NORTH HOUSTON RHEUMATOLOGY REGISTRATION FORM

Please fill out the entire packet (Please Print)

Today's Date(mm/dd/yyyy):	PCP or referring provider:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs. ☐ Ms.
Preferred Language	Birth Date(mm/dd/yyyy):	Age:	Gender: M ☐ F ☐
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

INSURANCE INFORMATION

Please give your insurance card to the receptionist.

IN CASE OF EMERGENCY

Name of local friend or relative/ Next of Kin:

Relationship to patient: Home Phone Number: ( ) Cell Phone Number: ( )

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.

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

Contact person	01/01/2016
Phone number	Homai Madisetty
	(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 the doctor to use HIPAA compliant digital scribe at your visit to facilitate faster transcriptions of medical notes.

☐ YES ☐ NO

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

☐ YES ☐ NO

Please list the names of the people 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:**_____

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 19701KingwoodDr. 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 isa 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:

OfficeVisit

Paymentisexpectedatthe time of service unless arrangements have been made prior to treatment. The officewillfileinsurance claims for services rendered, but patients are not relieved of responsibilityforpayment because they have insurance unless a contract prohibits billing the patient, such asacontractbetween this practice and a HMO.

Patientsmustpaycopays or deductibles before surgical procedures are performed and at the time that officeservicesarerendered,absent an insurance carrier contract provision to the contrary.

Most HMOandPPOpatientshavecopayments, deductibles, or coinsurance. Our practice is obligatedtoprovidemedicallynecessary services to patients as required by the standard of care set by the professionandcontractswithinsurance carriers. We also must be mindful that in many cases, we cannotbillthepatientforamountsleft unpaid by carriers when we have a contract with the patient'sinsurancecarrier.Thispractice keeps its agreements and will not bill or charge patients when ourcontractsdonotpermitit.

Complaintsrelatedtobilledchargesshall be directed to the billing office for resolution.

When Patients Are Billed

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

After we receive payment fromtheinsurance company, this office will reconcile the explanation of payment, and then bill the patientforthe 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:

Patientswill be billed (when an insurance carrier contract does not prevent billing) when a claim is denieddue to benefit limits, services are not covered, when there is a pre-existing condition or when there isstill 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 notsettled 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 60th 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: o Never Married o Married o Divorced o Separated o Widowed

Spouse/Significant Other: oAlive/Age __ oDeceased/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) o Self o Family o Friend o Doctor o Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Do you have an orthopedic surgeon? o Yes o 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~~)

_____

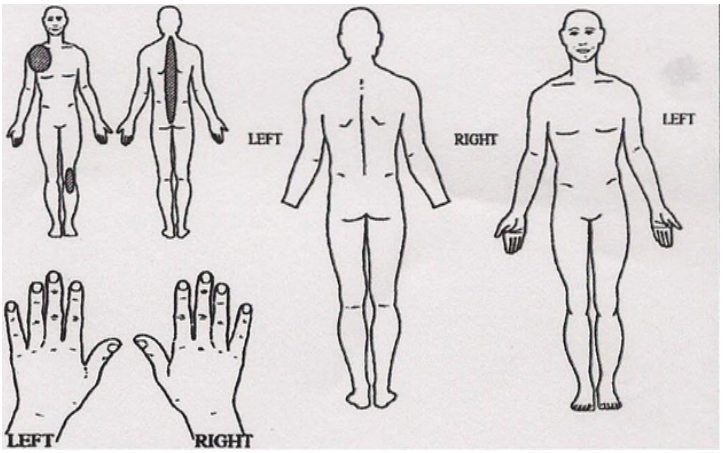
_____

_____

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, Wolle F and PinaJS T. CUrrent Comment- Uslening to the patient - A practical guide fD self report ~onnaires in dinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by pemission.

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
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	
Other arthritis conditions:					

Patients Name Date(mm/dd/yyyy): _____ Physician Initials_____

Patient History Form © 1999 American College of Rheumatology

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

oRecent weight gain

Amount _____

oRecent 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 Mater ial
- 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? 0 Yes 0 No

How many days apart? _____ _____ _

Date of last period? _____/____/_____

Date of last pap? _____/____/_____

Bleeding after menopause? 0 Yes 0 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
- Nod_u_le_s_/b_u_/m ps
- 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 _____

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SOCIAL HISTORY

Do you drink caffeinated beverages? Cups/ glasses per day? ____

Do you smoke? o Yes o No o Past - How long ago? _______________

Do you drink alcohol? o Yes o No Number per week _______________

Has anyone ever told you to cut down on your drinking?

o Yes o No

Do you use drugs for reasons that are not medical? o Yes o No

If yes, please list: _____________________________________

____

Do you exercise regularly? o Yes o No Type ____

Amount per week ____

How many hours of sleep do you get at night? ______________________

Do you get enough sleep at night? o Yes o No

Do you wake up feeling rested? o Yes o No

Previous Operations

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

Any previous fractures? o No o Yes Describe: ____

Any other serious injuries? o No o Yes Describe: ____

PAST MEDICAL HISTORY

Do you now or have you ever had: ***(check if "yes')***

o Cancer
o Goiter
o Cataracts
o Nervous breakdown
o Bad headaches
o Kidney disease
o Anemia
o Emphysema
o Heart problems
o Leukemia
o Diabetes
o Stomach ulcers
o Jaundice
o Pneumonia
o HIVIAIDS
o Glaucoma
o Asthma
o Stroke
o Epilepsy
o Rheumatic fever
o Colitis
o Psoriasis
o High Blood Pressure
o Tuberculosis

Other significant illness (please list) ______________________________

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

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)

o Cancer__________________
o Leukemia __________________
o Stroke ____________________
o Colitis ____________________
o Heart disease ______________
o High blood pressure ___________
o Bleeding tendency _____________
o Alcoholism __________________
o Rheumatic fever ____________
o Epilepsy___________________
o Asthma __________________
o Psoriasis _________________
o Tuberculosis _______________
o Diabetes __________________
o Goiter ____________________

Patient's Name__________________ Date(mm/dd/yyyy): _________________ Physician Initials ___________

Patient History Form © 1999 American College of Rheumatology

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.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐
			☐	☐	☐

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

Drug names l Dosage	
Non-Steroidal Anti-inflammatory Drugs (NSAIDs) — *Circle any you have taken in the past*	
☐ Ansaid (flurbiprofen) ☐ Arthrotec (diclofenac + misoprostil) ☐ Aspirin ☐ Celebrex	
☐ 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)	
Pain Relievers	
Acetaminoohen (Tvlenol)	
Codeine (Vicodin, Tylenol 3) 3)	
Proooxvohene lDarvonlDarvocet)	
Other:	
Disease Modifvina Antirheumatic Druas (DMARDS)	
Hvdroxvchloroauine (Plauuenil)	
Penicillamine (Cunrirnine or Deoen\	
Methotrexate (Rheumatrex)	
Azathioprine (lmuran)	
Sulfasalazine (Azulfidine)	
Cvcloohosohamide (Cvtoxan\	
Etanercept (Enbrel)	
Infliximab (Remicade)	
Other:	

Patient's Name

Date(mm/dd/yyyy): _____ _ Physician Initials _____

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NORTH HOUSTON RHEUMATOLOGY ASSOCIATES P.A

ADVANCED PRACTICE NURSE CONSENT FOR TREATMENT

Our clinics have on staff advanced practice nurses (NP) to assist in the delivery of medical care.

An advanced practice nurse is not a doctor. An advanced practice nurse is a registered nurse who has received advanced education and training in the provision of health care.

An advance practice nurse can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

I have read the above statement and hereby consent to the services of an advanced practice nurse for my health care needs.

I understand that at any time I can refuse to see the advanced practice nurse and request to see a physician.

Name: _____

Signature: _____

Date: _____