

# NORTH HOUSTON RHEUMATOLOGY REGISTRATION FORM

**Please fill out the entire packet (Please Print)**

Today's Date(mm/dd/yyyy):		PCP or referring provider:	
<b>PATIENT INFORMATION</b>			
Patient's last name:		First:	Middle:
		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	
Preferred Language	Birth Date(mm/dd/yyyy):	Age:	Gender : M <input type="checkbox"/> F <input type="checkbox"/>
Street address:		Social Security #:	Contact Number:
Door/Apt.No:	City:	State:	Zip Code:
Employer:		Employer Phone Number:	
Preferred Pharmacy:	Pharmacy Address:	Pharmacy Phone Number:	
How did you hear about us ?	Referral	Friends & Family	Online      Others
<b>INSURANCE INFORMATION</b>			
<b>Please give your insurance card to the receptionist.</b>			
<b>IN CASE OF EMERGENCY</b>			
Name of local friend or relative/ Next of Kin:			
Relationship to patient:		Home Phone Number:	Cell Phone Number:
		(      )	(      )
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize North Houston Rheumatology Associates or insurance company to release any information required to process my claims.</p>			
_____		_____	
Patient/ Guardian Signature		Date(mm/dd/yyyy):	
Ethnicity: _____			
Race: _____			
E-Mail Address: _____			

Please Read this form and sign

**NOTICE OF PRIVACY PRACTICES**

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

**SUMMARY:**

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this notice.

We want to assure you that your medical/ protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

Effective date of this Notice	01/01/2016
Contact person	Homai Madisetty
Phone number	(281)319-4700

**Acknowledgement of Notice of Privacy Practices**

**“I hereby acknowledge that I have received a copy of this practice’s NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way.”**

\_\_\_\_\_  
Patient or Representative Name (PLEASE PRINT)

\_\_\_\_\_  
Patient or Representative Signature

Patient refused to sign  Patient was unable to sign because

\_\_\_\_\_  
Date(mm/dd/yyyy)

**NORTH HOUSTON RHEUMATOLOGY ASSOCIATES P.A.**

**CONSENT FORM**

Due to the new laws enacted by Congress, we are required to have signed this consent form prior to receiving treatment.

Do you consent to a medical examination and any procedures or tests deemed necessary by Dr. Prashanth Palwai and Dr. Rama Palwai, while you are in our office?

YES

NO

Do you consent to the staff releasing information about appointments and or test results to someone on your list?

YES

NO

Do you consent to the staff leaving messages on an answering machine or voice mail system, or receiving emails regarding appointments and/or test results?

YES

NO

Do you consent to receive automated calls and texts regarding appointments and service reviews?

YES

NO

**Please list the names of the person or persons to whom we can discuss medical information with:**

**NAME**

**RELATIONSHIP**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**If you wish this consent to be effective indefinitely or until you have revoked it please sign this form.**

**Signature:** \_\_\_\_\_ **Date(mm/dd/yyyy):** \_\_\_\_\_

**You may revoke this consent at any time. By revoking consent you will receive no further treatment from this office.**

# North Houston Rheumatology Associates

**KINGWOOD** 19701 Kingwood Dr. Bldg # 4 Ste A KINGWOOD, TEXAS 77339  
**THE WOODLANDS** 920 MEDICAL PLAZA DR., SUITE 350 THE WOODLANDS, TEXAS 77380  
**TOMBALL** 425 HOLDERRIETH ST, SUITE 108 TOMBALL, TEXAS 77375  
**PHONE:** 281-319-4700 **ANSWERING SERVICE:** 281-812-5639 **FAX:** 281-319-4702

## Patient Responsibility Consent Form

- \$25 Same day cancellation/No Show fee

As a provider's office we try to accommodate our patients as best as we can. Same day cancellations prevent us from scheduling other patients that may need to come in. As a courtesy, our office calls to confirm appointments the day before but appointments remain patient responsibility. We ask for at least a 24 hour notice when cancelling otherwise a \$25 same day cancellation/ no show fee will be accessed. **NO EXCEPTIONS.**

We also acknowledge there may be dates that the practice will be closed or physicians may be out of the office and we'll have to cancel patient appointments. For these circumstances we will make it a priority to cancel these appointments in a timely manner.

- Referrals

It is the **patients' responsibility** to know if their insurance requires a referral and to obtain the referral from their PCP (both for initial visit and follow up appointments). A referral through the insurance will be required if you have an HMO plan (or any other plan that requires referrals), meaning there must be an authorization number, approval dates and must be approved by the insurance company. A hand-written referral from PCP will not suffice. If the referral hasn't been received from the PCP's office at the time of your appointment, or you fail to bring one in with you, you will have to be rescheduled. This also applies to patients who are currently insured through PPO plans that may later switch to a HMO plan. **Please keep in mind that claims will be denied by insurance for no referral on file, resulting in patient being responsible for entire balance.**

- Outstanding Balance

Outstanding balances and office visit payments are due prior to seeing the doctor. We verify insurances before your office visits. This only includes co-payments and will not include Injections or other procedures done in office during your visit. These extra charges will be billed and it will be patient responsibility if insurance does pay/cover.

I, \_\_\_\_\_, understand and accept my responsibilities as a patient.  
(Print Name)

Patient Signature: \_\_\_\_\_ Date(mm/dd/yyyy): \_\_\_\_\_

# **Billing the Patient**

## **NORTH HOUSTON RHEUMATOLOGY ASSOCIATES**

**Initial: 6/1/2013**

**Revised:**

### **Purpose:**

This is a professional office that renders quality care to patients. Our duty is to preserve the dignity and confidentiality of our patients while receiving appropriate payment for the medical care we have provided. The following details this practice's policies and procedures regarding patient billing. This policy is intended to comply with the provisions of Texas Occupations Code Chapter 101.

### **Policy:**

#### **Office Visit**

Payment is expected at the time of service unless arrangements have been made prior to treatment.

The office will file insurance claims for services rendered, but patients are not relieved of responsibility for payment because they have insurance unless a contract prohibits billing the patient, such as a contract between this practice and a HMO.

Patients must pay co pays or deductibles before surgical procedures are performed and at the time that office services are rendered, absent an insurance carrier contract provision to the contrary.

Most HMO and PPO patients have copayments, deductibles, or coinsurance. Our practice is obligated to provide medically necessary services to patients as required by the standard of care set by the profession and contracts with insurance carriers. We also must be mindful that in many cases, we cannot bill the patient for amounts left unpaid by carriers when we have a contract with the patient's insurance carrier. This practice keeps its agreements and will not bill or charge patients when our contracts do not permit it.

Complaints related to billed charges shall be directed to the billing office for resolution.

#### **When Patients Are Billed**

This office will honor any request a patient makes to use an alternative billing address, but any patient making such a request must provide a suitable alternative for billing purposes.

After we receive payment from the insurance company, this office will reconcile the explanation of payment, and then bill the patient for the unpaid amount unless a contract with an insurance carrier prohibits it.

# Billing the Patient

Any claim denied due to patient ineligibility will be billed directly to the patient.

**Initial: 6/1/2013**

**Revised:**

Patients will be billed (when an insurance carrier contract does not prevent billing) when a claim is denied due to benefit limits, services are not covered, when there is a pre-existing condition or when there is still a patient responsibility balance on the account.

## **Mailing Statements**

Statements will be mailed every 45 days and will be:

- Consistent,
- Professional in appearance,
- An accurate reflection of all charges and payments

## **Past Due Accounts**

If the patient has not settled his or her account after the third statement ,We will send a letter to the patient stating that unless payment is received in 10 days, the practice will turn the account over to an outside collection agency.

At that point, we will turn any unpaid accounts over to a collection agency.

This practice DOES charge interest for amounts past due and left unpaid by a third-party payor.

This practice charges interest, a rate of 5.5% per annum is imposed on amounts commencing on the 60<sup>th</sup> day from and after the sum is due and payable.

I Acknowledge,

---

# North Houston Rheumatology Associates

## Patient History Form

Name: \_\_\_\_\_ Date of Birth(mm/dd/yyyy): \_\_\_\_\_

**MARITAL STATUS:**

Never Married     Married     Divorced     Separated     Widowed

Spouse/Significant Other:     Alive/Age \_\_\_     Deceased/Age \_\_\_\_\_ Major Illnesses \_\_\_\_\_

**EDUCATION** (circle highest level attended):

Grade School 7 8 9 10 11 12                      College 1 2 3 4                      Graduate School: \_\_\_\_\_

Occupation \_\_\_\_\_ Number of hours worked/average per week \_\_\_\_\_

Referred here by: (check one)     Self                       Family                       Friend                       Doctor                       Other Health Professional

Name of person making referral: \_\_\_\_\_

The name of the physician providing your primary medical care: \_\_\_\_\_

Do you have an orthopedic surgeon?  Yes  No If yes, Name: \_\_\_\_\_

Describe briefly your present symptoms: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date symptoms began (approximate): \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later)

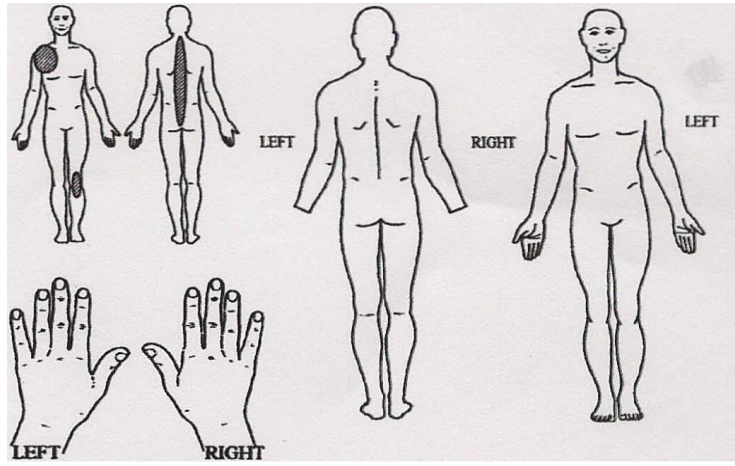
\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list the names of other practitioners you have seen for this problem:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please shade all the locations of your pain over the past week on the body figures and hands.

Example:



Adapted from CUNHAQ, Wollé F and PinaJS T. Current Comment- Uslening to the patient - A practical guide ID self report -onnaires in dinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

**RHEUMATOLOGIC (ARTHRITIS) HISTORY**

At any time have YOU or a blood relative had any of the following? (check if "yes")

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
<input type="checkbox"/>	Arthritis (unknown type)		<input type="checkbox"/>	Lupus or "SLE"	
<input type="checkbox"/>	Osteoarthritis		<input type="checkbox"/>	Rheumatoid Arthritis	
<input type="checkbox"/>	Gout		<input type="checkbox"/>	Ankylosing Spondylitis	
<input type="checkbox"/>	Childhood arthritis		<input type="checkbox"/>	Osteoporosis	

Other arthritis conditions: \_\_\_\_\_

Patients Name \_\_\_\_\_ Date(mm/dd/yyyy): \_\_\_\_\_ Physician Initials \_\_\_\_\_

## SYSTEMS REVIEW

As you review the following list, please check any of those problems, which have significantly affected you.

Date of last mammogram \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of last eye exam \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of last chest x-ray \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of last Tuberculosis Test \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of last bone densitometry \_\_\_\_/\_\_\_\_/\_\_\_\_

### Constitutional

- Recent weight gain  
Amount \_\_\_\_\_
- Recent weight loss  
Amount \_\_\_\_\_
- Fatigue
- Weakness
- Fever

### Eyes

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness
- Feels like something in eye
- Itching eyes

### Ears-Nose-Mouth- Throat

- Ringing in ears
- Loss of hearing
- Nosebleeds
- Loss of smell
- Dryness in nose
- Runny nose
- Sore tongue
- Bleeding gums
- Sores in mouth
- Loss of taste
- Dryness of mouth
- Frequent sore throats
- Hoarseness
- Difficulty in swallowing

### Cardiovascular

- Pain in chest
- Irregular heart beat
- Sudden changes in heart beat
- High blood pressure
- Heart murmurs

### Respiratory

- Shortness of breath
- Difficulty in breathing at night
- Swollen legs or feet
- Cough
- Coughing of blood
- Wheezing (asthma)

### Gastrointestinal

- Nausea
- Vomiting of blood or coffee ground  
Material
- Stomach pain relieved by food or milk
- Jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools
- Heartburn

### Genitourinary

- Difficult urination
- Pain or burning on urination
- Blood in urine
- Cloudy, "smoky" urine
- Pus in urine
- Discharge from penis/vagina
- Getting up at night to pass urine
- Vaginal dryness
- Rash/ulcers
- Sexual difficulties
- Prostate trouble

### *For Women Only:*

- Age when periods began: \_\_\_\_\_ -  
Periods regular?  Yes  No  
How many days apart? \_\_\_\_\_ -  
Date of last period? \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of last pap? \_\_\_\_/\_\_\_\_/\_\_\_\_  
Bleeding after menopause?  Yes  No  
Number of pregnancies? \_\_\_\_\_ -  
Number of miscarriages? \_\_\_\_\_ -

### Musculoskeletal

- Morning stiffness  
Lasting how long?  
\_\_\_\_\_ Minutes \_\_\_\_\_ Hours
- Joint pain
- Muscle weakness
- Muscle tenderness
- Joint swelling  
List joints affected in the last 6 mos.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Integumentary (skin and/or breast)

- Easy bruising
- Redness
- Rash
- Hives
- Sun sensitive (sun allergy)
- Tightness
- Nodules/bumps
- Hair loss
- Color changes of hands or feet in the cold

### Neurological System

- Headaches
- Dizziness
- Fainting
- Muscle spasm
- Loss of consciousness
- Sensitivity or pain of hands and/or feet
- Memory loss
- Night sweats

### Psychiatric

- Excessive worries
- Anxiety
- Easily losing temper
- Depression
- Agitation
- Difficulty falling asleep
- Difficulty staying asleep

### Endocrine

- Excessive thirst

### Hematologic/Lymphatic

- Swollen glands
- Tender glands
- Anemia
- Bleeding tendency
- Transfusion / when? \_\_\_\_\_

### Allergic/Immunologic

- Frequent sneezing
- Increased susceptibility to infection

Patient's Name \_\_\_\_\_

Date(mm/dd/yyyy): \_\_\_\_\_

Physician Initials \_\_\_\_\_

Patient History Form © 1999 American College of Rheumatology



**SOCIAL HISTORY**

Do you drink caffeinated beverages?  
 Cups/ glasses per day? \_\_\_\_\_  
 Do you smoke?  Yes  No  Past - How long ago? \_\_\_\_\_  
 Do you drink alcohol?  Yes  No Number per week \_\_\_\_\_  
 Has anyone ever told you to cut down on your drinking?  
 Yes  No  
 Do you use drugs for reasons that are not medical?  Yes  No  
 If yes, please list: \_\_\_\_\_  
 \_\_\_\_\_

Do you exercise regularly?  Yes  No  
 Type \_\_\_\_\_  
 Amount per week \_\_\_\_\_  
 How many hours of sleep do you get at night? \_\_\_\_\_  
 Do you get enough sleep at night?  Yes  No  
 Do you wake up feeling rested?  Yes  No

Previous Operations

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures?  No  Yes Describe: \_\_\_\_\_  
 Any other serious injuries?  No  Yes Describe: \_\_\_\_\_

**FAMILY HISTORY:**

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings: \_\_\_\_\_ Number living: \_\_\_\_\_ Number deceased : \_\_\_\_\_  
 Number of children Number living \_\_\_\_\_ Number deceased \_\_\_\_\_ List ages of each \_\_\_\_\_  
 Health of children: \_\_\_\_\_

Do you know of any blood relative who has or had: (check and give relationship)

Cancer \_\_\_\_\_  Heart disease \_\_\_\_\_  Rheumatic fever \_\_\_\_\_  Tuberculosis \_\_\_\_\_  
 Leukemia \_\_\_\_\_  High blood pressure \_\_\_\_\_  Epilepsy \_\_\_\_\_  Diabetes \_\_\_\_\_  
 Stroke \_\_\_\_\_  Bleeding tendency \_\_\_\_\_  Asthma \_\_\_\_\_  Goiter \_\_\_\_\_  
 Colitis \_\_\_\_\_  Alcoholism \_\_\_\_\_  Psoriasis \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date(mm/dd/yyyy): \_\_\_\_\_ Physician Initials \_\_\_\_\_

**PAST MEDICAL HISTORY**

Do you now or have you ever had: (check if "yes")  
 Cancer  Heart problems  Asthma  
 Goiter  Leukemia  Stroke  
 Cataracts  Diabetes  Epilepsy  
 Nervous breakdown  Stomach ulcers  Rheumatic fever  
 Bad headaches  Jaundice  Colitis  
 Kidney disease  Pneumonia  Psoriasis  
 Anemia  HIV/AIDS  High Blood Pressure  
 Emphysema  Glaucoma  Tuberculosis  
 Other significant illness (please list) \_\_\_\_\_

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

**MEDICATIONS**

Drug allergies:  No  Yes To What? \_\_\_\_\_

Type of reaction: \_\_\_\_\_

**PRESENT MEDICATIONS** (List any medications you are taking Include such items as aspirin vitamins laxatives calcium and other supplements etc)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped?		
			A Lot	Some	Not At All
1.			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3.			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5.			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7.			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8.			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9.			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10.			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**PAST MEDICATIONS** Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken.

Drug names   Dosage	
<b>Non-Steroidal Anti-inflammatory Drugs (NSAIDs)</b>	
<b>Circle any you have taken in the past</b>	
Ansaïd (flurbiprofen)      Arthrotec (diclofenac + misoprostil)      Aspirin Daypro (oxaprozin)      Disalcid (salsalate)      Dolobid      Feldene (piroxicam)      Indocin (indomethacin) Meclomen      Ibuprofen      Nalfon (fenoprofen)      Naprosyn      Oruvail (ketoprofen) Tolectin (tolmetin)      Trilisate (choline magnesium trisalicylate)      Vioxx      Voltaren (diclofenac)	
<b>Pain Relievers</b>	
Acetaminooohen (Tvlénol)	
Codeine (Vicodin, Tylenol 3)3)	
Proooxvohene  Darvon Darvocet)	
Other:	
<b>Disease Modifvina Antirheumatic Druas (DMARDS)</b>	
Hvdroxvchloroauine (Plauuenil)	
Penicillamine (Cunrirmine or Deoen\	
Methotrexate (Rheumatrex)	
Azathioprine (Imuran)	
Sulfasalazine (Azulfidine)	
Cvcloohosohamide (Cvtoxan\	
Etanercept (Enbrel)	
Infliximab (Remicade)	
Other:	

Patient's Name \_\_\_\_\_

Date(mm/dd/yyyy): \_\_\_\_\_

Physician Initials \_\_\_\_\_

