WELCOME TO OUR PRACTICE

www.arthritispa.com

Please arrive 30 minutes prior to your scheduled time with: *1)* your new patient paperwork filled out, and *2)* your test results pertaining to your New Patient visit. If you do not have your test results your appointment will be rescheduled.

INJECTIONS and/or INFUSIONS will not be administered on your first visit

Your appointment is scheduled for ______________ Time: __________ am / pm

Location: ________________________ Office.

For your first office visit please bring the following:

- All Insurance cards. If you cannot bring the original cards, please bring a copy of the front and back of all you medical cards, including your prescription card.
- Photo identification
- Referrals and co pay if required
- Medical records
- Federal regulation mandates that all copayments must be paid in full at the time of your visit. For your convenience we accept cash, checks, most major credit cards and debit cards. In addition, we offer Care Credit. Information on the Care Credit plan is included on our website: www.arthritispa.com along with directions to our office. If you are unable to keep this initial appointment, please give 48 hours cancellation notice to avoid being charged a cancellation fee of $100.00. If you have any questions please feel free to call us at 215-657-6776. We look forward to your visit and sincerely hope that we can help you.
- **Follow up appointment:**

Date: __________________________ Time: __________ am / pm

Location________________________________ Office

**** Currently we do not accept patients with Medicaid, Medical Assistance, workman's compensation claims or auto accident patients. If you have scheduled your appointment because of your case or have Medical Assistance Insurance, please call the office to cancel your appointments. ****

Specializing in Rheumatoid Arthritis, Osteoarthritis, Osteoporosis, Lupus, Lyme Disease

Main Office:
Willow Grove Office
2360 Maryland Road
Willow Grove, Pa 19090
Phone: 215-657-6776
Fax: 267-913-5961

Other Offices:
Jenkintown Office
Noble Plaza Bldg.
801 Old York Rd,
Suite 320
Jenkintown, Pa 19046
Phone: 215-657-6776
Fax: 267-913-5961

Doylestown Office
The Pavilion
599 West State Street,
Suite 310
Doylestown, Pa 18901
Phone: 267-893-6780
Fax: 267-913-5961

Newtown Office
One Summit Square,
Suite 101
1717 Langhorne-Newtown Rd.
Langhorne, PA 19047
Phone: 215-657-6776
Fax: 267-913-5961

Huntingdon Valley Office
727 Welsh Road,
Suite 201
Huntingdon Valley, PA
19006
Phone: 215-947-8701
Fax: 215-947-8704

v.8/02/21.1

Phone Number: 215-657-6776. Fax Number 267-913-5961.

NAME (LAST, FIRST, MIDDLE)	DOB	RACE	LANGUAGE	SEX
PHONE NUMBER	EMAIL		SOCIAL SECURITY NUMBER	
ADDRESS	CITY, STATE, ZIP		REFERRING PHYSICIAN	

PRIMARY EMPLOYER	PHONE NUMBER	SECONDARY EMPLOYER (IF APPLICABLE)	PHONE NUMBER
ADDRESS		ADDRESS	
CITY, STATE, ZIP		CITY, STATE, ZIP	

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN ABOVE)

NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP TO PATIENT	DOB	LANGUAGE	SEX
ADDRESS	CITY, STATE, ZIP		PHONE NUMBER	

PRIMARY INSURANCE COMPANY NAME		SECONDARY INSURANCE COMPANY NAME	
POLICY NUMBER	GROUP NUMBER	POLICY NUMBER	GROUP NUMBER
PHARMACY NAME		PHARMACY PHONE NUMBER	
PHARMACY ADDRESS			

I request that payment of any and all authorized insurance benefits be made either to me or on my behalf to Rheumatic Disease Associates, Ltd, for professional services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand that, as these services were performed for me or my legal dependent, I am financially responsible for all charges whether or not paid by insurance. Should my account be forwarded to collections, I understand and agree as the patient or my dependent that all legal and collection fees are my responsibility.

Signature of Patient/Guardian:____ Date:______________________

AUTHORIZATIONS. ALL PATIENTS

I authorize any holder of medical or other information about me to release this information to my insurance company, its intermediaries or carriers, to my attorney or another physician's office. I hereby authorize direct payment of medical and/or surgical benefits, to include major medical benefits to which I am entitled, Medicare, Private Insurance, and any other health plan to Rheumatic Disease Associates, LTD.I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing. I understand that, as these services were performed for me or my legal dependent, I am financially responsible for all charges whether or not paid by insurance.

Signature of Patient or Responsible Party:____ Date:______________________

MEDICARE PATIENTS

I request that payment of authorized Medicare/Medigap benefits be made to me or on my behalf to Rheumatic Disease Associates, LTD for any services furnished me by Rheumatic Disease Associates, LTD. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

Medicare Beneficiary Signature:____ Medicare Number:____________________________ Date:__________________

Patient History Form

Rheumatic Disease Associates, Ltd.

Patient Name: ______________________________ Date of Birth: ______________

Reason for today's visit:

____

____

Current medical conditions that other physicians treat you for:

____

____

Current prescriptions and vitamins, the dose and how often taken:

____

____

Past medications for arthritis or arthritis-related problems:

____

____

Past medical history such as surgeries and procedures and dates they were done:

____

____

Family health history (please only include parents and siblings):

____

____

Medication allergies and reaction you had to it:

____

____

NOTE: Please bring copies of all bloodwork results, Xrays, MRI's, bone scans and doctor's progress notes, even if your doctor states they will fax it, we do not always receive it.

Health Assessment Questionnaire Disability Index (HAQ-DI)©

Please select the response which best describes your abilities OVER THE PAST WEEK:

DRESSING & GROOMING **Are you able to:**	WITHOUT Difficulty	WITH SOME Difficulty	WITH MUCH Difficulty	UNABLE TO DO
Dress yourself, including shoelaces and buttons?	1	2	3	4
Shampoo your hair?	1	2	3	4

ARISING **Are you able to:**	WITHOUT Difficulty	WITH SOME Difficulty	WITH MUCH Difficulty	UNABLE TO DO
Stand up from a straight chair?	1	2	3	4
Get in and out of bed?	1	2	3	4

EATING **Are you able to:**	WITHOUT Difficulty	WITH SOME Difficulty	WITH MUCH Difficulty	UNABLE TO DO
Cut your own meat?	1	2	3	4
Lift a full cup or glass to your mouth?	1	2	3	4
Open a new milk carton?	1	2	3	4

WALKING **Are you able to:**	WITHOUT Difficulty	WITH SOME Difficulty	WITH MUCH Difficulty	UNABLE TO DO
Walk outdoors on flat ground?	1	2	3	4
Climb up five steps?	1	2	3	4

HYGIENE **Are you able to:**	WITHOUT Difficulty	WITH SOME Difficulty	WITH MUCH Difficulty	UNABLE TO DO
Wash and dry your body?	1	2	3	4
Take a tub bath?	1	2	3	4
Get on and off the toilet?	1	2	3	4

REACH **Are you able to:**	WITHOUT Difficulty	WITH SOME Difficulty	WITH MUCH Difficulty	UNABLE TO DO
Reach and get down a 5-pound object (such as a bag of sugar) from above your head?	1	2	3	4
Bend down to pick up clothing from the floor?	1	2	3	4

GRIP **Are you able to:**	WITHOUT Difficulty	WITH SOME Difficulty	WITH MUCH Difficulty	UNABLE TO DO
Open car doors?	1	2	3	4
Open previously opened jars?	1	2	3	4
Turn faucets on and off?	1	2	3	4

ACTIVITIES **Are you able to:**	WITHOUT Difficulty	WITH SOME Difficulty	WITH MUCH Difficulty	UNABLE TO DO
Run errands and shop?	1	2	3	4
Get in and out of a car?	1	2	3	4
Do chores such as vacuuming or yard work?	1	2	3	4

RHEUMATIC DISEASE ASSOCIATES, LTD.

RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I, ____________________________________, have received the Rheumatic Disease Associates
(print patient's name)

Notice of Privacy Practices. This form will become a part of my medical record.

Patient's signature: ____________________________________ Date received: ______________

Patient's Date of Birth: ________________________________

If received by another responsible party, please print name and relationship to patient:

____

Responsible Party's Signature: ____

****

Permission for release of patient's private health information

Rheumatic Disease Associates is permitted to release my Private Health Information to:

____ ______________________________

(Print name) (relationship)

By means of: (check all that apply)

______ phone ______ message on answering machine

______ copies of records ______ in person

And/or to:

____ ______________________________

(Print name) (relationship)

By means of: ______ phone ______ message on answering machine

______ copies of records ______ in person

Notice of Privacy Practices

Rheumatology Specialty Center
2360 Maryland Rd.,
Willow Grove, PA 19090
Phone: 215-657-6776
Effective Date: April 14, 2003
Revised Date: March 10, 2018

Your Information. Your Rights. Our Responsibilities.

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

1. **Ask for an electronic or paper copy of your health record**
   - You can ask to see or get an electronic or paper copy of your health record and other health information we have about you. Ask us how to do this.
   - We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
2. **Ask us to correct your health record**
   - You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
   - We may say "no" to your request, but we'll tell you why in writing within 60 days.
3. **Request confidential communications**
   - You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
   - We will say "yes" to all reasonable requests.
4. **Ask us to limit what we use or share**
   - You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
   - If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
5. **Get a list of those with whom we've shared information**
   - You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
   - We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
6. **Get a copy of this Privacy Notice**
   - You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.
7. **Choose someone to act for you**
   - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
   - We will make sure the person has this authority and can act for you before we take any action.
8. **File a complaint if you feel your rights are violated**
   - You can complain if you feel we have violated your rights by contacting us using the information at the end of this document.
   - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 877-696-6775, or visiting: www.hhs.gov/ocr/privacy/hippa/complaints/.
   - We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

1. **In the situations below, you have both the right and choice to tell us to:**
   - Share information with your family, close friends, or others involved in your care
   - Share information in a disaster relief situation
   - Include your information in a hospital directory

   If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
2. **In the situations below, we never share your information unless you give us written permission:**
   - Marketing purposes
   - Sale of your information
   - Most sharing of psychotherapy notes
3. **In the case of fundraising:**
   - We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

1. **Treat you**
   - We can use your health information and share it with other professionals who are treating you.

     Example: A doctor treating you for an injury asks another doctor about your overall health condition.
2. **Run our organization**
   - We can use and share your health information to run our practice, improve your care, and contact you when necessary.

     Example: We use health information about you to manage your treatment and services.
3. **Bill for your services**
   - We can use and share your health information to bill and get payment from health plans or other entities.

     Example: We give information about you to your health insurance plan so it will pay for your services.

How Else Can We Use or Share Your Health Information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

1. We can share health information about you for **certain situations** such as:
   - Preventing disease
   - Helping with product recalls
   - Reporting adverse reactions to medications
   - Reporting suspected abuse, neglect, or domestic violence
   - Preventing or reducing a serious threat to anyone's health or safety
2. **Do research**

   We can use or share your information for health research.

3. **Comply with the law**

   We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

4. We can share health information about you with **organ procurement organizations.**
5. We can share health information with a **coroner, medical examiner, or funeral director** when an individual dies.
6. Address **workers' compensation, law enforcement, and other government requests.**

   We can use or share health information about you:
   - For workers' compensation claims
   - For law enforcement purposes or with a law enforcement official
   - With health oversight agencies for activities authorized by law
   - For special government functions such as military, national security, and presidential protective services
7. We can share health information about you in response to a **court or administrative order, or in response to a subpoena.**

State-Specific Disclosure Restrictions

Pennsylvania Health Privacy Law

Except as required by law, we will not share any HIV-related information, mental health or substance abuse treatment records without your written permission.

Our Responsibilities

1. We are required by law to maintain the privacy and security of your protected health information.
2. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
3. We must follow the duties and privacy practices described in this Notice and give you a copy of it.
4. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

We can change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our web site.

Complaints

If you believe your privacy rights have been violated, contact our Practice Privacy Officer at:

Telephone Number: 215-657-6776

Privacy Complaint Email Address: tmcdevitt@arthritispa.com

Rheumatic Disease Associates, Ltd.
C. Michael Franklin, MD, FACP, FACR, RhMSUS
Charles Pritchard, MD, FACP, FACR, RhMSUS
David J Chesner, DO, FACR, FACOI
Elana R. Eisner, MD, FACP, FACR, RhMSUS
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Lawrence Leventhal, MD, FACP, FACR
Thomas A. Quinn, DO, MSH
Kevin Lu, MD
Anjali Bal, MD
Lori Walton, PA-C
Caroline Kearney, PA-C
Wendy Grace, MSN, CRNP
Jamie Lobbenberg, MSN, CRNP
Amanda Di Grazia, CRNP

Authorization for Release of Protected Health Information

Patient's Name: ______________________________ Date of Birth: ________________

Address: ________________________________ Phone:______________________

I, ______________________________________
Patient Signature
, authorize ____

to release my personal health information to____
(HealthCare Provider/Other)
Address: ____or Fax to:________________________

Dates of information to be disclosed: From ___________ to__________. *(If left blank, only information from the past two years will be disclosed.)*

Description of information to be released, including dates, if applicable:

____

I do not want the following information disclosed (as defined by applicable state and federal laws):
_________ Alcohol/Drug Abuse | _________HIV Test Results | ________Mental Health/Developmental Disabilities

Your rights with respect to this authorization: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures already made in reliance upon this authorization or needed for an insurer to contest a claim/policy as authorized by law if signing the authorization was a condition to obtaining insurance coverage.

Signature of patient/legal representative:______________________________ Date: ___/___/___

If signed by a person other than the patient, complete the following:
Individual is: ___ a minor; _____legally incompetent or incapacitated; _______deceased
Legal authority: _____parent; ____ guardian; ____next of kin/executor of deceased;___**activated** POA for health care.

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