

## **WELCOME TO OUR PRACTICE**

[www.arthritispa.com](http://www.arthritispa.com)

**Please email or fax copies of all blood work results, x-rays, MRIs, bone scans and doctor progress notes prior to your scheduled appointment. New patient paperwork should be brought with you to your first appointment.**

**Email: medrecsfax@arthritispa.com**

**Fax: 267-913-5961**

**For your first office visit please arrive 15 minutes prior to your scheduled time with the following:**

- New patient paperwork (filled out)
- All Insurance cards. If you cannot bring the original cards, please bring a copy of the front and back of all your medical cards, including your prescription card.
- Referrals and co pay if required
- Photo identification
- 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](http://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.

**New patient appointment:**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ am / pm

Location: \_\_\_\_\_ Office.

**Follow up appointment:**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ am / pm

Location: \_\_\_\_\_ Office.

**Please Note: \*INJECTIONS and/or INFUSIONS will not be administered on your first visit\***

**\*\* 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. \*\***

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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: 215-657-6776  
Fax: 267-913-5961



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

NAME (LAST, FIRST, MIDDLE)		DOB	RACE	LANGUAGE	SEX
PHONE NUMBER	ALT. PHONE NUMBER	EMAIL		PRIMARY PHYSICIAN	
ADDRESS		CITY, STATE, ZIP		REFERRING PHYSICIAN	
PRIMARY EMPLOYER		EMPLOYER PHONE NUMBER	SECONDARY EMPLOYER (IF APPLICABLE)	EMPLOYER 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: \_\_\_\_\_

Rheumatic Disease Associates, Ltd.

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Reason for today's visit:

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Current medical conditions that other physicians treat you for:

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

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Past medications for arthritis or arthritis-related problems:

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

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

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Medication allergies and reaction you had to it:

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**NOTE: Please email or fax copies of all blood work results, x-rays, MRIs, bone scans and doctor progress notes prior to your scheduled appointment. Thank you.**

**Email: medrecsfax@arthritispa.com**

**Fax: 267-913-5961**

# Health Assessment Questionnaire Disability Index (HAQ-DI)©

**NAME:**

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

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

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

<u>EATING</u>	WITHOUT Difficulty	WITH SOME Difficulty	WITH MUCH Difficulty	UNABLE TO DO
Are you able to: 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

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

<u>HYGIENE</u>	WITHOUT Difficulty	WITH SOME Difficulty	WITH MUCH Difficulty	UNABLE TO DO
Are you able to: 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

<u>REACH</u>	WITHOUT Difficulty	WITH SOME Difficulty	WITH MUCH Difficulty	UNABLE TO DO
Are you able to: 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

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

<u>ACTIVITIES</u>	WITHOUT Difficulty	WITH SOME Difficulty	WITH MUCH Difficulty	UNABLE TO DO
Are you able to: 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: \_\_\_\_\_

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**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/](http://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.

## Notice of Privacy Practices

### 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](mailto:tmcdevitt@arthritispa.com)**



**Rheumatic Disease Associates, Ltd.**

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Anjali Bal, MD  
Lori Walton, PA-C  
Caroline Kearney, PA-C  
Shilo Dorley, PA-C  
Amanda Di Grazia, MSN, CRNP

**Authorization for Release of Protected Health Information**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

I, \_\_\_\_\_ authorize \_\_\_\_\_  
(Print Name) (HealthCare Provider/Other)

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 healthcare

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