ARTHRITIS AND RHEUMATIC DISEASE ASSOCIATES, P.C.

PLEASE PRINT PATIENT INFORMATION

NAME_____TODAY'S DATE_____

AGE_____ DATE OF BIRTH_____ SS#_____

ADDRESS_____CITY_____ STATE_____ ZIP_____

HOME PHONE_____ BUSINESS PHONE_____ CELL PHONE_____

OCCUPATION_____

EMPLOYER_____ ADDRESS_____

NUMBER OF CHILDREN AND AGES_____

MARITAL STATUS: S M W D SEP SPOUSE'S NAME_____

SPOUSE'S EMPLOYER_____ADDRESS_____

OCCUPATION_____

PATIENT REFERRED BY_____ PHONE #_____

ADDRESS_____

PERSON RESPONSIBLE IF PATIENT IS A MINOR OR STUDENT:

NAME_____ ADDRESS_____

PHONE_____ OCCUPATION_____ SS#_____

EMPLOYER_____ BUSINESS PHONE_____

BUSINESS ADDRESS_____

PLEASE COMPLETE THE FOLLOWING INSURANCE INFORMATION. THIS INFORMATION IS NEEDED IN THE EVENT THE PATIENT WERE HOSPITALIZED. ALSO, PLEASE SIGN BACK OF THIS SHEET.

INSURANCE COMPANY_____

ADDRESS_____ PHONE_____

POLICY # OR I.D.#_____GROUP #_____CODE #_____

POLICYHOLDER'S NAME_____ SS#_____

POLICYHOLDER'S DOB_____ SIGNATURE_____

IN ORDER TO CONTROL OUR COSTS OF BILLING, WE REQUEST THAT OFFICE VISITS BE PAID AT THE TIME SERVICE IS RENDERED. WE WOULD RATHER CONTROL OUR BILLING COSTS THAN BE FORCED TO RAISE OUR FEES.

PATIENT'S AUTHORIZATION

I,_____, hereby authorize Neil I. Stahl, M.D. to apply for benefits on my behalf for covered services rendered by Neil I. Stahl, M.D. I request payment from _____ be made directly to Neil I. Stahl, M.D.

(INSURANCE COMPANY NAME)

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim. I permit a copy for this authorization to be used in place of the original.

This authorization may be revoked by either me or the above carrier at any time in writing. I am responsible for deductibles and co-pays not covered by my insurance.

_____ ____ _____
SIGNATURE OF SUBSCRIBER OR BENEFICIARY DATE

_____
IDENTIFICATION NUMBER

I, the undersigned, hereby acknowledge that I have requested the services of Neil I. Stahl, M.D. either for myself or for another person; and, further, each signatory states and understands that he is jointly and severally liable for the payment of all bills hereby incurred. I also agree to pay reasonable attorney fees should it become necessary for the filing of a civil suit to collect said bills.

There is a $30.00 charge for each returned check.

I will also be responsible for a collection agency fee of 30 percent for all balances remaining unpaid after 90 days, which will be charged to my account.

I will also be responsible for any missed appointments not cancelled at the rate of a Brief Office Visit.

_____ _____
SIGNATURE PATIENT, OR PARENT IF PATIENT IS A MINOR DATE

_____ _____
SPOUSE DATE

**********MANAGED CARE PATIENTS**********

***I understand that if I do not present a valid referral from my primary care physician at the time of service, that I will be responsible for the bill in the event that my claim is denied by my insurance company.

_____ _____
SIGNATURE OF PATIENT, OR PARENT IF PATIENT IS A MINOR DATE

AUTHORIZATION TO LEAVE MESSAGES

In an effort to protect our patients' rights to medical confidentiality, we will leave messages for patients only when they have given their permission. Please indicate your preference regarding the leaving of messages below.

I,_____, grant permission to a representative of Arthritis and Rheumatic Disease Associates, P.C., to do the following:

Leave a message on my answering machine/voice mail or with anyone in my household who answers the telephone.

YES	NO
_____	_____

Some reasons we might leave a message are to confirm the time and date of an appointment or to leave tests results.

If you do not want us to leave messages for you, please check NO above. A YES above indicates your consent.

Your signature below acts as your authorization.

_____ _____

Signature Date

_____

Print name

RESPONSIBILITY FOR PAYMENT OF SERVICES

I, _____, understand that my insurance company, _____, may determine as ineligible payment of certain covered services and may not provide coverage for other services rendered to me by Dr. Neil I. Stahl. Furthermore, I agree to be fully responsibility for the payment of these either noncovered or covered services that are determined to be ineligible for payment to the participating physician (i.e., Dr. Neil I. Stahl) under the terms of my insurance plan.

_____
Signature

_____
Date

Date	Service	Initials

MEMORANDUM

TO: All patients and pharmacy benefits plans

SUBJECT: Prescriptions and prescription refills

It has come to our attention that we are spending inordinate amounts of time filling and refilling prescriptions.

For patients: Please fill prescriptions that we write for you within a reasonable period of time either at a local pharmacy or by mail order. Do not hold these prescriptions and then try to get them filled just before you run out of a medication (especially for mail-order prescriptions). You may want to advise your pharmacy to NOT fax a request for a prescription for which you were given a written prescription. These faxes will be ignored by this office unless you specifically request that we respond to the fax. In that case you will be billed $25.00 for the time required to review your chart and fax in a prescription.

For pharmacy benefits plans: When we provide the patient with a correctly-written prescription, please do not fax us a form for the same prescription which we then have to fill out and sign again. This causes inefficiency and wastes the time of our staff and Dr. Stahl. Pharmacy benefits plans which persist in this activity will cause patients to be billed for this service, and since it will be construed to be a "non-covered" service, the patient will have to pay out of pocket ($25.00 charge).

Thank you,
Office Manager

_____
Patient's Signature of Receipt and Date

5-5-09

ARTHRITIS AND RHEUMATIC DISEASE ASSOCIATES, P.C.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ('HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures or my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do, then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

Attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

_____

Date: Initials: Reason:

_____

_

ARTHRITIS AND RHEUMATIC DISEASES ASSOCIATES, P.C.

MEDICAL HISTORY

NAME: _____

AGE: _____ SEX:_____ RACE: _____

CURRENT MEDICATIONS: DOSAGE:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

(Please list additional medications, if any, at bottom of page)

MEDICATION ALLERGIES: _____

PREVIOUS OPERATIONS (type & when performed):

_____

_____

_____

_____

PRESENT ILLNESSES: _____

_____

_____

_____

DO YOU SMOKE? YES _____ NO_____ IF YES, _____ PACKS/DAY X _____ YEARS

DO YOU DRINK ALCOHOL REGULARLY? YES _____ NO _____

IF YES, _____BEERS/DAY _____DRINKS/DAY

DATE OF LAST PHYSICAL EXAM: _____

ARTHRITIS AND RHEUMATIC DISEASE ASSOCIATES, P.C.

SYSTEMS REVIEW

NAME:_____

GENERAL: Weight Loss: _____ Weight Gain: _____ How Much and Over What Period of Time? _____ Persistent Fever _____ How high? _____

ARTICULAR: Morning Stiffness _____ Duration _____ Joint Pain _____ Which Joints? _____

SKIN: Rashes _____ Extreme Sun Sensitivity _____ Psoriasis _____ Hair Loss _____ Discoloration of Fingertips on Exposure to Cold_____

LYMPHATICS: Recurrent Swelling of Lymph Nodes _____ Location _____

RESPIRATORY: Recurrent Infections/Bronchitis _____ Pneumonia _____ Pleurisy _____ Cough _____ Other _____

CARDIOVASCULAR: Palpitations _____ Irregular Heart Beat _____Chest Pains _____ History of Mitral Valve Prolapse _____

GASTROINTESTINAL: Ulcers _____ Colitis _____ Recurrent Diarrhea _____ Cramps ____ Nausea _____ Vomiting _____ Heartburn _____ Trouble Swallowing _____

EYES & MOUTH: Chronic Dry Eyes _____Corneal Ulcerations _____ Chronic Dry Mouth _____ Mouth Ulcers _____ Bleeding Gums _____

NEURO: Weakness _____ Numbness in Extremities _____

SLEEP: Poor _____ Fair _____ Good _____ Frequent Awakenings_____

REVIEWED BY:_____, M.D

HEALTH ASSESSMENT QUESTIONNAIRE (mHAQ)

NAME _____ DATE _____

Please mark the one response which best describes your usual abilities over the past few days.

	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE To Do
1. Dress yourself, including tying shoelaces and doing buttons.	_____	_____	_____	_____
2. Get in and out of bed?	_____	_____	_____	_____
3. Lift a full cup or glass to your mouth?	_____	_____	_____	_____
4. Walk outdoors on flat ground?	_____	_____	_____	_____
5. Wash and dry your entire body?	_____	_____	_____	_____
6. Bend down and pick up clothing from the floor?	_____	_____	_____	_____
7. Turn regular faucets on and off?	_____	_____	_____	_____
8. Get in and out of the car?	_____	_____	_____	_____

SUBJECT ASSESSMENT OF PAIN & DISEASE ACTIVITY

PAIN: How much pain have you had because of your arthritis since the last time you filled out this form? Put a mark on the scale at the appropriate number to show how severe your pain has been.

NO PAIN _____PAIN AS BAD AS
0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100 IT COULD BE

DISEASE ACTIVITY**:** Considering all the ways arthritis affects you, put a mark on the scale at the appropriate number to show how well you are doing.

VERY WELL _____ VERY POORLY
0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

SKIN DISEASE ACTIVITY**:** (Psoriasis Patients Only) Put a mark on the scale at the appropriate number to show the activity of your SKIN disease only.

VERY WELL _____ VERY POORLY
0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100