and understand that failure to provide notice may result in a cancellation fee. In the event of an emergency while receiving care at SMG, I authorize SMG staff to arrange for care and treatment necessary to address the emergency medical condition.

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

I acknowledge that the patient or guarantor signing below is financially responsible for all charges for medical services provided by SMG and payment is due on the date of service. If an insurance/health plan claim is filed by SMG, I request that payment of all benefits be made directly to SMG. I agree to pay for any services or out-of-pocket expenses which are not covered by insurance. I acknowledge receipt and acceptance of SMG's Payment Policies provided with this form. I acknowledge that I will be responsible for payment of legal and collection fees in addition to the outstanding balance should SMG refer my account to an outside agency for collection.

RELEASE OF INFORMATION/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I consent to SMG's release of the patient's protected health information (PHI) for treatment, payment and operations purposes in accordance with HIPAA. I acknowledge that SMG may release medical records and PHI to the third-party health plan or payer, including Medicare, Medicaid, health insurer, HMO, or other company or program that arranges or pays for the cost of some or all of the patient's health care. SMG may also release PHI to other health care providers involved in treating the patient including physicians, hospitals, laboratories, pharmacies and others. I have been provided with SMG's Notice of Privacy Practices that further describes the uses and disclosures of certain PHI by SMG. To facilitate treatment or payment, including communication of appointment reminders, prescriptions/refills, laboratory results and other information, I consent to SMG sharing PHI with the following individuals:

Name:_____ Relationship:_____ Phone Number:_____
Name:_____ Relationship:_____ Phone Number:_____
Name:_____ Relationship:_____ Phone Number:_____

Initial all applicable information:

_____Medical/Treatment/PHI including retrieval of medical records and prescription refills
_____Lab/Ancillary Testing/Radiology/MRI/Imaging Results
_____Billing/Insurance Information
_____Authorized to leave message on voice mail or by other designated communication systems
_____Other, Describe_____

ADVANCE DIRECTIVES FOR HEALTH CARE *(Living Will/Healthcare Directive, Durable Power of Attorney for Healthcare)*

(If applicable to the practice setting, patient to initial appropriate statement):

_____The patient does NOT have an Advance Directive

_____The patient has the following Advance Directive(s): _____
_____
and will provide a copy to the attending SMG physician practice

****

_____
Print Patient's Full Name *Patient Date of Birth*

_____ _____
Print Name of Guarantor/Legal Representative *Relationship to Patient*

_____ _____
Signature & Date Signed *Witness to Signature if applicable*

Patient Narcotic Agreement

CARONDELET
RHEUMATOLOGY

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This agreement is to help both you and your provider to comply with the law regarding controlled pharmaceuticals. Please initial each statement below acknowledging that you have read it and are in agreement.

_____ I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.

_____ I understand that this Agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this Agreement.

_____ In this case, my provider will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug dependence treatment program may be recommended.

_____ I would also be amenable to seek psychiatric treatment, psychotherapy and/or psychological treatment if my provider deems necessary.

_____ I will communicate fully with my provider about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

_____ I will not use any illegal controlled substances, including marijuana, cocaine, neither etc. nor will I misuse or self-prescribe/medicate with legal controlled substances. Use of alcohol will be limited to times when I am not driving or operating machinery and will be infrequent.

_____ I will not share my medication with anyone.

_____ I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider.

_____ I will safeguard my pain medication from loss, theft, or unintentional use by others, including youth. LOST OR STOLEN MEDICATION WILL NOT BE REPLACED.

_____ I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. NO REFILLS WILL BE AVAILABLE DURING EVENINGS OR ON THE WEEKENDS.

_____ I agree I will use my medicine at a rate no greater that the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time. DO NOT CALL THE OFFICE AND ASK FOR AN EARLY REFILL.

_____ I agree to follow these guidelines as they have been explained to me.

All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This agreement is entered into on this _____ day of _____, 201___.

Patient Signature: _____ Print Name: _____

Provider Signature: _____ Print Name: _____

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Medication List

Patient Name: _____ DOB: _____ Date: _____

Name of Medication:	Strength:	How Often:	Prescribed By:

Drug Allergies:	Supplements Taken:
1)	1)
2)	2)
3)	3)
4)	4)
5)	5)
6)	6)

CARONDELET
RHEUMATOLOGY

Medical History Form

Name: _____ Date of Birth: _____

Which physician referred you to Dr. Box?

Name: _____

Telephone: _____

Address: _____

_____

Primary Care Physician: (If different from above)

Name: _____

Telephone: _____

Fax: _____

Address: _____

_____

What is your main complaint for which you are seeing Dr. Box?

_____

_____

When did this problem first begin?

_____

_____

Medications: List what medications you have taken for this problem and rank their effectiveness with
0 = not effective at all, 1 = mildly effective, 3 = markedly effective. (e.g.: Ibuprofin, Tylenol, prednisone, etc.)

_____

_____

_____

_____

_____

_____

Circle any of the following problems you have had: swollen joints, gout, recurrent tendonitis, carpal tunnel syndrome, hands turning color in cold, rashes after short exposure to the sun, faction rashes in butterfly pattern, recurrent “pink eye” or iritis, sudden bald patches, recurrent crops of mouth ulcer or vaginal ulcers, seizures, recurrent pleurisy or pericarditis, recurrent protein in urine, low white blood cell count, low platelets, recurrent anemia, psoriasis (scaly, patchy rashes), bloody diarrhea, family history of rheumatoid, lupus, or other types of arthritis.

Past Medical History: (please list any other medical conditions you are being treated for):

_____

_____

_____

_____

Surgeries: List previous surgeries, reason for surgery and approximate date:

_____

_____

_____

_____

Allergies: List medication allergies and reaction (e.g. rash, swelling, etc.)

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Social History:

Marital Status: Married Single Divorced Widowed

Previous Marriages (number): _____

Children (number): _____ Daughters: _____ Sons: _____

Employment/Occupation: _____

History of Tobacco Use:

Average present packs per day: _____

If quit, how many years ago? _____

How many total years smoked and how many packs per day? _____

Alcohol Use: Average number of ounces/glasses of wine and/or beer per day or week: _____ per _____.

Family History: (especially any history of arthritis or autoimmune diseases):
Father: Living Deceased Cause of Death: _____
Other significant Illnesses: _____

_____

Mother: Living Deceased Cause of Death: _____
Other significant Illnesses: _____

_____

Brothers/Sisters: Number Living: _____ Number Deceased: _____
Causes of Death: _____

_____

Other Significant Family Illnesses: (i.e. cancer, stroke, heart attack, diabetes, autoimmune diseases, etc. and which family member has the illness:

_____ _____

_____ _____

_____ _____

_____ _____

Review of Previous Illnesses or Conditions
Head, Ears, Nose and Throat: (Circle) Severe Headaches, changes in vision over the past year, change in hearing over the past year, difficulty swallowing, hoarseness, nasal allergies, recurrent sinus infections, list others:

Neck: Goiter, recent lumps, other: _____

Lungs: Asthma or wheezing on exercise or at other times, recurrent bronchitis or pneumonia, shortness of breath on exertion, shortness of breath when lying down, having to sit up in bed at night to catch breath, coughing up sputum each morning, coughing up blood, other (list):

_____

_____

Heart: Hypertension, high cholesterol, chest pain on exertion, cardiac palpitations or abnormal rhythm, poor circulation to feet, previous heart catheterization or angioplasty or stent or bypass surgery, surgery for aneurysm or poor circulation to legs, other (list): _____

_____

Gastroentestinal: Prior ulcers; reflux or acid coming up into esophagus or throat with bending over, a big meal or at night; heartburn, recurrent or persistent diarrhea, chronic constipation, vomiting blood, bloody stools, black stools, diverticulitis, recurrent unexplained abdominal pain, hepatitis, liver disease, persistent undigested food in stool, pancreatitis, splenectomy, other gastrointestinal problems, other (list):

_____

_____

_____

Kidney: Recurrent bladder or kidney infections, kidney stones, frequency of urination, frequent nighttime urination, burning on urination, urgency, loss of urine with cough or sneeze, blood in urine, polycystic kidneys, kidney failure, protein in urine consistently, other (list):

_____

_____

_____

Neurological: Previous stroke, neuropathy, Bell's palsy, multiple sclerosis, insomnia, persistent or recurrent numbness of extremities, paralysis or significant weakness, un-coordination, recurrent vertigo (room spinning or feeling you got off of a merry-go-round), other (list):

_____

_____

_____

Endocrine: Diabetes, thyroid disease, parathyroid disease, Cushing's, other (list):

_____

_____

_____

Weight at age 18: _____ Highest Weight: _____

Hematology/Oncology: Anemia, leukemia, cancer, other (list):

_____

_____

_____

Female: Uterine or vaginal bleeding, current vaginal discharge, fibroids, endometriosis, pelvic infections, other (list): _____

_____

_____

Last Menstrual Period: _____

Number of Pregnancies: _____ Normal Deliveries: _____

Miscarriages or Abortions: _____

Male: Recurrent prostate infection, prostate cancer, elevated PSA, difficulty starting or stopping stream, inability emptying bladder, discharge, other, (list): _____

_____

_____

Arthritis/Rheumatism: History of swollen, red, warm joints, painful joints, hands/feet turning color in cold or with stress, rashes on short sun exposure, recurrent rash in butterfly pattern over cheeks, scaly/patchy rashes or psoriasis, recurrent conjunctivitis or pink eye or iritis, recurrent mouth/nasal/vaginal ulcerations, patchy bald spots, seizures/convulsions, recurrent pleurisy or pericarditis (inflammation around sack of heart or lung), protein in urine or pus in urine with negative culture, hemolytic anemia (red cells breaking up or being destroyed), low platelet count, low white blood cell count, blood diarrhea, or Chrohn's or ulcerative colitis, other (list): _____

_____

_____

Other Medical Conditions:

_____

_____

_____

_____

I have reviewed this information with the patient:

_____ _____

Physician's Signature Date