Marietta Rheumatology Associates, P.C.
Registration Information

Name: _____ Today's Date: _____

Address: _____ SSN: _____

_____ DOB: _____

Home Phone: _____ Cell Phone: _____

Marital Status: _____

Place of Employment: _____ Work Phone: _____

Email Address: _____

Primary Language: English – Spanish – Other Ethnicity: Hispanic - Not Hispanic

Race: Caucasian – African American – Hispanic – Asian – Other: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____ Relation: _____

Primary Care Physician Name: _____ Phone: _____

Referring Physician Name: _____ Phone: _____

Insurance Information:

Primary Insurance Company: _____

Name of Policyholder: _____ Policyholder DOB: _____

Relation to Policyholder: _____ Policyholder SSN: _____

Policyholder Employer Name: _____

Secondary Insurance Company: _____

Name of Policyholder: _____ Policyholder DOB: _____

Relation to Policyholder: _____ Policyholder SSN: _____

Policyholder Employer Name: _____

Assignment of Benefits/Consent for Treatment:

I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all charges not paid my insurance. I authorize this office to release all information necessary to secure payment. I hereby voluntarily consent to treatment at this office and authorize such treatment, examination, medications and diagnostic procedures including the use of lab and radiographic studies, as ordered by my physician.

_____ _____

Patient Signature Date

Marietta Rheumatology Associates, P.C. Office Policies

PAYMENT:

* **Payment is due in full at the time of service.** All co-pays, deductibles, and co-insurance are the patient's responsibility.
* We will file insurance only with the plans we are contracted with.
* If you are a self pay patient, you will be responsible for the full payment at the time of your visit.
* There will be a forty dollar ($40.00) service charge for any returned checks. This charge is not payable by your insurance plan. Once a check is returned, all further payments will be accepted only in cash or by credit card.

VISITS:

* A $25 no show fee will be charged for any missed appointment not canceled within *24 hours prior to the appointment.* Exceptions will be made for extraordinary circumstances such as hospitalizations.

REFERRALS:

* Many insurance companies require a referral in order to pay for your visit and procedures. **It is the patient's responsibility to obtain these documents.** If your insurance requires a referral and you did not obtain it you will not be seen. If your referral has expired and you have not obtained a new referral, you will not be seen, your visit will be rescheduled after you have obtained it.

DOCUMENTS:

* Disability and FLMA forms will not be filled out until you have been an established patient for six months or longer. There will be a charge for all disability/FLMA forms, letters needed and other such forms. This charge ranges from $25 - $100 depending on the length and complexity of the forms. This charge is not payable by your insurance company.
* Medical records shall not be released without a written, signed consent. There will be a charge for copying and mailing medical records directly to the patient. We follow the State of Georgia's fee schedule for all medical record fees. The final charge for medical records depends upon the number of pages that are copied. This charge is not payable by your insurance company. There is no charge for your medical records to be sent directly to another physician.

MEDICATIONS:

* We do not accept prescription refill via fax from your pharmacy. You or your pharmacy must call to request a medication refill. If you have missed and or canceled your last visit, it is at the Physicians discretion if he will approve refills without an office visit. You may be required to come in for an office visit before medication refills will be given. All controlled substances will ONLY be given at the time of your visit. **We do NOT accept refill request for controlled substances over the phone.**

By signing below, you indicate that you have received and read our office policies.

_____
Printed Name of Patient

_____ _____
Signature of Patient Date

MARIETTA RHEUMATOLOGY
ASSOCIATES, P.C.

670 North Avenue, Suite A
Marietta, GA 30060

Telephone (770)590-8328
Fax (770)590-8231

Mohammed Y. Abubaker, M.D. **Roel N. Querubin, M.D.**

Patient Name: _____ Date: _____

MEDICAL HISTORY FORM

Reason for visit _____ Duration of Symptoms _____

Name of Referring Physician _____ Telephone _____ Fax no. _____

Name of previous Rheumatologist _____ Last office visit (mo/year) _____

Current Medications (**include Dose, how often**) 1. 2.

3. 4. 5. 6.

7. 8. 9. 10.

Rheumatologic Diagnosis _____ Date of diagnosis (mo/year) _____

List all other previous Medical Conditions/Diagnosis (ex: Diabetes, hypertension, etc.) _____

_____

_____

Allergies (list medication and reaction) _____

Previous Surgeries/Hospitalizations (include date) _____

Family History of Rheumatologic Conditions _____

Family History of other Medical Conditions _____

Social History: Marital Status _____ Employment _____ Number of children _____

Previous Alcohol use? _____ Current Alcohol Use? _____ List amount weekly _____

Any History of Smoking? _____ How many years? _____ Number of Packs per week _____

IV/Recreational drug use? _____ Sexually Transmitted disease? ___ Type _____

Tested for HIV? _____ Date _____ Result _____ Previous Transfusion? _____ Date _____

Please place a mark (✓) on each line below to indicate your level of symptoms recently

Joint pain on an Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Joint swelling on an Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Joint warmth on an Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Joint redness on an Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Joint tenderness on an Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Joint stiffness when I awake in the mornings lasts how long on an average day?
None 0----|----|----|----|----|----|----|----|----|---- 60 Minutes or
None 0----|----|----|----|----|----|----|----|----|---- 12 Hours or
All day

Back/Neck pain on an Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Back/Neck tenderness on Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Back/Neck stiffness when I awake in the mornings lasts how long on an average day?
None 0----|----|----|----|----|----|----|----|----|---- 60 Minutes or
None 0----|----|----|----|----|----|----|----|----|---- 12 Hours or
All day

Difficulty Dressing, Bathing: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Difficulty with Housework: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe or Not Performed

Difficulty with Yardwork: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe or Not Performed

Difficulty with Job responsibilities: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe or Not Working

Difficulty Falling Asleep: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Difficulty Staying Asleep: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Sleep Average # of Hours per night: (Include the time falling asleep through the time getting out of bed the next day)
None 0----|----|----|----|----|----|----|----|----|----10 Hours

Fatigue on Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Depressed Mood on Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Circle/Complete the most appropriate response

Exercise performed: None, circuit training, exercise bike, jogging, pilates, swimming, walking, water therapy, weights, yoga. Other _____

Average number of days per week? 0 1 2 3 4 5 6 7 Days

How long on average day of exercise? 0 5 10 15 20 30 45 60 minutes

Currently Working: No Part Time Full Time

Circle all that apply: Have you experienced any of the following recently? **Describe**

Fever. Chills. _____

Skin rash. Nail changes. Hair loss. Bald patches on scalp. _____

Headache. Loss of consciousness. Numbness. Muscle weakness. _____

Eye Dryness. Eye Redness. Eye tearing. Visual changes / Loss of vision. _____

Shortness of Breath. Cough. Wheeze. _____

Blue/white/Purple Color changes of the fingers or Color changes of the toes. _____

Dry mouth . Sores in mouth. _____

Pain in chest. Difficulty in breathing at night while lying flat. Swollen legs or feet. _____

Nausea. Vomiting. Diarrhea. Abdominal pain. Blood in stools. _____

Previous medications mark (✓)

	Tried	Couldn't tolerate		Tried	Couldn't tolerate		Tried	Couldn't tolerate
Prednisone	☐	☐	Cortisone	☐	☐	Anaprox	☐	☐
Ansaid	☐	☐	Aspirin	☐	☐	Cataflam/voltaren	☐	☐
Clinoril/Sulindac	☐	☐	Daypro	☐	☐	Disalcid/salsalate	☐	☐
Feldene/pyroxicam	☐	☐	Ibuprofen/motrin	☐	☐	Indocin/indomethacin	☐	☐
Lodine	☐	☐	Meclomen/meclofen	☐	☐	Mobic / Meloxicam	☐	☐
Naproxen/naprosyn	☐	☐	Orudis / ketoprofen	☐	☐	Oruvail	☐	☐
Relafen	☐	☐	Tolectin/ tolmetin	☐	☐	Toradol	☐	☐
Bextra	☐	☐	Celebrex	☐	☐	Vioxx	☐	☐
Arava	☐	☐	Cytoxan	☐	☐	Enbrel	☐	☐
Humira	☐	☐	Imuran	☐	☐	Methotrexate	☐	☐
Orencia	☐	☐	Plaquenil	☐	☐	Remicade	☐	☐
Remicade	☐	☐	Rituxan	☐	☐	Sulfasalazine	☐	☐

List all other **Previous** Medications used for Rheumatologic symptoms

a. Muscle medications, Narcotic Pain medications _____

b. Antidepressants, Sleep medications _____

MARIETTA RHEUMATOLOGY ASSOCIATES, PC
670 NORTH AVENUE
SUITE A
MARIETTA GA 30060
PHONE 770 590-8328
FAX 770 590-8231

Patient Pharmacy Information

Patient Name: _____ DOB:_____

Pharmacy Information _____

Pharmacy Address _____

_____

Pharmacy Phone: _____

Please note, if you are unsure of any information, please provide at least the pharmacy name and phone number. Also if you change pharmacies, please let the office know as soon as possible. Thank you

Patient Signature: _____ Date:_____

Receipt of Notice of Privacy Practices
Written Acknowledgment Form

I, _____, have received a copy of Marietta Rheumatology's Notice of Privacy Practices.

_____ _____
Signature of Patient Date

Patient Authorization

Patient Name: _____ DOB:_____

Medical Information and /or Test Results can be Given to:

____No One Except Myself
____The Following Person(s):_____

_____

Medications/Prescriptions may be picked up by the following:_____

_____

Leave Detailed Messages? Yes or No

Regarding: _____Prescriptions _____Results _____Appointments

_____ _____
Signature Date

HIPAA Notice of Privacy Practices

Marietta Rheumatology Associates, P.C.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**