CHECK LIST

Please remember to:

- Complete all forms and bring them with you
- Contact your primary care provider to confirm approval of your referral – if approval is required by your insurance company
- Please confirm your referring physician has forwarded **or** bring all laboratory reports, x-rays (original films, if possible) and reports, physician office visit notes and medication in their original containers with you
- Arrive 10 minutes prior to your scheduled visit
- All co-payments and outstanding balances will be collected at check-in as well as payment in full for our self-pay patients. Please bring cash, check, VISA or MasterCard as payment.

Date___/___/___

Community
Rheumatology
OF ANDERSON

PATIENT INFORMATION

(PLEASE PRINT)

Last Name_____First Name_____Middle Initial_____

Address_____Phone_____

City_____State____Zip_____Cell Phone_____

Birth Date_____Sex_____ Marital Status S M W D

Social Security#_____Name of physician:_____

EMPLOYMENT

Patient Employed By_____

Address_____May we contact you at work? Y N

City/State_____Zip_____Phone_____Ext._____

PERSON FINANCIALLY RESPONSIBLE FOR THE ACCOUNT

Last Name_____First Name_____Middle Initial_____

Address_____

City_____State_____Zip_____Phone_____

Relationship to Patient_____

IN CASE OF EMERGENCY WHO SHOULD WE NOTIFY

Name_____Relationship to Patient_____

Home #_____Cell phone#_____

NAME OF REFERRING PHYSICIAN_____Phone_____

PHARMACY_____Phone_____

PRIMARY INSURANCE INFORMATION

Name of Insurance_____Subscriber Name:_____

Member #_____Group #_____Subscriber's SSN_____

Relationship to Patient_____Subscriber's DOB_____

SECONDARY INSURANCE

Name of Insurance_____Subscriber Name:_____

Member #_____Group #_____Subscriber's SSN_____

Relationship to Patient_____Subscriber's DOB_____

Release of Protected Health Care Information via Telephone to Answering Machine or Voicemail:

I give consent and authorization for the medical or billing staff of my physician's office to leave Protected Health Care Information about me or for me on my answering machine or voice mail at the number I have listed below. I understand I may revoke this privilege at any time by submitting my request in writing to this office.

Phone_____ Patient Initials_____

Who may we leave test results with if the patient cannot be reached?

Name_____Relationship_____Phone_____

Patient Name:_____Date___/___/_____

CONSENT TO RELEASE OF INFORMATION: I hereby authorize release of any medical information necessary regarding my examination and treatment to any insurance company involved in payment for my care. I authorize the insurance carrier to make payments, otherwise payable to me, directly to the provider. A photocopy of my signature on file can be used in place of the original. In addition, I hereby designate the physician and his agents or employees to appeal claims on my behalf in accordance with the Indiana Code, Title 27, Chapter 8 and 13.

Patient Initials_____

ONLY if you are a Medicare and/or Medigap patient, please complete the following:

Yes	No	1)	Have you recently joined a Medicare HMO or Advantage plan? If yes, which one?_____
Yes	No	2)	Do you or your spouse work in a company which has more than 20 employees and have insurance coverage through that job?
Yes	No	3)	Are you covered by an HMO/PPO which makes Medicare secondary?
Yes	No	4)	Is this illness covered by the Veterans' Administration?
Yes	No	5)	Is this illness covered by the Federal Black Lung or End Stage Renal Disease program?
Yes	No	6)	Is this illness due to an automobile accident?
Yes	No	7)	Is this illness due to an injury at work?
Yes	No	8)	Are you receiving Medicaid benefits?

This office is required to keep your signature on file authorizing us to file Medicare for you and to release information to that payer if they require it for proper consideration of a claim. Please read and sign the following statement:

MEDICARE/MEDIGAP AUTHORIZATION: I request that payment of authorized Medigap and/or Medicare benefits be made either to me or on my behalf to **Community Rheumatology of Anderson** for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to _____(name of Medigap insurer) and/or the Center for Medicare and Medicaid Services any information needed to determine these benefits or the benefits payable for related services.

Patient Initials_____

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY PRACTICES:
This is to acknowledge my receipt of this facility's Notice of Privacy Practices. Patient Initials_____

GENERAL CONSENT FOR TREATMENT
I, the patient, or his or her representative, recognizing the need for medical care, authorize the physicians to render such routine non-invasive medical/surgical care, tests, procedures, drugs and other services and supplies under the general and specific instruction of the physician. This form is to provide authorization for "routine" services only and not for complex diagnostic or therapeutic procedures. Except for emergency or extraordinary circumstances, it is my understanding that additional consents will be obtained by the treating physician if more invasive services are to be performed. I understand and am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guarantee has been made to me as to the result of treatment or examination. I understand that it is my right to consent, or to refuse consent, to any proposed procedure or therapeutic course. Patient Initials_____

CONSENT FOR MEDICAL TREATMENT OF A MINOR (if applicable)
I (we) the undersigned parent, parents, or legal guardian of _____, a minor, do hereby authorize and consent to any medical exam or treatment rendered under the general or special supervision a duly licensed physician, licensed under the provisions of the laws in the State of Indiana. It is understood that this authorization is given in advance of any specific diagnosis, treatment or medical care being required but is given to provide authority and power to render care, which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

List any restrictions:_____

Parent or legal guardian signature_____

FINANCIAL RESPONSIBILITY AGREEMENT
The undersigned hereby guarantees payment for all services rendered by the physician and in the event this account is turned over for collection, shall be responsible for all costs incurred, including but not limited to reasonable attorney fees, court costs and collection costs.

Patient/Beneficiary Signature _____ Date___/___/_____

Community *Rheumatology* OF ANDERSON

1210A Medical Arts Blvd, Suite 200
Anderson, IN 46011
(765) 298-4050
(765) 298-4960 fax

Patient Name: _____ Birthdate: ____/____/____
LAST FIRST M.I.

Address: _____ Age: _____ Sex: ☐ F ☐ M
STREET APT#

_____ Home phone: _____
CITY STATE ZIP

Problem being seen for today: _____ Onset date: _____

Referring physician: _____ Primary Care Physician: _____

PAST MEDICAL HISTORY:

Significant illness (please list)

_____

_____

_____

_____

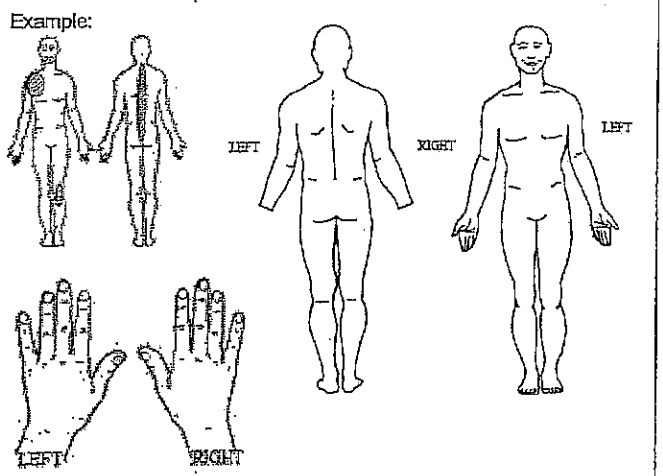
_____

_____

_____

_____

Please shade all the locations of your pain over the past week on the **body figures** and hands.



SURGICAL HISTORY:

Operation:	Year:	Reason:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Any previous fractures? ☐ No ☐ Yes Describe: _____

Any other serious injuries? ☐ No ☐ Yes Describe: _____

MEDICATIONS

DRUG ALLERGIES: ☐ No ☐ Yes (If yes, please list drug allergies below)

Name of Drug	Type of Reaction
1.	
2.	
3.	
4.	
5.	

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium, and other supplements, etc.)

Name of Drug	Dose (include strength & # of pills per day)	How long have you taken this medication	Please check: Helped?		
			A Lot	Some	Never
1.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐

PAST MEDICATIONS (List any medications taken in the past to help relieve your condition that you are being seen for today)

Name of Drug	Begin	End	Please check: Helped?		
			A Lot	Some	Never
1.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐

Preferred Pharmacy Name : _____

Address: _____

_____

Phone #: _____

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Age	Any Medical Problems?	Age	Any Medical Problems?
Mother				
Father				

Please list any significant medical problems of "immediate" family members.

_____

_____

_____

SOCIAL HISTORY:

Marital Status: ❑ Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Who do you live with _____ Number of children_____

Education (circle highest level attended):
Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School_____
Occupation_____ Number of hours worked/average per week_____
Currently on disability? ❑ Yes ❑ No Disability pending ❑ Yes ❑ No

Do you drink caffeinated beverages? _____
Cups/glasses per day? _____
Do you smoke? ❑ Yes ❑ No ❑ Past – How long ago? _____
Exposed to second hand smoke? ❑ Yes ❑ No

Do you have tattoos? ❑ Yes ❑ No
Had any blood transfusions? ❑ Yes ❑ No
Do you use any IV drugs? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No Number per week _____
Has anyone ever told you to cut down on your drinking? ❑ Yes ❑ No

Do you take Calcium regularly? ❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ Yes ❑ No
If yes, please list:
_____

Do you exercise regularly? ❑ Yes ❑ No
Type _____
Amount per week _____

How many hours of sleep do you get at night? _____
Do you get enough sleep at night? ❑ Yes ❑ No
Do you wake up feeling rested? ❑ Yes ❑ No

Women only:
Age at menopause _____
Contraception ❑ Yes ❑ No If yes, what type? _____

Date of last:
TB Test _____ Pneumovax _____ Flu Vaccine _____

Date of last Dexa (Bone Density) Scan: _____ Location: _____

Result of Dexa (Bone Density) Scan – if known : _____

SYSTEMS REVIEW

As you review the following list, please check any of those problems which have significantly affected you **recently**. Please add any problems not listed below.

GENERAL
- ❑ fevers
- ❑ chills
- ❑ drenching night sweats
- ❑ anorexia
- ❑ fatigue
- ❑ weight loss (over 10 lbs)
  - ❑ intentional
  - ❑ unintentional

EYES
- ❑ eye pain
- ❑ eye pain with bright light
- ❑ red eyes
- ❑ dry eyes
- ❑ double vision
- ❑ sudden, unexplainable vision loss

EARS/NOSE/THROAT
- ❑ nose bleeds
- ❑ nasal ulcers
- ❑ oral ulcers
- ❑ hearing loss
- ❑ ringing in ears
- ❑ hoarseness
- ❑ chronic sinus problems
- ❑ pain with swallowing food
- ❑ excessive dry mouth

CARDIOVASCULAR
- ❑ fluid around heart
- ❑ inflammation of heart lining or muscle
- ❑ difficulty breathing at rest
- ❑ difficulty breathing with exertion
- ❑ heart valve problems
- ❑ chest pain
- ❑ discoloration of fingers/toes
  If yes, what color changes do you experience?_____

RESPIRATORY
- ❑ dry cough
- ❑ productive cough
- ❑ increasing shortness of breath
- ❑ cough up blood
- ❑ chest pain with deep breathing

GASTROINTESTINAL
- ❑ heart burn
- ❑ PUD
- ❑ rectal bleeding
- ❑ black, tarry stool
- ❑ persistent abdominal pain
- ❑ difficulty swallowing

WOMEN'S HEALTH
- ❑ miscarriages
  how many _____
  age of gestation _____
- ❑ preterm births
- ❑ eclampsia/pre-eclampsia

GENITOURINARY
- ❑ blood in urine
- ❑ protein in urine
- ❑ history of Glomerulonephritis
- ❑ kidney failure

MUSCULOSKELETAL
- ❑ joint pain
- ❑ joint swelling
- ❑ joint stiffness
- ❑ morning joint stiffness
  what area(s) is stiff?
  _____
  _____
  how long does stiffness last?
  _____
- ❑ muscle pain
- ❑ muscle weakness
- ❑ back pain

SKIN
- ❑ rash
- ❑ facial rash
- ❑ skin thickening
- ❑ rash after sun exposure
- ❑ fingertip ulcers
- ❑ leg ulcers
- ❑ hair loss

NEUROLOGIC
- ❑ seizures
- ❑ spotty visual loss
- ❑ migraine
- ❑ weakness
- ❑ numbness
- ❑ strokes

PSYCHIATRIC
- ❑ depression
- ❑ anxiety
- ❑ memory loss
- ❑ suicidal ideation
- ❑ hallucinations
- ❑ paranoia

ENDOCRINE
- ❑ cold intolerance
- ❑ heat intolerance
- ❑ excessive hunger
- ❑ excessive thirst
- ❑ excessive urination

HEME/LYMPHATIC
- ❑ abnormal bruising
- ❑ bleeding
- ❑ enlarged lymph nodes
- ❑ blood clots
- ❑ anemia
- ❑ low white cells
- ❑ low platelets

ALLERGIC/IMMUNOLOGIC
- ❑ hives
- ❑ hay fever
- ❑ persistent infections
- ❑ HIV exposure

SLEEP
- ❑ trouble falling asleep
- ❑ trouble staying asleep
- ❑ excessive daytime drowsiness
- ❑ snoring
- ❑ naps during the day
- ❑ history of sleep apnea
- ❑ using CPAP/BIPAP

OTHER
_____
_____
_____
_____

Community
Rheumatology
OF ANDERSON

1210A Medical Arts Blvd, Suite 200
Anderson, IN 46011
(765) 298-4050 • (765) 298-4960 fax
www.communityanderson.com/rheumatology

PATIENT FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Please understand that payment for services is a part of that relationship. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

PATIENT INFORMATION: A fully completed, current patient registration will be on file in the patient chart during the time in which the patient is considered an active patient. Patient registration will be updated by the patient yearly and will include where the patient can be reached by phone. A signature by the responsible party is required.

INSURANCE CLAIMS:

Primary Insurance: We will file claims with the patient's insurance upon the patient's submission of proof of insurance (i.e., insurance card indicating coverage, identification number and group number). In the event the patient has insurance coverage but cannot provide documentation, payment is due at the time of service. Upon receipt of the insurance card, we will submit the health insurance claim form indicating patient payment at time of service.

Secondary Insurance: Claims will be filed with secondary insurance if adequate information is received at the time of service. However, if payment is not received in our office within 45 days after filing, the responsibility will be transferred to the patient and due upon receipt.

PATIENT FINANCIAL RESPONSIBILITY: If no insurance is to be filed by us, or if we are not a participating provider in your insurance plan, **full payment is expected**. If necessary, we can set up a payment schedule. Payment arrangements will be made with a signed Payment Agreement and the approval of the Office Manager.

Co-payments, deductibles, co-insurance and payment for non-covered services are due at the time of service. We accept cash, checks and credit cards.

MINORS/DEPENDENTS: Children under the age of 18 will require the signature of a responsible party on the registration form.

(continued on back of page)

WORKERS' COMPENSATION: Workers' compensation will be filed if the patient notifies us when scheduling the appointment and supplies billing information at check-in. Details of the accident will be required and a workers' compensation form must be completed.

METHOD OF PAYMENT: Acceptable methods of payment are cash, check, VISA and MasterCard. VISA and MasterCard payments can also be accepted by phone or fax.

PAST DUE ACCOUNTS: Any outstanding balance, after insurance has paid, will be invoiced to you on a statement. Payment is due upon receipt of the statement.

Prolonged delinquency in payment may result in preparation of account for small claims court, collection agency and/or credit bureau reporting with possible discharge from the practice.

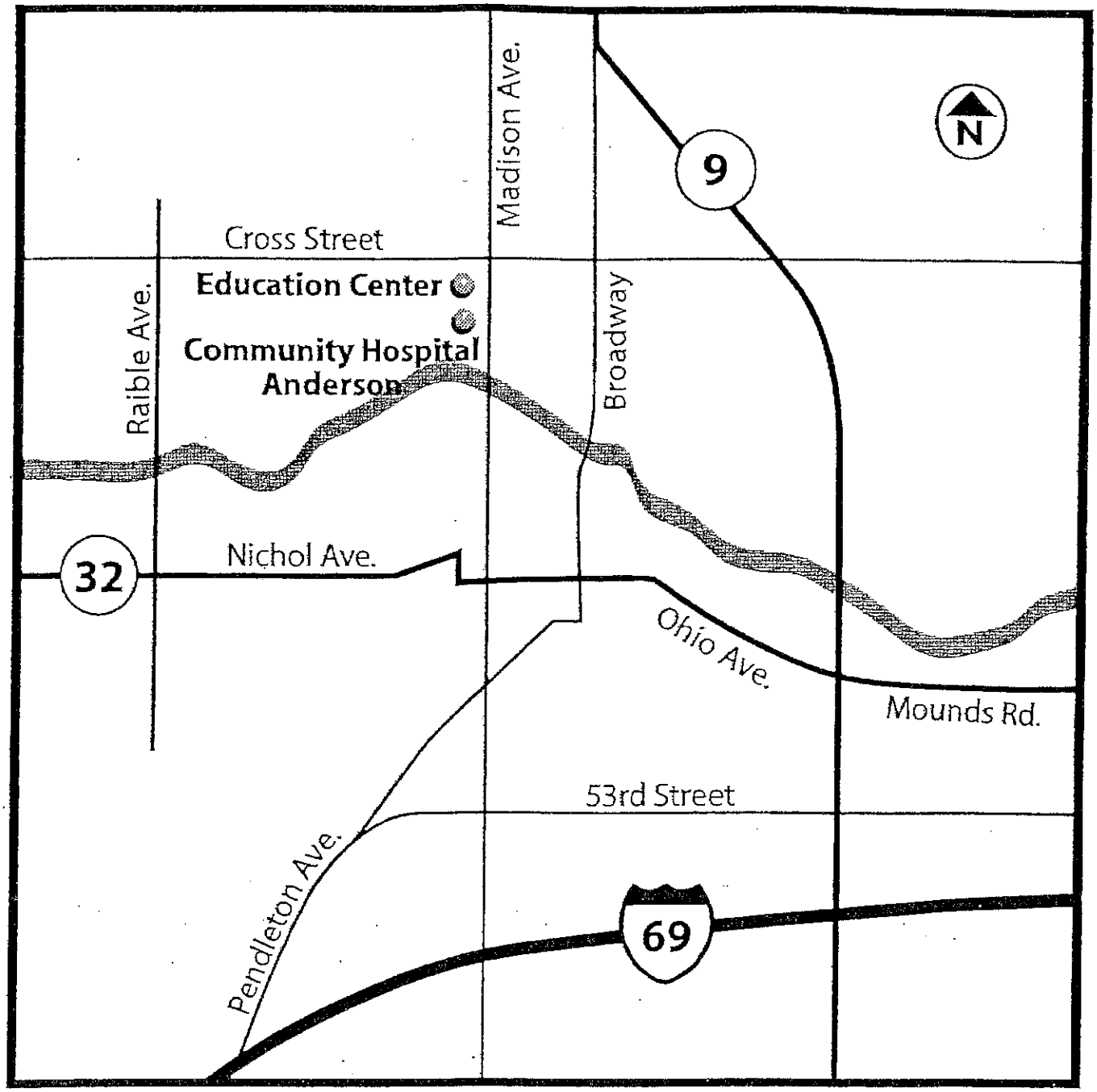
In the event an account is turned over for collection, the person financially responsible for the account will be responsible for all collection costs including reasonable attorney fees and court costs.

A patient may remit in full for all outstanding charges owed on account including amounts previously placed with the collection service. Under these circumstances, a physician may reserve the right to re-establish the patient to active status in the practice.

MISSED APPOINTMENTS: We request the courtesy of a 24-hour notice of cancellation. Consecutive missed appointments without notice will be documented and may result in discharge from the practice.

ACCOUNT CONSULTATION: Physicians do not discuss financial issues. Our billing staff is trained to discuss your account and make payment arrangements. They will be happy to help you, but if you need further assistance please ask to speak with the Office Manager.

MEDICAL RECORDS: If you need us to transfer your records to another physician, please contact the office. They will provide you with the HIPAA compliant documents.



Community Rheumatology of Anderson

1210A Medical Arts Blvd. Suite 200
Anderson, IN 46011
765-298-4050 Fax: 765-298-4960

We are located on the west side of Community Hospital
in the1210A building.