Rheumatology Associates
of Central Florida

New Patient Appointment

Checklist

- ☐ Insurance Cards
- ☐ Driver's License
- ☐ All Recent Lab work
- ☐ All Recent Xrays/ Dexa Scan
- ☐ Last 2 Office Visit Notes from your referring Doctor

All forms can be faxed **prior** to your appointment date at (407) 859-3719.

Thank you for choosing

Rheumatology Associates of Central Florida

3160 Southgate Commerce Blvd

Suite 30

Orlando, FL 32806

Tel: (407) 859-4540

Rheumatology Associates
of Central Florida

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

Please use only Black or Blue Ink! Thank you!

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 _____

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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

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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: _____

_____

_____

_____

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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 very knowledgeable about the various insurance plans with which we participate, you are in the best position to understand the detailed terms of your speci 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 alwa 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 t maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prom and accurate payment for services from the insurance carrier. We do expect patients to be interactive and responsible for communicating with your insuran 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 a information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. It is the patient responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessita patient payment for all charges. When insurance is involved, we are contractually obligated to collect copayments, coinsurance, and deductibles, as outlin 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 ha 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 f 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, 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 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 th 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 immunotherapy services and the cancellation of upcoming appointments. The balance may also be considered for referral to an outside collectic 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 fu 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/cred 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 hr 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.

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 yo 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 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 c 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 pe 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

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*****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.

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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

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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 of 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 no 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 to 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) or by email (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

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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:

Name: _____

Address: _____

_____

Ph: _____

Fax: _____

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