Notice to Patients

Your Appointment is scheduled on _____________ at __________.

****Please note: Payment is due at time of service****

Things you will need a the time of your appointment:

- All current insurance cards; including prescription cards.
- Drivers License
- Completed New Patient Packet
    - Must be completed in **BLACK** pen.
    - Bring completed packet to appointment. The receptionist will ask for it when you check in.
    - If the packet is not filled out, you must arrive 45 minutes prior to your appointment time to complete the packet. ***Not doing this could result in your appointment being rescheduled.***
- All medical records that would pertain to the reason why you are being seen.

Your first appointment usually lasts about an hour. At this appointment, your health history will be discussed in detail as well as the reason for the visit. There will also be a physical exam. Lab work and diagnostic imaging may be ordered at this time.

The second visit generally consists of a scanning ultrasound to aid in the diagnostic process.

The third visit is a comprehensive appointment. All available records, lab work, X-Rays, scanning images, etc. will be reviewed and discussed, as well as available treatment plan options.

Please plan to arrive 30 minutes early for your appointment.

We look forward to seeing you!

Note: Please be aware that we are not a pain management clinic. We do not guarantee pain medications. To learn more about this, you may visit our website at https://managearthritis.net

Signature:____ Date:____________________

Ananda Walaliyadda, MD, FACR, CCD, RMSK, RhMSUS
Diplomate of The American Board of Rheumatology

Pocatello Office
1448 East Center Street, STE E
Pocatello, Idaho 83201

Rigby Office
711 Rigby Lake Drive, STE 1400
Rigby, Idaho 83442

Ph: 208-234-1300 Fax: 208-234-1333
Website: http://managearthritis.net

Last Name ____________________________________First Name __________________________Middle Initial ______

Date of Birth___________________ Age ________Birth Place ____________________Social Security # ______________

Address____________________________________City____________________State_______________ZIP________

Home Phone # ________________________Cell Phone #_____________________

Email Address____

Employer____ Work Phone #__________________

Emergency Contact Name_____________________________ Relationship___________________Phone#____________

MARITAL STATUS: Single / Separated / Married / Life Partner / Divorced / Widowed

Race (please circle one) American Indian / Asian / African American / White (Caucasian) / Hispanic / Latino / Other

Preferred Language _______________________

Referring Physician____

Primary Care Physician____

Preferred Pharmacy____

Do you have an Advanced Directive (Living Will)? No _____ yes _____

Are you currently under HOSPICE CARE or receiving care at a Skilled Nursing Facility (SNF)? YES___NO___

INSURANCE INFORMATION:

Primary Insurance______________________________________ Policy Holders Name __________________________

Policy Holders Date Of Birth_______________________Sex________Employer__________________________

Policy#__________________________Group#__________________________

Secondary Insurance______________________________________ Policy Holders Name__________________________

Policy Holders Date Of Birth_______________________ Sex________ Employer__________________________

If there is any change in your personal information (ie. Marriage, divorce, change in address or phone number, etc.) you are responsible for notifying our office immediately **in writing** to update your records. Thank you.

Signature:_______________________________________ Date:____________________

Arthritis Specialty Center

CURRENT MEDICATIONS/VITAMINS/SUPPLIMENTS: (Use separate paper if needed)

Name of Medication	Dose/strength and quantity taken per day	How long taking medication	Has this helped? Please specify a lot, some, not at all

PAST TRIED AND FAILED MEDICATIONS (please circle all that apply):

Medication	Did this help?	Medication	Did this help?
Motrin/Ibuprofen		Humira (adalimumab) -Self Inject	
Celebrex/celoxib		Enbrel (etanercept) – Self Inject	
Mobic/Meloxicam		Simponi/SimponiAria (golimumab) – Self Inject / Infusion	
Aleve/Naproxen		Cimzia (certolizumab pegol) – Self inject / Provider Inject	
Indomethacin		Orencia (abatacept) – Self Inject / Infusion	
Tylenol/Acetaminophen		Actemra (tocilizumab) – Self Inject / Infusion	
Prednisone/Steroids		Remicade (infliximab) – Infusion	
Methotrexate/Rheumtrex		Rituxan (rituximab) – Infusion	
Sulfasalazine/Azulfidine		Benlysta (belimumab) – Infusion	
Arava/leflunomide		Gabapentin/Neurontin	
Imuran/Azathioprine			
Plaquenil/Hydroxychlorquine			
Colcrys/Cholchicine		Hyalgan / Synvisc (joint injections)	
Allopurinol		Kenalog / Depo-medrol (joint injections)	
Uloric			
Probenecid			

Signature:____ Date:_____________________

MEDICAL HISTORY (please circle all that apply):

Cancer (type) ____When diagnosed: ___________________________________

Psychiatric Problems (type) ____________________________Heart Problems (type):_______________________________

Fractures ____

Hyperthyroidism	Hypothyroidism	Hyperparathyroidism	High Blood Pressure
Cataracts	Diabetes	Headaches/Migraines	Arthritis-unknown type
Glaucoma	Anemia	Emphysema	Rheumatic Fever
Pneumonia	Tuberculosis	Stomach Ulcers	Rheumatoid Arthritis
HIV/AIDS	Asthma	Stroke	Ankylosing Spondylitis
Iritis	Gout	Psoriasis	Psoriatic Arthritis
Jaundice	Epilepsy	Lupus	Childhood Arthritis
Crohn's Disease	Scleroderma	Sjogren's Disease	Fibromyalgia
Goiter	Osteopenia	Osteoporosis	Osteoarthritis
Kidney Disease	Colitis	Depression	Hepatitis

Other ____

Natural or Alternative Therapies used (chiropractor, magnets, massage, acupuncture, meditation): _________________

____

ALLERGIES/INTOLERANCES:

Medication/Other	Type of Reaction

SURGICAL HISTORY:

Month/Year	Type of Surgery	Reason for Surgery

HOSPITILIZATIONS: Within the last year

Month/Year	Reason (include ER visits and admissions)

Signature:____ Date:_____________________

Arthritis Specialty Center

FAMILY HISTORY: (grandparents, parents, siblings, children)

Cancer (type) ____________________ Psychiatric Problems (type) _____________________________________

Heart Problems (type):______________________________ Fractures (Hip/Wrist)___________________________

Hyperthyroidism	Hypothyroidism	Hyperparathyroidism	High Blood Pressure
Cataracts	Diabetes	Headaches/Migraines	Arthritis-unknown type
Glaucoma	Anemia	Emphysema	Rheumatic Fever
Pneumonia	Tuberculosis	Stomach Ulcers	Rheumatoid Arthritis
HIV/AIDS	Asthma	Stroke	Ankylosing Spondylitis
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Crohn's Disease	Scleroderma	Sjogren's Disease	Fibromyalgia
Goiter	Osteopenia	Osteoporosis	Osteoarthritis
Kidney Disease	Colitis	Depression	

Other ____

SOCIAL HYSTORY:

EDUCATION (circle highest level attended): High School 9 10 11 12 College 1 2 3 4 Grad School____________

Occupation: ______________________________ Number of hours worked/per week (average): __________________

Do you smoke? yes / no / sometimes Are you interested in quitting? ______

Do you chew tobacco? yes / no / sometimes

Do you exercise? yes / no / sometimes

Do you sleep well at night? yes / no / sometimes

Do you wake up feeling rested? yes / no / sometimes

Do you drink caffeinated beverages? yes / no / sometimes If yes, how much per day? ____________

Do you drink alcohol? yes / no / sometimes If yes, what kind? ____________________ How often? _______________

Do you use drugs for reasons other than medical? Yes / no / sometimes If yes, please explain______________________

Please shade the areas where you experience pain

Briefly describe your present symptoms: ________________

____

____

Date (approximate) symptoms began: __________________

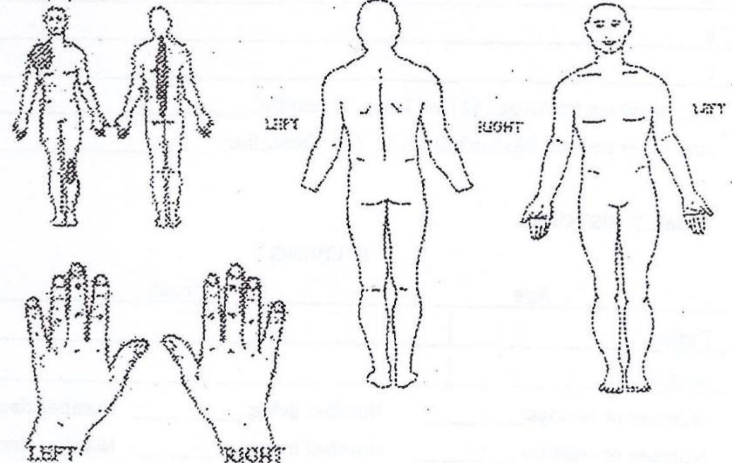
List any treatment for the symptoms

(physical therapy, surgery, injections): __________________

____

List any other practitioners you have seen for this problem:

____



Signature:_______________________________________ Date:____________________

Multi-Dimensional Health Assessment Questionnaire

Please place a check (✓) in the appropriate spot to indicate the amount of pain you are having today in each of the joint areas listed below:

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Left Fingers	☐ 0	☐ 1	☐ 2	☐ 3	Right Fingers	☐ 0	☐ 1	☐ 2	☐ 3
Left Wrist	☐ 0	☐ 1	☐ 2	☐ 3	Right Wrist	☐ 0	☐ 1	☐ 2	☐ 3
Left Elbow	☐ 0	☐ 1	☐ 2	☐ 3	Right Elbow	☐ 0	☐ 1	☐ 2	☐ 3
Left Shoulder	☐ 0	☐ 1	☐ 2	☐ 3	Right Shoulder	☐ 0	☐ 1	☐ 2	☐ 3
Left Hip	☐ 0	☐ 1	☐ 2	☐ 3	Right Hip	☐ 0	☐ 1	☐ 2	☐ 3
Left Knee	☐ 0	☐ 1	☐ 2	☐ 3	Right Knee	☐ 0	☐ 1	☐ 2	☐ 3
Left Ankle	☐ 0	☐ 1	☐ 2	☐ 3	Right Ankle	☐ 0	☐ 1	☐ 2	☐ 3
Left Toes	☐ 0	☐ 1	☐ 2	☐ 3	Right Toes	☐ 0	☐ 1	☐ 2	☐ 3
Neck	☐ 0	☐ 1	☐ 2	☐ 3	Back	☐ 0	☐ 1	☐ 2	☐ 3

***** Our office uses an automated system to remind you of your upcoming appointments and to also contact you in regards to your account and health information. *****

Preferred number to call for appointment reminders: ☐ Home ☐ Cell ☐ Work

Would you also like to receive a text message reminder? ☐ Yes ☐ No

Do you authorize personal health information to be left via voicemail or text? ☐ Yes ☐ No

Please provide the best phone number to receive direct communications via our office ________________

☐ **I authorize Arthritis Specialty Center to send me calls and/or texts for my upcoming appointments and to communicate about information on my account and my health information**.

FOR OFFICE USE ONLY

1. Kiosk Data (0-10):

1=0.3	16=5.3
2=0.7	17=5.7
3=1.0	18=6.0
4=1.3	19=6.3
5=1.7	20=6.7
6=2.0	21=7.0
7=2.3	22=7.3
8=2.7	23=7.7
9=3.0	24=8.0
10=3.3	25=8.3
11=3.7	26=8.7
12=4.0	27=9.0
13=4.3	28=9.3
14=4.7	29=9.7
15=5.0	30=10

2. PN (0-10):

3. PTGL (0-10):

RAPID 3 (0-30)

Cat:

HS = >12

MS = 6.1-12

LS = 3.1-6

R= ≤ 3

OFFICE USE ONLY

- ☐ Advance Directive (once a year) (≥65) NO____ YES____
- ☐ RA Disease Activity (every visit)
  (RAPID3 Score) Low (0-6) / Mod (6.1-12)/ Sev (>12)
- ☐ RA Glucocorticoid Management (every visit)
  No Glucocorticoid / <10mg / >10mg (documented)
- ☐ FALL Risk Assessment (once a calendar year) (≥ 65)
  Falls in the last year ______ Did injury occur? NO ____YES ____
- ☐ Medication reconciliation
- ☐ Height/Weight in vitals – If abnormal BMI, additional charting needed
  (BMI Normal Range ≥18.5 to <25 kg/m2)
- ☐ Tuberculosis Monitoring – If on TNF, additional charting needed

Provider Orders:____
____

BP	HR	TEMP	O2	WT	HT

Signature:____ Date:_____________________

AUTHORIZATION FOR DISCLOSURE OF PATIENT INFORMATION

Date of Request: ___________________________________

Patient's Name: _________________________________Date of Birth: _____________________* LAST 4 SSN___________

Address: _______________________________________ City/State/Zip ____

I authorize Arthritis Specialty Center to **RELEASE** or **OBTAIN** information from the following family members, individuals, or health care providers:

Please provide FIRST and LAST name:

1. Name ____ Phone ______________________ City_______________
2. Name ____ Phone ______________________ City_______________
3. Name ____ Phone ______________________ City_______________
4. Name ____ Phone ______________________ City_______________
5. Name ____ Phone ______________________ City_______________
6. Name ____ Phone ______________________ City_______________
7. Name ____ Phone ______________________ City_______________
8. Name ____ Phone ______________________ City_______________

***AUTHORIZATION VALID FOR:**

This request **and** any **future requests** until I am no longer a patient at Arthritis Specialty Center or I have revoked this request in writing. ____________ (initials).

I understand that:

- My right to healthcare treatment is not conditioned on this authorization
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- **The first copy of your records will be provided free of charge. A charge will be applied for each additional copy.**

Signature of patient: ____ Date: _____________

*YOU ARE ENTITLED TO A COPY OF THIS DOCUMENT *

Signature:____ Date:____________________

FINANCIAL RESPONSIBILITY POLICY

Your insurance policy is a contract between you and your insurance company, not our office. All fees are due at the time treatment is provided. As a courtesy, our office will bill your primary and secondary insurance. Your insurance may pay all or part of your financial obligation to Arthritis Specialty Center. However, you are responsible to see that all accounts are completely paid within 90 days. At 90 days, if the undersigned fails to pay the FULL AMOUNT for goods or services rendered, a reasonable collection fee will be assessed and the account will be turned over to a collection agency.

As our patient, you are responsible for all authorizations or referral's needed to seek treatment in this office.

It is very important for you to understand that it is impossible for our office to know what your particular insurance plan will cover, what it will allow, or what it will pay for services we render to you. Many times your insurance company will not provide this information until after we receive the Explanation of Benefits (EOB) from them. Therefore, by becoming a patient of Arthritis Specialty Center you assume complete and total responsibility for all charges.

- □ I understand and accept financial responsibility for payment of all accounts with Arthritis Specialty Center.

Signature of patient or responsible party____
Patient's Name (Printed) ____

CONSENT TO TREATMENT

I hereby give permission for the providers of Arthritis Specialty Center to examine and render medical treatment, and to provide to referring/consulting physician, insurance companies, their representatives, or my attorney, information they may require regarding my condition while under treatment. I also agree to follow ALL prescribed treatment. I authorize the release of any information required or acquired in the course of examination or treatment.

- □ I consent to treatment.

Signature of patient or responsible party____

PATIENT PRIVACY ACKNOWLEDGEMENT

Our practice is dedicated to maintaining the privacy of your Individually Identifiable Health Information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. If you would like to review our privacy practices in more detail please ask our staff. A copy is available in the waiting room. The Provider's Privacy contact Officer for Arthritis Specialty Center is Amanda Hernandez.

I hereby acknowledge that I have been presented this notice of Privacy Practices, and consent to treatment.

Signature of patient or responsible party____
Patient's Name (Printed) ____Date__________________

Signature:_____________________________________ Date:___________________