arthritis CARE
RHEUMATOLOGY CARE | RESEARCH

Smitha Chiniga Reddy M.D.

Phone: 858.312.1717 | Fax: 858.435.0207 | eFax: 858.207.0041

Arthritis Care & Research Center, Inc.

15725 Pomerado Rd, Ste 117, Poway, CA 92064
272 Church Ave, Ste 1, Chula Vista, CA 91910

NEW PATIENT REGISTRATION INFORMATION

LAST NAME _____ **FIRST NAME**_____

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

SSN#_____-_____-_____

HOME ADDRESS_____

HOME PHONE_____ MOBILE PHONE_____

EMPLOYER_____ WORK PHONE_____

WORK ADDRESS_____

REFERRING PHYSICIAN_____ PHONE_____

PRIMARY PHYSICIAN_____ PHONE_____

EMERGENCY CONTACT NAME_____

ADDRESS_____

PHONE_____ RELATIONSHIP_____

PRIMARY INSURANCE_____ MEMBER #_____

PRIMARY SUBSCRIBER_____ PRIMARY GROUP #_____

SECONDARY INSURANCE_____ MEMBER#_____

SECONDARY SUBSCRIBER_____ SECONDARY GROUP NO. _____

PHARMACY NAME_____ PHONE_____

PHARMACY ADDRESS_____

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, and authorize payment directly to ARTHRITIS CARE AND RESEARCH CENTER, INC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment will remain as as valid as an original. I hereby authorize ARTHRITIS CARE AND RESEARCH CENTER, INC to release all informaiton necessary to my insurance companies to secure the payment.

I understand that I am financially responsible for all charges incurred whether or not covered by my insurance.

SIGNED_____ DATE_____

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PATIENT HISTORY & MEDICATIONS

Drug Allergies ☐ NO ☐ YES To What? _____

_____

Type of Reaction _____

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 & number of pills per day)	How long have you taken this medication	Please check: Helped? A Lot	Some	Not At All
1.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐

Describe briefly your present symptoms. _____

_____

_____

Date Symptoms Began (approximate): _____

Diagnosis: _____

Previous Treatment for this problem (including physical therapy, surgery, and injections; medications to be listed later).

_____

_____

_____

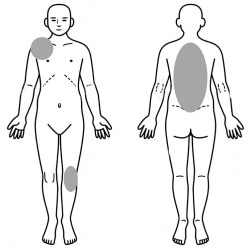
Please list the names of other practitioners you have seen for this problem:

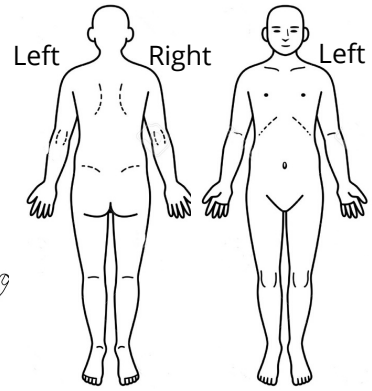
_____

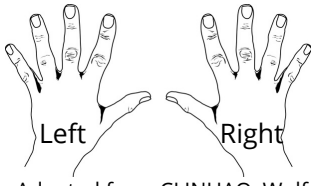
_____

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

Example







Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
☐	Arthritis (unknown type)		☐	Lupus or "SLE"	
☐	Osteoarthritis		☐	Rheumatoid Arthritis	
☐	Gout		☐	Ankylosing Spondylitis	
☐	Childhood arthritis		☐	Osteoporosis	
Other arthritis conditions:					

Patient's Name_____ Date_____Physician Initials _____

SOCIAL HISTORY

Do you drink caffeinated beverages?
Cups/glasses per day?_____
Do you smoke? □ Yes □ No □ Past – How long ago?_____
Do you drink alcohol? □ Yes □ No Number per week_____
Has anyone ever told you to cut down on your drinking?
□ 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

PAST MEDICAL HISTORY

Do you now or have you ever had: *(check if "yes")*

□ Cancer	□ Heart problems	□ Asthma
□ Goiter	□ Leukemia	□ Stroke
□ Cataracts	□ Diabetes	□ Epilepsy
□ Nervous breakdown	□ Stomach ulcers	□ Rheumatic fever
□ Bad headaches	□ Jaundice	□ Colitis
□ Kidney disease	□ Pneumonia	□ Psoriasis
□ Anemia	□ HIV Aids	□ High Blood Pressure
□ Emphysema	□ Glaucoma	□ Tuberculosis

Other significant illness (please list)_____
_____
Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)
_____
_____
_____

Previous Operations

Type	***Year***	***Reason***
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? □ No □ Yes Describe: _____

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

On the scale below, circle a number which best describes your situation; Most of the time, I function…

1	*2*	*3*	*4*	*5*
Very Poorly	Poorly	OK	Well	Very Well

Patient's Name_____ Date_____Physician Initials _____

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Authorization to Release Protected Health Information
(HIPAA Compliant Request for Information/Medical Records)

I hereby give permission to release my, below checked, Protected Health Information (PHI) also known as My Medical Records to Arthritis Care and Research Center, Inc.

Be certain that information is accurate and complete. Incomplete authorizations are invalid.

_____
Name of Medical Office/Company/Entity you want to send records to ACRC.

_____
Street Address

_____
City State ZIP Code

_____
Phone Number Fax Number

☐ Release a copy of my entire chart including X-rays and lab reports

☐ Release records for this specific date of service_____

☐ Release specific information _____

☐ I am requesting my PHI to be disclosed for reason_____

I understand this information may be subject to re-disclosure by the recipient and no longer protected by the privacy rule. I release you from all liability that may arise from your compliance with this request to release records.
I understand that this authorization will automatically expire one year from the date executed. I understand I may revoke this consent at any time in writing, except to the extent that action has already been taken.

I understand that I have a right to receive a copy of this authorization upon my request.

Patient Signature _____**Date** _____

Witness Signature _____ **Date** _____

Please send My Records to:

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HIPAA COMPLIANCE REQUIREMENT

PATIENT CONSENT TO THE USE/DISCLOSURE OF PRIVATE HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I, _____, understand that as part of my health care, Arthritis Care and Research Center, Inc (ACRC), originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify services billed were actually provided,

and,

- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

On occasion, ACRC may have confidential health information about you, such as laboratory results, which we may wish to convey to you by telephone. Please indicate below how you would like us to handle this:

☐ Call this number ( ) _____ to leave all health-related information.

☐ Leave ☐ Do Not Leave detailed messages on the answering machine.

☐ Write only, do not call (This means your doctor can NEVER call you, even with lab results.

My confidential health information may be discussed with the following people:

1. _____ 2. _____ 3. _____

My signature acknowledges that I have received from ACRC a copy of the Notice of Privacy Policies for ACRC Patients brochure.

Patient's Signature_____Date_____

Printed Name _____

Address_____Home Phone_____

Person to notify in case of Emergency_____

Phone_____Relationship_____

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Patient Acceptance of Financial Responsibility

Arthritis Care and Research Center, Inc will bill your insurance as a courtesy. However, you are responsible for all charges for services rendered. In the event services rendered are not covered by your insurance company, we require that you remit payment to Arthritis Care and Research Center, Inc (ACRC).

Additionally, if your insurance provider does not remit payment in a timely manner (within 60 days your insurance is billed), we will transfer balance to your responsibility and require you to remit payment to ACRC for all outstanding insurance balances over 60 days. The outstanding balances may include, but not limited to

* Office visit co-payments
* Annual deductibles
* Services that are not covered by your health plan
* Administrative charges not paid at the time of your service
* Interest charges for overdue patients charged as per California law

In addition, your insurance company may require an authorization or pre-certification for certain procedures, services, drugs and supplies that will be provided to you. As a courtesy, we will contact your insurance company for authorization for services. However, it is your ultimate responsibility to understand what your insurance company covers and assure that you have authorization for services. We may request your assistance in following up with our authorization requests and delayed payments. Your assistance in contacting your insurance company will often facilitate a more timely approval of services, prevent delays in treatment and expedite payment for your services.

We frequently experience difficulty with insurance plans. Our policy is that we will bill your primary and secondary policies. If you do not receive payment within 60 days we bill your insurance company and we will transfer the balance to your responsibility and require that you remit your payment to ACRC. To prevent this we suggest for you to communicate with your insurance company to assure that they are paying for the services we render. In addition, should our billing office contact you for assistance in obtaining payment for your insurance, your prompt response to their calls would be appreciated.

You will be charged for a missed appointment charge of $25.00 for all appointments that you miss and fail to give at least 24 hour notice.

I understand and agree that I (or the named below who is financial responsible for me) am financially responsible for my services and will pay my outstanding balance within 10 days of receipt of my monthly statements.

Print Patient Name

Responsible Party Name

Patient's Signature

Responsible Party's Signature

Date