



Appointment Date/Fecha de su Cita: _____

Appointment Time/Hora de su Cita: _____

Welcome to Advanced Rheumatology of South Florida.

Attached are your new patient forms.

Please visit our website at **www.arheumatology.com**.

When you arrive for your first appointment, please bring the following with you:

- New patient forms
- Health Insurance card/s
- Picture/photo identification
- List of medications you are currently taking
- Any recent laboratory or radiology results
- Referral and/or authorization from insurance

Bienvenido a Advanced Rheumatology of South Florida.

Adjunto están las formas para pacientes nuevos.

Por favor visite nuestro sitio web **www.arheumatology.com**.

Cuando venga a su primera visita por favor traiga:

- Formas para paciente nuevo
- Tarjeta de seguro de salud
- Identificación con foto
- Lista de medicamentos que está tomando
- Resultado de laboratorio o radiología
- Referido de su seguro



Name: _____ Date: _____ Is this your first time visit to this office? Yes ___ No ___

Date of birth: _____ Sex: Female ___ Male ___ Age: _____

Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Race: American Indian ___ African American ___ Asian ___ White ___ Other ___

Ethnicity: Hispanic or Latino ___ Non-Hispanic or Latino ___ Other ___

Address: _____ Apt/ Suite#: _____

City: _____ State: _____ Zip Code: _____

Home Phone#: _____ Cell Phone#: _____ Work Phone#: _____

Email Address: _____

Patient Social Security#: _____ Driver's License #: _____

Occupation: _____ Retired/Retirement Date: _____

Employer Name & Address: _____

Spouse Name: _____ Date of birth: _____

Home Phone#: _____ Cell Phone#: _____ Work Phone# _____

Primary Care Physician: _____ Office Phone#: _____

Referring Physician: _____ Referred By: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone #: _____

Insurance Information

Do you have medical Insurance? Yes ___ No ___ More than one policy? Yes ___ No ___

Primary Insurance Name: _____ Secondary Insurance Name: _____

Policy Holder Name: _____ Policy Holder Name: _____

Policy Holder ID#: _____ Policy Holder ID#: _____

Assignment of Benefits and Release of Information

I authorize payment of medical benefits to the above named provider of professional services rendered and I also authorize the release of any medical information to process this claim.

Signature: _____

Date: _____

Patient/ Parent of minor

Past Medical History

Patient name: _____ Date: _____

Do you suffer from? If yes, mark where appropriate:

- ☐ Arthritis
- ☐ Asthma
- ☐ Gout
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Psoriasis
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid Disease
- ☐ Stroke
- ☐ Ulcerative Colitis/Crohn's
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Other: _____

Previous surgeries:

- ☐ Hysterectomy
- ☐ Appendix Removal
- ☐ Tonsils removed
- ☐ Gall Bladder Removed
- ☐ Knee Replacement
- ☐ Hip Replacement
- ☐ Cataracts
- ☐ Other: _____

Side: _____

Side: _____

Obstetrics:

Please list how many:

Pregnancies: _____ Births: _____ Miscarriages: _____

Please list all your medications:

Social History:

Smoking: ☐ Yes ☐ No

Drinking: ☐ Yes ☐ No

Drugs: ☐ Yes ☐ No

Allergies: _____

Hospitalizations:

Diseases that run in your family?

Review of Systems

Constitutional

- _Recent weight gain
- _Recent weight loss
- _Fatigue
- _Weakness
- _Fever
- _Night sweats

Eyes

- _Pain
- _Redness
- _Loss of vision
- _Double or blurred vision
- _Dryness

Ears-Nose-Mouth-Throat

- _Loss of hearing
- _Nosebleeds
- _Loss of smell
- _Sore tongue
- _Bleeding gums
- _Sores in mouth
- _Dryness of mouth
- _Frequent sore throat
- _Hoarseness
- _Difficulty swallowing

Cardiovascular

- _Chest pain
- _Irregular heart beat
- _Heart murmurs
- _Swollen legs or feet

Respiratory

- _Shortness of breath
- _Cough
- _Coughing of blood
- _Wheezing (asthma)

Gastrointestinal

- _Nausea
- _Vomiting of blood or coffee grounds
- _Stomach pain relieved by food or milk
- _Persistent diarrhea
- _Blood in stools
- _Black stool
- _Heartburn

Genitourinary

- _Difficult urination
- _Pain or burning upon urination
- _Blood in urine
- _Cloudy "smoky" urine
- _Discharge from penis/vagina
- _Frequent urination at night
- _Vaginal dryness
- _Rash

- _Sexual difficulties

- _Prostate trouble

Musculoskeletal

- _Morning stiffness
- Lasting how long? _____
- _Joint pain
- _Muscle Weakness
- _Muscle tenderness
- _Joint swelling

Integumentary

- _Easy bruising
- _Rash
- _Hives
- _Sun Sensitivity (sun allergy)
- _Tightness
- _Nodules/Bumps
- _Hair loss
- _Color changes of hand/feet in the cold

Neurological System

- _Headaches
- _Dizziness
- _Fainting
- _Muscle spasm
- _Loss of consciousness
- _Sensitivity/ pain of hand and/or feet
- _Memory loss

Psychiatric

- _Excessive worries
- _Anxiety
- _Easily losing temper
- _Depression
- _Agitation
- _Difficulty staying asleep
- _Difficulty falling asleep

Endocrine

- _Excessive thirst

Hematologic/Lymphatic

- _Swollen glands
- _Tender glands
- _Anemia
- _Bleeding Tendency
- _Transfusion, When? _____

Allergic/Immunologic

- _Frequent sneezing
- _Increased susceptibility to infection

Name: _____

Date: _____



Consent to Obtain External Prescription History

I, _____, authorize the provider and staff of Advanced Rheumatology of South Florida to view my external prescription history via the RxHub service.

I understand that prescription history from multiple unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by the providers and staff, and if may include prescription information back in time for several years.

MY SIGNATURE CERTIFES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

Consentimiento para Obtener Historia Externa de Medicamentos

Yo, _____, autorizo a los proveedores y personal de Advanced Rheumatology of South Florida a obtener mi historia de recetas/medicinas externas a través de los servicios de RxHub.

Entiendo que la historia de medicamentos proveniente de otros proveedores, compañías de seguro y farmacias puede ser vista por los proveedores y personal de esta oficina, y que puede incluir recetas/medicamentos de hace varios años atrás.

CON MI FIRMA ACEPTO QUE HE LEIDO Y ENTENDIDO LO QUE ESTA ESCRITO EN ESTE CONSENTIMIENTO Y AUTORIZO ACCESO A LA INFORMACION.

Patient Signature/Firma del paciente

Date/Fecha

Witness/Testigo

Date/Fecha

Arthrocentesis: Joint Injection/Aspiration Information and Consent

During my consultation with the provider, I may be required to have an arthrocentesis. This procedure may help in the evaluation of arthritic syndromes, as well as to relieve pain and improve joint function.

Procedure:

- a) Placing a needle into a joint and injecting medication, or/and
- b) Aspiration of fluid from the joint

Purpose:

- a) Pain relief
- b) Diagnostic evaluation of synovial fluid

Risks:

- a) Joint infection
- b) Bleeding, primarily in patients who are taking blood thinners
- c) Allergic reaction to the medication

This procedure will only be performed if the provider and I agree that it is necessary and/or beneficial. The procedure will be performed by the provider. With my signature I acknowledge that I have read and understood the above risks and benefits, and that this is not a commitment to accept the procedure either implicitly or explicitly. I will inform the provider and the staff of **any allergies to steroids, lidocaine, and chicken derivatives** before the procedure is performed. Finally, I understand that this procedure will not be offered to me without signing this form.

Artrocentesis: Información y Consentimiento para Inyección/Aspiración de Articulaciones

Durante mi consulta con el proveedor, puede ser necesario realizar una artrocentesis. Este procedimiento puede ayudar en la evaluación de problemas articulares, al tratamiento de los síntomas, y al mejoramiento de la función articular.

Procedimiento:

- c) Insertar una aguja en una articulación e inyectar medicamento, y/o
- d) Aspirar fluido de la articulación.

Propósito:

- c) Aliviar el dolor
- d) Evaluación diagnóstica del líquido sinovial.

Riesgos:

- d) Infección de la articulación
- e) Sangramiento, principalmente en pacientes que usan anticoagulantes.
- f) Reacción alérgica al medicamento.

El procedimiento se realizará solo si el proveedor y yo acordamos que es beneficioso o necesario. El procedimiento será ejecutado por el proveedor. Con mi firma acepto que he leído y entendido los beneficios y riesgos antes mencionados y que esto no constituye un compromiso para aceptar el procedimiento, implícita o explícitamente. Antes de que se realice el procedimiento, notificaré al proveedor y su personal si sufro de cualquier **alergia a la cortisona, lidocaína o derivados del pollo**. Finalmente, entiendo que este procedimiento no me será ofrecido si no he firmado este consentimiento.

Patient's name/Nombre del paciente: _____ **Date/Fecha:** _____

Patient's signature/Firma del paciente: _____



AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Records Needed: _____

Patient: _____ DOB: _____

I Authorize: _____

(Name of facility/person holding information)

(Street Address)

(City, State, Zip)

Phone: _____ Fax: _____

to release general medical information from my medical records as well as Psychiatric/Psychological information, alcohol and/or drug abuse information, Human Immunodeficiency Virus (HIV) test and other information pertaining to these tests or to treatment in connection with these test results to:

ADVANCED RHEUMATOLOGY OF SOUTH FLORIDA

3659 SOUTH MIAMI AVE. SUITE 3005

MIAMI, FL 33133

Fax: **866-756-8423** or **305-860-6590**

Patient signature: _____ Date: _____



OFFICE POLICIES

Welcome to Advanced Rheumatology of South Florida. Thank you for choosing us. We look forward to partnering with you to address your health concerns, and will do all we can to provide you the best medical care. In order to familiarize you with how our office works, we are providing this information which we hope you will find helpful.

OUR PROVIDERS

Our physicians and other providers are committed to deliver the highest level of care possible in a friendly, caring, and efficient environment. Our providers stay up to date on the latest scientific research for the diagnosis and treatment of rheumatic diseases. They provide 24/7 coverage for your medical needs.

APPOINTMENTS

In order to serve you most effectively, we see patients by appointments only. Please call 305-860-6260 to schedule your appointments. If you are unable to keep your appointment, we ask you to inform us at least 24 hours in advance so that we can make that time available for someone else. We urge you to be on time for your appointment. We will charge a \$50.00 administrative fee for patients who do not show up for their appointment or who do not notify us in advance as stated above. We will charge a \$100.00 administrative fee for patients who do not show up for their infusion appointment or who do not notify us in advance as stated above.

FORMS

There is a \$25.00 administrative fee for completion of any disability, FMLA or related paperwork.

TELEPHONE CALLS

Please call our office during our regular office hours with questions regarding your care, prescription refills or results of any source; as we do not have access to your records after regular office hours. All calls will be addressed within 24 hours except on weekends and Holidays. Medication refills will not be provided during weekends or Holidays.

AFTER HOURS SERVICE

For urgent medical questions after hours, please call the regular office number 305-860-6260 and our 24-hour answering service will contact the provider on call to return your call promptly. For all your non-urgent issues we urge you to call the office during regular hours, Mondays through Thursday from 8:00 AM to 5:00 PM, Fridays 8:00 AM to 4:00 PM. Office closes one hour for lunch at around noon.

Feel free to ask any staff member for help if you do not to understand any of the above policies.

I have read and understand the above office policies.

Signature: _____

Date: _____

Print Patient's Name: _____

DOB: _____



NOTICE OF PRIVACY NOTICES

This Notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

The privacy of your health information is important to us.

Our Legal Duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice has been revised in May, 2013 and will remain in effect until we replace it.

Uses and Disclosures of Health Information: We use and disclose health information about you for treatment, payment, and healthcare operations.

Examples:

- **For treatment:** We may use or disclose health information to a physician or other healthcare provider providing treatment to you.
- **For Payment:** We may use or disclose your health information to obtain payment for services we provided to you.
- **For Healthcare Operations:** We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, licensing or credentialing activities.

Your authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

To Your Family, Friends and Persons Involved in Care: We must disclose your health information to you, as described above. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare. We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general location, or death. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information.

Required By Law: We may use or disclose your health information when we are required to do so by law.

Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Court Orders and Subpoenas: We may disclose information in response to an appropriate court order or subpoena.

Law enforcement: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Threat to Health or Safety: We may use and disclose your health information when necessary to prevent a serious threat to your health and safety, or the health and safety to the public, or another person.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may disclose



your health information to the extent necessary to avert a serious threat to your health or safety, or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances, we may disclose to authorized Federal Officials health information required for lawful intelligence, counterintelligence, and other national security entities. We may disclose protected health information to correctional institutions or law enforcement official having lawful custody of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters). We may also contact you to provide information about treatment alternatives or other health-related information that may be of interest to you.

Patient Rights: You have the right to look or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the top of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time.

- **Right to Accounting of Disclosures:** You have the right to receive a list of instances in which us, or any of our business associates disclosed your health information for purposes other than treatment, payment, and healthcare operations.

All requests for an Accounting of Disclosures must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. If you request this accounting more than once in a 12-month we may charge you a reasonable fee for responding to these additional requests.

- **Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency)

Questions and Complaints: If you want more information about our privacy practices, or have questions or concerns, please do not hesitate to contact us.

If you are concerned that we have violated your privacy rights, or disagree with a decision made about accessing your health information, or in response to a request you made, you may file a complaint using the contact information in the top of this Notice, or by contacting The Office of Civil Rights, Department of Health and Human Services. All complaints are to be submitted in writing. You will not be penalized for filing a complaint.



I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Please indicate below if one or more of the following is an acceptable method to inform you of results, contact you, or if you would like to have your health information shared with anyone else besides yourself:

☐ OK to leave message in voicemail

☐ OK to release information to:

Name: _____ Phone: _____

Name: _____ Phone: _____

Primary Physician: _____ Referring Physician: _____

☐ Other: _____

☐ None of these methods are acceptable alternatives.

Patient Name: _____ DOB _____

Signature: _____ Date: _____

Email Address: _____

Visit our PATIENT PORTAL at: www.arheumatology.com