New Patient History - Rheumatology

T. Alexander Edgil, MD | Patricia Kachur, MD | Brian Kirby, MD
R. Andrew Meyerholz, MD | Michael VandenBerg, MD | Kathryn Carpenter, PA-C

Dear Patient,

The Department of Rheumatology would like to welcome you to our practice. Our healthcare team consists of board-certified physicians, nationally-certified physician extenders, nurses, medical assistants, and patient service representatives. It is our goal to provide you with a high level of medical care and attentive customer service. The following guidelines allow us to provide you with the best service possible. We expect all patients to be an active participant and share mutual responsibility in their personal health care.

- Please bring to your appointment:
  - Medical Insurance CardsoDriver's License or State ID Card
  - New Patient Paperwork (Completely filled out)
  - Current Medication List. (Include prescriptions, over the counter, supplements, and vitamins)
  - Patients are expected to pay all financial obligations at the time of service. Any out of pocket copays, deductibles, co-insurances, etc., are due at the time of your visit. If you are unable to pay your copay, please contact our office prior to your appointment.
- Should you not be able to make your new patient appointment, we do require a minimum notice of 24 hours. If you "no show" or cancel your appointment less than 24 hours prior, you will be charged a $50.00 fee.
- We do ask that you arrive at the Rheumatology Department at least 30 minutes prior to your appointment with all of the above requested items. The check-in process can be extensive at your first visit. This helps expedite the process.
- For after-hours emergencies, you may call (850) 474-8000. The Doctors' Call Center will deliver your message to our On-Call Rheumatologist. You should proceed to your nearest Emergency Room for any life-threatening issues.
- We accept all medication requests for prescription refills during normal office hours only, Monday through Thursday. Unfortunately, we will not be able to refill narcotics on weekends or holidays.

We appreciate your cooperation in these matters. Our office hours are from 7:00 a.m. to 4:00 p.m., Monday through Thursday. If you have any questions, concerns, or suggestions, please feel free to contact our office at (850) 474-8387.

Sincerely,

Medical Center Clinic

Musculoskeletal Center

Department of Rheumatology

MUSCULOSKELETAL CENTER

New Patient History - Rheumatology

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Date: _____ Birth Date: _____

Name: _____ Age: _____ Sex at birth: ☐F ☐M

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ ☐ Home ☐ Work ☐ Cell

_____ ☐ Home ☐ Work ☐ Cell

Referred by:

☐Self ☐Family ☐Friend ☐Doctor ☐Other Health Professional

Name of person making referral: _____

Primary Care Physician: _____

Do you have an orthopaedic surgeon? ☐Yes ☐No If yes, name: _____

Date symptoms began (approximate): _____

Briefly describe your present symptoms:

Diagnosis given? ☐No ☐Yes (please list)

Previous treatment for this problem: (include physical therapy, surgery, and injections. Medications will be listed later.)

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

T. Alexander Edgil, MD | Patricia Kachur, MD | Brian Kirby, MD
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Rheumatologic (Arthritis) History:

At any time, have you or a blood relative had any of the following: *(please check if yes)*

	Yourself	Blood Relative	Relationship
Arthritis	☐	☐	
Osteoarthritis	☐	☐	
Rheumatoid Arthritis	☐	☐	
Gout	☐	☐	
Lupus or "SLE"	☐	☐	
Anklyosing Spondylitis	☐	☐	
Childhood arthritis	☐	☐	
Osteoporosis	☐	☐	
Other Arthritis Conditions:	☐	☐	

Review of Systems: *Please check all that apply:*

General:

- ☐ Recent weight gain
  Amount:
- ☐ Recent weight loss
  Amount:
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever

Nervous System:

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle spasms
- ☐ Loss of consciousness

Ears:

- ☐ Ringing in ears
- ☐ Loss of hearing

Eyes:

- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feeling of something in your eye

Nose:

- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Dryness

Mouth:

- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness

Throat:

- ☐ Frequent sore throat
- ☐ Hoarseness
- ☐ Difficulty in swallowing

Review of Systems - continued: *Please check all that apply:*

Neck:

- ☐ Swollen Glands
- ☐ Tender Glands

Heart and Lungs:

- ☐ Pain in chest
- ☐ Irregular heart beat
- ☐ Sudden changes in heartbeat
- ☐ Shortness of breath
- ☐ Difficulty in breathing at night
- ☐ Swollen legs or feet
- ☐ High blood pressure
- ☐ Heart murmurs
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing
- ☐ Night sweats

Stomach and Intestines:

- ☐ Nausea
- ☐ Vomiting of blood or coffee-ground material
- ☐ Yellow jaundice
- ☐ Stomach pain relieved by food or milk
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stool
- ☐ Heartburn

Kidney, Urine, and Bladder:

- ☐ Difficult urination
- ☐ Pain or burning on urination
- ☐ Cloudy, "smoky" urine
- ☐ Pus in urine
- ☐ Discharge from penis / vagina
- ☐ Frequent urinations
- ☐ Getting up at night to pass urine
- ☐ Vaginal dryness
- ☐ Rash / ulcers
- ☐ Sexual difficulties
- ☐ Prostate trouble

Blood:

- ☐ Anemia
- ☐ Bleeding Tendency

Menstrual:

Age when periods began: _____

Are your periods regular? _____

How Many Days Apart? _____

Date of Last Period: _____

Date of Last Pap Smear: _____

Bleeding after menopause: _____

Skin:

- ☐ Easy Bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive (sun allergy)
- ☐ Tightness
- ☐ Nodules / bumps
- ☐ Hair loss
- ☐ Color changes of hands/feet in cold

Muscles, joints, and bones:

- ☐ Morning stiffness lasting how long?

  _____ Minutes _____ Hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint swelling, list joints affected in the last 6 months:

Habits:

Do you drink coffee? ☐ Yes ☐ No How many cups per day? _____

Do you smoke? ☐ Yes ☐ No Cigarettes per day? _____

Alcohol Intake: ☐ Heavy ☐ Moderate ☐ Light ☐ None

Do you use drugs for reasons that are not medical? ☐ Yes ☐ No

If yes, please list: _____

Date of last eye examination: _____

Date of last chest x-ray: _____

Date of last tuberculosis test: _____

Past Personal History:

Do you or have you had: *(please mark if yes)*

- ☐ Cancer
- ☐ Leukemia
- ☐ Epilepsy
- ☐ Bad headaches
- ☐ Pneumonia

If you selected cancer, please specify type, or list any other significant illness: (please list)

Previous Operations:

Type	Year	Surgeon	City
1.			
2.			
3.			
4.			
5.			
6.			

Previous fractures? ☐ Yes ☐ No Please describe:

Other serious injuries? ☐ Yes ☐ No Please describe:

Family History:

Do you know of any blood relative who has or has had: (check and give relationship)

- ☐ Asthma
- ☐ Alcoholism
- ☐ Bleeding tendency
- ☐ Cancer Relation: Type:
- ☐ Colitis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Goiter
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Leukemia
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Tuberculosis

Marital Status:

☐ Never married ☐ Married ☐ Divorced ☐ Separated

Spouse: If living, age _____ If deceased, age at death _____

Major illnesses: _____

Education: *(Highest Grade/Level/Degree Attained)*

_____

Occupation: _____ Number of hours worked per week _____

Please check the one best answer for your abilities at this time:

Over the last week, were you able to:	**Without ANY Difficulty**	**With SOME Difficulty**	**With MUCH Difficulty**	**UNABLE To Do**
Dress yourself, including tying shoelaces and doing buttons?	☐	☐	☐	☐
Get in and out of bed?	☐	☐	☐	☐
Lift a full cup or glass to your mouth?	☐	☐	☐	☐
Walk outdoors on flat ground?	☐	☐	☐	☐
Wash and dry your entire body?	☐	☐	☐	☐
Bend down to pick up clothing from the floor?	☐	☐	☐	☐
Turn regular faucets on and off?	☐	☐	☐	☐
Get in and out of a car, bus, train, or airplane?	☐	☐	☐	☐
Walk two miles or three kilometers?	☐	☐	☐	☐
Participate in recreational activities and sports?	☐	☐	☐	☐

How much pain have you had because of your condition over the past week ?

No Pain **Pain as bad as it could be**

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10.0

Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

Very Well **Very Poorly**

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10.0

Medications:

Any drug allergies? _____ Yes _____ No

If Yes, which drugs and reactions?

Current Medication List:

(List ALL medications that you are taking at this time. Include items such as aspirin, vitamins, laxatives, calcium supplements, etc.)

Name of Drug	Dose (Include strength and number of pills per day)	How long have you taken this medication?	Please check one, did the medication help? Yes	Some	No
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

Notice of Health Information Privacy Practices

Effective September 23, 2013

Medical Center Clinic℠
HEALTHCARE CENTERED AROUND YOU

This notice describes how your health information may be used and disclosed and how you can get access to this information. Please review it carefully.

Thank you for choosing the Medical Center Clinic for your healthcare needs. Each time you visit one of our providers, we create a record of the care and services you receive to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of your records of your care received by a provider at Medical Center Clinic and explains how we may use and disclose your health information as well as your rights regarding the health information we maintain about you.

We are required by law to make sure that health information that identifies you is kept private; give you this Notice of our legal duties and privacy practices with respect to your health information; and follow the terms of the Notice currently in effect. We reserve the right to change our privacy practices and this Notice at any time.

WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN PERMISSION IN THE FOLLOWING CIRCUMSTANCES:

Treatment: We will use and disclose your health information to provided medical treatment to you, and to coordinate or manage your health care related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. For example, we may use and disclose your health information when you need a prescription, lab work, an x-ray or other health care services. Also, we may use and disclose your health information when referring you to another health care provider.

Payment: We may use and disclose your health information to bill and receive payment. For example: A bill may be sent to you or your insurance company. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Operations: We may use and disclose health information about you for health care operations. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including compliance program activities and business planning.

Business Associates: We may disclose your health information to our Business Associates to carry out treatment, payment or health care operations. For example, we may disclose health information about you to a company who bills insurance companies on our behalf to enable that company to help us obtain payment for the services we provide.

Appointment Reminders, Treatment Alternatives or Health-Related Services: We may contact you to provide appointment reminders, tell you about health-related services, to recommend possible treatment options or alternatives that may be of interest to you.

Research: We may use and disclose information to researchers or to collect information in databases used for research. Research projects are reviewed and approved by a Review Board to protect the privacy of your health information.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to ad-verse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Military and Veterans: If you are a member of the armed forces, or separated or discharged from the military services, we may disclose your health information as required by national military command authorities or the Department of Veterans Affairs.

Public Health: We may disclose your health information to a public health authority that is permitted by law to collect or receive the information for the purpose of preventing or controlling disease, injury, or disability.

Correctional Institution: If you are an inmate of a correctional institution, we may disclose to the institution or agents thereof, health information necessary to provide you with healthcare; to protect your health and

safety or the health and safety of other individuals; or for the safety and security of the correctional institution.

Law Enforcement: We may disclose health information in response to a valid subpoena, warrant, summons or similar process. We may also release information for purposes of locating a suspect, a fugitive, a material witness, or missing person.

Health Oversight Activities: Federal law makes provisions for your health information to be released to an appropriate health oversight agency for activities such as audits, investigations, and inspections. This includes government agencies that oversee the healthcare system, government benefit programs, other government regulatory pro-grams, and the civil rights laws.

SPECIAL CIRCUMSTANCES

Florida Privacy Laws: Health information related to substance abuse, mental health, or sexually transmissible diseases have special privacy protections in Florida. We will not disclose health information relating to substance abuse, mental health, or sexually transmissible disease unless: 1) the patient consents in writing, or 2) a court order requires disclosure of the information, or 3) medical personnel need information to meet a medical emergency, or 4) qualified personnel use the information for the purpose of conducting scientific research, management audits, financial audits or program evaluation, or 5) it is necessary to report a crime or a threat to commit a crime, or 6) to report abuse or neglect as required by law.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or law that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your revocation. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights with respect to your health information:

Right to Inspect and Copy Your Health Information: You have the right to see and obtain copies of health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

Right to Amend: If you think that health information we have about you is incorrect or incomplete, you may ask us to correct or add to the information, but we are not required to agree to the requested amendments.

Right to an Accounting of Disclosures: You have the right to request an "accounting" of certain disclosures of your protected health information.

Right to Request Restrictions: You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment or health care operations, but we are not required to agree to the requested restrictions.

We will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to your health plan for purposes of carrying out payment or your health plan's operations; and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

Right to Request Confidential Communications: You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

Right to Breach Notification: You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to Obtain a Copy of This Notice: You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

QUESTIONS OR COMPLAINTS

If you have questions about this Notice, or believe that your privacy rights have been violated, please contact Sharon Hoyle, CHC, CHPC, CPC, Corporate Compliance and Privacy Officer toll free at 1-866-822-3571, by e-mail at privacy.officer@medicalcenterclinic.com, or by U.S. Mail at:

Medical Center Clinic
Attn: Sharon Hoyle, Corporate Compliance and Privacy Officer
8333 N. Davis Hwy
Pensacola, FL 32514

You have the right to file a written complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

PLACE LABEL HERE OR LEGIBLY PRINT
PATIENT"S FIRST AND LAST NAME AND MCC#

Print Patient First and Last Name

Print MCC#

Medical Center Clinic℠
HEALTHCARE CENTERED AROUND YOU

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

Thank you for choosing Medical Center Clinic for your health care needs.

We are required by law to provide you with a copy of our Notice of Privacy Practices ("Notice"). To ensure that our records are accurate, please sign below to acknowledge that you have been provided with a copy of our Notice.

Patient Signature _____ Date of Signature _____

If a personal representative signs on behalf of the patient, please complete the below additional information:

Personal Representative's Name (Print) _____ Relationship to Patient _____

OFFICE USE ONLY

A good faith attempt was made to obtain the patient's written acknowledgement of receipt of MCC's Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual declined to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please describe below)

_____

_____

Employee Name (please print) _____ Date _____

PLACE LABEL HERE OR LEGIBLY PRINT
PATIENT"S FIRST AND LAST NAME AND MCC#

Print Patient First and Last Name

Print MCC#

Medical Center Clinic℠
HEALTHCARE CENTERED AROUND YOU

PATIENT INSURANCE ASSIGNMENT & RESPONSIBILITIES ACKNOWLEDGEMENT

Please read each section thoroughly and sign acknowledgement below:

Consent to Treatment: I consent to care, treatment, testing, and all other services performed by healthcare providers at Medical Center Clinic. I understand that I have the right to refuse any proposed care, treatment, testing, surgery, or other procedure. I understand that I have the right to ask questions and discuss my care with my healthcare provider.

Lifetime Insurance Assignment: I hereby instruct and direct my past and/or present insurance company to issue payment directly to:

West Florida Medical Center Clinic, P.A.
8333 North Davis Highway
Pensacola, FL 32514

for all medical, surgical and diagnostic expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to MCC and I agree to pay, within sixty (60) days of the date of the first monthly bill, any balance of said charges over and above this insurance payment, including applicable copayments, deductible, non-covered services and items, unauthorized services or any fees denied, except to the extent my liability for any such balance is limited by agreement or law applicable to MCC. A photocopy of this assignment shall be considered as effective and as valid as the original. Furthermore, I understand that 1) MCC accepts Medicare assignment and Medicare payments will be directed to MCC and 2) Medical Center Clinic does not accept responsibility for collecting insurance or negotiating the settlement of a disputed insurance claim and any account balance not paid in full within sixty (60) days of the date of the first monthly bill is considered delinquent. I agree to pay reasonable attorney's fees and collection expenses should my account be referred for collection procedures.

Patient Financial Responsibility Policy: Co-payments, deductibles, co-insurance, and all other appropriate payment will be due at time services are rendered. Insurance companies require physician offices to collect all applicable patient portions prior to services being rendered.

Tobacco-Free Campus: Use or sale of tobacco products (cigarettes, including electronic; cigars; pipes; and smokeless tobacco) is prohibited on all Medical Center Clinic premises, campuses, parking lots and grounds.

I acknowledge and understand all of the above notices and assignments and will comply with all specified responsibilities.

Signature of Patient or Legal Representative

Date