



3160 Southgate Commerce Blvd., Ste. 30  
 Orlando, FL 32806-8557  
 Phone: (407) 859-4540  
 Fax: (407) 859-3815

**Patient Medical Information Form**

Date: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
 Patient Name: \_\_\_\_\_ Male or Female \_\_\_\_\_  
 Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Medication Allergies: (List drug name and reaction)**

- 1. \_\_\_\_\_ 3. \_\_\_\_\_
- 2. \_\_\_\_\_ 4. \_\_\_\_\_

**Past Surgical History: (Includes biopsies, D&C's, tonsillectomy, etc.)**

- 1. \_\_\_\_\_ 3. \_\_\_\_\_
- 2. \_\_\_\_\_ 4. \_\_\_\_\_

**Medical Problems: (Past and Present: Include serious injuries and any fractures)**

- 1. \_\_\_\_\_ 3. \_\_\_\_\_
- 2. \_\_\_\_\_ 4. \_\_\_\_\_
- 5. \_\_\_\_\_ 6. \_\_\_\_\_

**Current Medication with Dosage: (Including Non-prescription drugs)**

- 1. \_\_\_\_\_ 3. \_\_\_\_\_
- 2. \_\_\_\_\_ 4. \_\_\_\_\_
- 5. \_\_\_\_\_ 6. \_\_\_\_\_

**OB/GYN History**

# of Pregnancies \_\_\_\_ # of Live Births \_\_\_\_ # of Stillborn/Miscarriages \_\_\_\_ Last GYN exam \_\_\_\_\_

Name of your Gynecologist: \_\_\_\_\_

Have you gone through menopause? Yes \_\_\_\_ No \_\_\_\_ If so, what age? \_\_\_\_\_

When was your last mammogram? \_\_\_\_\_

**Other**

When was your Chest X-Ray? \_\_\_\_\_

Have you had a DEXA scan? Yes \_\_\_\_ No \_\_\_\_ If so, when was your last scan? \_\_\_\_\_

Date of most recent immunizations: Tetanus \_\_\_\_\_ Flu \_\_\_\_\_ Pneumonia \_\_\_\_\_ COVID \_\_\_\_\_

When was your last PPD (TB skin test)? \_\_\_\_\_ Positive \_\_\_\_ Negative \_\_\_\_



3160 Southgate Commerce Blvd., Ste. 30  
 Orlando, FL 32806-8557  
 Phone: (407) 859-4540  
 Fax: (407) 859-3815

**Family History**

Please list the relationship to you of Blood Relatives who have had the following diseases.

Diabetes _____	Arthritis _____
Rheumatoid Arthritis _____	Cancer _____
High Blood Pressure _____	Lupus _____
Heart Disease _____	Gout _____
Kidney Disease _____	Psoriasis _____
Thyroid Disease _____	Other _____
Osteoporosis _____	

**Social History**

Marital Status \_\_\_\_\_ # of Children \_\_\_\_\_

Hobbies or interests \_\_\_\_\_

Highest level of education completed \_\_\_\_\_

Current Occupation \_\_\_\_\_

Sources of unusual stress \_\_\_\_\_

# of cigarettes smoked per day \_\_\_\_\_ # of alcoholic drinks per day \_\_\_\_\_ # cups of coffee per day \_\_\_\_\_

Do you or have you ever used recreational drugs? \_\_\_\_\_

What is your exercise program? \_\_\_\_\_

How many days per week do you exercise? \_\_\_\_\_

**Activities of Daily Living**

List daily activities with which you have trouble because of your arthritis or muscle pain (eg: combing hair, bathing, kitchen activities, yard work, etc.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list the physician who should get copies of your office visits:

Doctor: \_\_\_\_\_ Address: \_\_\_\_\_

Please list any family member that can receive information regarding your care:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

May we leave a voice mail regarding medical information on your phone? \_\_\_\_\_ Yes \_\_\_\_\_ No

**SYSTEM REVIEW**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Acct #: \_\_\_\_\_

Pain Scale (circle one)

0    1    2    3    4    5    6    7    8    9    10

No Pain ☺

Moderate Pain ☹

Worst Possible Pain ☹

**SYSTEMIC/HEENT**

If answered yes, please explain:

Y  N  Fatigue

\_\_\_\_\_

Y  N  Weight Gain/Weight Loss

\_\_\_\_\_

Y  N  Insomnia

\_\_\_\_\_

Y  N  Dry Eyes

\_\_\_\_\_

Y  N  Dry Mouth

\_\_\_\_\_

Y  N  Oral Ulcers

\_\_\_\_\_

**GI**

Y  N  Heartburn

\_\_\_\_\_

Y  N  Abdominal Pain

\_\_\_\_\_

Y  N  Constipation (frequent)

\_\_\_\_\_

Y  N  Diarrhea (frequent)

\_\_\_\_\_

Y  N  Rectal Bleeding

\_\_\_\_\_

**GU/GYN**

Y  N  Urinary Burning

\_\_\_\_\_

Y  N  Urinary Bleeding

\_\_\_\_\_

Y  N  Menstrual Irregularity

\_\_\_\_\_

Y  N  Menopause

\_\_\_\_\_

**CARDIOVASCULAR/PULMONARY**

Y  N  Edema (fluid retention)

\_\_\_\_\_

Y  N  Chest Pain

\_\_\_\_\_

Y  N  Palpitations

\_\_\_\_\_

Y  N  Shortness of Breath

\_\_\_\_\_

Y  N  Cough

\_\_\_\_\_

Y  N  Wheezing

\_\_\_\_\_

**NEUROLOGIC/PSYCIATRIC**

If answered yes, please explain:

Y  N  Numbness/Tingling/Burning Sensation

\_\_\_\_\_

Y  N  Poor Balance

\_\_\_\_\_

Y  N  Muscle Weakness

\_\_\_\_\_

Y  N  Frequent Headache

\_\_\_\_\_

Y  N  Anxiety

\_\_\_\_\_

Y  N  Depression

\_\_\_\_\_

**HEMATOLOGIC/ENDOCRINOLOGIC/DERMATOLOGY**

Y  N  Easily Bruises

\_\_\_\_\_

Y  N  Enlarged Lymph Nodes

\_\_\_\_\_

Y  N  Heat Intolerance

\_\_\_\_\_

Y  N  Cold Intolerance

\_\_\_\_\_

Y  N  Hair Loss

\_\_\_\_\_

Y  N  Rash

\_\_\_\_\_

**MS-SK**

Y  N  Joint Swelling

\_\_\_\_\_

Y  N  Joint Pain

\_\_\_\_\_

Y  N  Muscle Pain

\_\_\_\_\_

Y  N  Broken Bones

\_\_\_\_\_

Y  N  Neck/Back Pain

\_\_\_\_\_

**SOCIAL HISTORY**

# Alcoholic Beverages/week \_\_\_\_\_

# Cigarettes/Cigars (circle one)/day \_\_\_\_\_

Describe regular exercise program: \_\_\_\_\_

Sources of stress: \_\_\_\_\_

**PAST HISTORY**

List any hospitalizations, new diagnoses, doctor visits since last seen in our office: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



3160 Southgate Commerce Blvd., Ste. 30  
 Orlando, FL 32806-8557  
 Phone: (407) 859-4540  
 Fax: (407) 859-3815

**Health Information Portability and Accountability Act (HIPAA)**

**PLEASE PRINT CLEARLY**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Healthcare Surrogate/Emergency Contact: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

Preferred Lab: \_\_\_\_\_ LabCorp \_\_\_\_\_ Quest

In general, the HIPAA privacy rule gives individuals the right to request a restriction of their health information. The individual is also provided the right to request confidential communications or that a communication of PHI (Protected Health Information) be made by alternative means, such as sending information to the individual's office instead of their home.

**I wish to be contacted in the following manner (check all that apply):**

**Home telephone:**

Ok to leave message with details \_\_\_\_\_  
 Leave message with call back number \_\_\_\_\_  
 Authorized person to speak with: \_\_\_\_\_

**Cell phone:**

Ok to leave message with details \_\_\_\_\_  
 Leave message with call back number \_\_\_\_\_

**Written Communication:**

Ok to mail to my home \_\_\_\_\_

**Email:**

Ok to send email with details \_\_\_\_\_

**Work Telephone:**

Ok to leave message with details \_\_\_\_\_  
 Leave message with call back number \_\_\_\_\_

**I give Rheumatology Associates of Central Florida, PA, permission to use and disclose PHI necessary to carry out treatment or payment. By signing this form, I understand that the privacy practices of the office have been disclosed to me.**

\_\_\_\_\_  
 Patient or Parent/Guardian Signature

\_\_\_\_\_  
 Printed Name

\_\_\_\_\_  
 Date

## **FINANCIAL POLICY**

Welcome and thank you for choosing Rheumatology Associates of Central Florida for your medical care!

We are committed to providing you with the highest quality care and achieving desired outcomes through a collaborative effort with you, our patient.

It is important that you understand our financial policy but equally important that you understand the terms of your medical coverage. Although our staff is very knowledgeable about the various insurance plans with which we participate, you are in the best position to understand the detailed terms of your specific plan. Typically, your insurance carrier provides you with specific benefit questions or concerns you may have regarding your coverage.

Our professional fees have been determined through careful consideration of reasonable and customary charges within our geographical area. We are always happy to discuss with you any questions you may have concerning a bill.

### **Insurance**

Please remember that your insurance is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment for services from the insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization, referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect copayments, coinsurance, and deductibles, as outlined by your insurance carrier.

### **Uninsured Patients**

If you do not have medical insurance, we will extend cash pay rates to you. These rates are only if payment is made in full at the time of service.

### General

- Please be prepared to pay the current visit as well as any past due balance on your account at the time of service unless payment arrangements have been made with the billing department **prior** to your visit.
- If the patient is a minor, the parent(s) or legal guardian(s) are responsible for payments. In cases where a written court document allows payment for medical costs it is the accompanying parents' responsibility to obtain reimbursement from the other party involved.
- Social Security Numbers are a necessary part of your financial information with our office. This information, as with any of your medical records, is protected with strict confidentiality. We are extending a line of credit by filing insurance for your charges and not collecting in full at the time of service, therefore we must have this information. If you do not wish to provide your social security number, we will require payment in full at the time of service.
- Balances that remain outstanding more than 60 days after the date of service (or payment by your insurance carrier) will result in a disruption of immunotherapy services and the cancellation of upcoming appointments. The balance may also be considered for referral to an outside collection agency.
- Accounts referred to an outside collection agency or attorney may be subject to a collection fee, which will be added to the original balance.
- Patients with unpaid delinquent accounts or accounts that have been sent to an outside collection agency will be expected to pay their account in full prior to being seen for a non-emergent visit.
- A \$35.00 fee will be assessed for any returned checks, plus any bank fees. We will require all future payments by cash, cashier's check, or debit/credit card.
- A \$100.00 fee will be applied to new patient accounts for no shows and cancellations with less than 24 hour notice.
- A \$50.00 fee will be applied to established patient accounts for no shows and cancellations with less than 24 hour notice.
- A \$50.00 fee will be applied to infusions, x-rays, and DEXA scans for no shows and cancellations with less than 24 hour notice.
- Our office is not party to your divorce decree. The financial responsibility for minors rests with the parent who signs the financial policy.



3160 Southgate Commerce Blvd., Ste. 30  
Orlando, FL 32806-8557  
Phone: (407) 859-4540  
Fax: (407) 859-3815

**Form Completion and Fees**

We understand that there may be times when you need a form completed by your physician (i.e. medical leave, disability forms). We are willing to assist you with these requests. These forms require research and time on the part of the staff and physicians. The volume of requests and complexity involved, make it difficult to complete them at the time of your visit. We ask that you allow 7-10 business days for completion of these requests. Based on the amount of information requested, fees will be discussed prior to completion.

**Medical Records**

A medical records release form must be filled out for the release of any medical records. Records released to the patient can be provided for a fee of \$1.00 per page for the first 25 pages and .25 cents for each page thereafter.

**I HAVE READ AND AGREE TO ACCEPT THE FINANCIAL POLICY(S) AS WRITTEN:**

\_\_\_\_\_  
Patient or Parent/Guardian Signature

\_\_\_\_\_  
Date





3160 Southgate Commerce Blvd., Ste. 30  
 Orlando, FL 32806-8557  
 Phone: (407) 859-4540  
 Fax: (407) 859-3815

**PRIVACY POLICY**

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

At Rheumatology Associates of Central Florida, PA, we are required to keep your health information secure and confidential, by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We need to release some or all of your health information, when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to.

If our privacy and security measures or systems are breached in any way, we will notify you.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue SW, Room 509F, Washington, DC 20201), online ([www.hhs.gov](http://www.hhs.gov)) or by email ([OCRComplaint@hhs.gov](mailto:OCRComplaint@hhs.gov)). You will not be retaliated against for filing a complaint.

Please contact our Privacy Officer, Nancy Deler at (407) 859-4540 for more information. To make a request, to file a complaint with us or for assistance regarding your health information privacy.

Acknowledgement

I have received a copy of Rheumatology Associates of Central Florida, PA, Notice of Privacy Practices.

\_\_\_\_\_  
 Patient or Parent/Guardian Signature

\_\_\_\_\_  
 Printed Name

\_\_\_\_\_  
 Date



3160 Southgate Commerce Blvd., Ste. 30  
Orlando, FL 32806-8557  
Phone: (407) 859-4540  
Fax: (407) 859-3815

### AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Purpose/need for information:

- Application for Insurance       Changing Physicians       Personal
- Regarding Insurance Claim       Specialist

**Specific Documentation Required:**

- Office Notes
- Laboratory Reports
- X-ray Reports \_\_\_\_\_  
(Reports Only – no films, please. Specify if necessary.)

**Other:**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Information Requested From: MD or Medical Facility**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**Forward Documentation To:**

Rheumatology Associates of Central Florida  
3160 Southgate Commerce Blvd., Ste. 30  
Orlando, FL 32806  
Ph: (407) 859-4540 Fax: (407) 859-3815  
Dr. Freeman   Dr. Hasselbring   Dr. Summers  
Dr. Raturi      Dr. Fitch

This information, including diagnosis and records of any evaluation, examination and/or treatment rendered to me.

This request is authorized to include any Federal and/or State protected information under Florida Statutes 394.569(9) Psychiatric Information, 397.053/396.112 Drug and/or Alcohol Abuse Information, 381.609 HIV and AIDS related conditions and/or 397.504(3) records of a minor client.

I understand that this authorization will expire one (1) year from the date of signature below or when acted upon, whichever occurs first. I hereby release the forwarding addressee, its employees and appointed representatives from any and all liability that may arise from the release of information as I have directed. If any changes, please notify the front desk.

\_\_\_\_\_  
Patient or Parent/Guardian Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Relationship

**\*\*\*EFFECTIVE IMMEDIATELY!\*\*\***

**Appointment No Show – 24 Hour Notice Policy**

A patient will be considered a “no show” if he/she misses his/her scheduled appointment time or cancels with less than a 24 hour notice. When this occurs, *Rheumatology Associates of Central Florida* loses the opportunity to care for other patients who need to be seen. If a 24 hour notice is not received or a “no show” occurs, you will be charged a fee:

- \$50.00 for an ESTABLISHED patient
- \$100.00 for a NEW PATIENT appointment
- \$50.00 for an INFUSION, X-RAYS or DEXA SCAN appointment

This fee is not covered by insurance and is therefore the sole responsibility of the patient. Please be aware that confirmation calls are a *courtesy* and not the responsibility of the office.

I, (print name) \_\_\_\_\_, understand and acknowledge that *Rheumatology Associates of Central Florida* has a policy to charge me a \$50.00 or \$100.00 fee if I fail to come for my scheduled appointment. I agree:

- To pay this fee, when applicable
- That I understand I will be unable to reschedule until fee has been paid

\_\_\_\_\_  
Patient or Parent/Guardian Signature

\_\_\_\_\_  
Date

*Pamela G. Freeman, M.D.*  
*Caryn G. Hasselbring, M.D.*  
*Laura B. Summers, M.D.*  
*Stacy Fitch, M.D.*  
*Rita Raturi, M.D.*  
*Alicia Frisby, P.A.*