Low County Rheumatology

A MEMBER OF Articularis HEALTHCARE

Phone (843) 572-4840 Fax (843) 606-9399
New Patient Dept. Phone (843) 572-4852

Gary E. Fink, M.D.
Gregory W. Niemer, M.D.
Alan N. Brown, M.D.
Colin C. Edgerton, M.D.
William M. Edwards, M.D.
Clarence W. Legerton III, M.D.
Jennifer K. Murphy, M.D.
Nicholas Holdgate, MD

We are looking forward to seeing you on, _____ with Dr._____

at our **North Charleston** location.

Welcome to our practice!

Our staff would like to take this opportunity to welcome you to our practice. We are delighted that you have chosen us for your medical needs. At Articularis Healthcare, we take great pride in the relationships that we have established with our patients and the ability to give a personalized approach to difficult problems.

As a patient of the Articularis Healthcare Group, Inc., we appreciate you following the guidelines of the practice which helps us maintain our goals.

Please arrive 15 minutes before your schedule appointment time with the completed paperwork to allow for the registration process. Please do not mail paperwork.

- There is a $25 no-show and cancellation fee for all appointments not kept or not cancelled within
- 72 hours prior to your appointment date unless there is some type of emergency. A credit/debit card number is required at the time of scheduling to secure all new patient appointments.
- Cash payments, deductibles and co-payments must be paid at the time of service. Payments for medical services not covered by insurance plans are the patient's responsibility.
- We do not accept Medicaid as a secondary insurance.
- Self-Pay patients are required to bring $250 to their initial visit. Additional financial assistance is available.
- Our Prescription Refill Policy is as follows: Please request refills at your visit. If you call in for refills, they will be called in between the hours of I0am-6pm. Please have the pharmacy name and number on hand when you call. Controlled substances will not be called in or filled after hours. A 24 hour advanced notice is required for all written prescriptions. All patient phone calls or request will be addressed by a nurse within 24 hours.
- Our Lab Results Policy is as follows: Please do not call asking to discuss lab results. Your doctor/staff will call only if labs are at critical values. Otherwise, any labs will be discussed at the next appointment. Additionally, if registered, your lab results will be available to view on the patient portal once they have been processed.

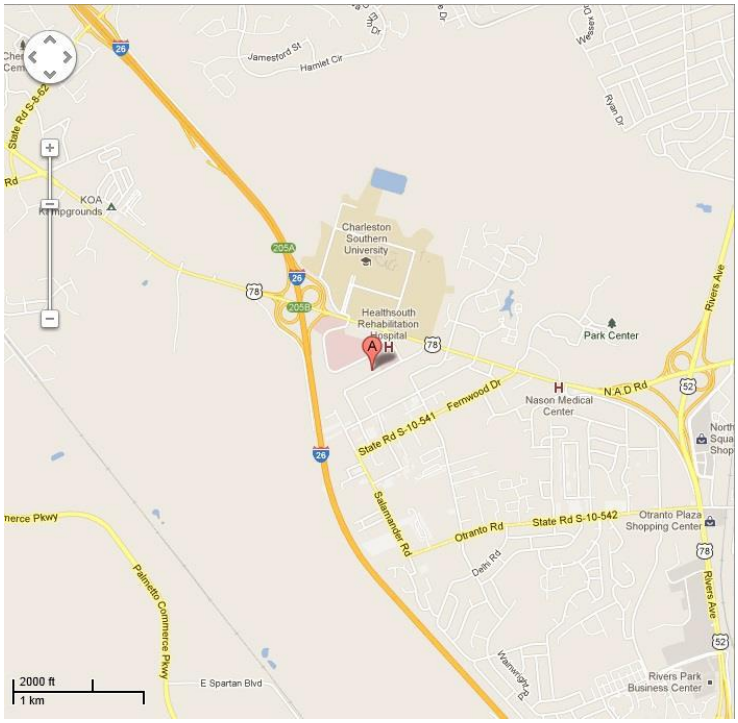
Please bring attached forms, your photo ID and insurance cards to your visit.

Please be aware that if you arrive over 15 minutes late to your appointment you will be asked to reschedule

Please see reverse side

Directions to the North Charleston Office

2860 Tricom Street, North Charleston, SC 29406



From Mount Pleasant/Downtown-Take I-526 to I-26 West to North Charleston exit 205-B to Highway 78 (University Blvd.) Turn right on Tricom Street. It will be the second traffic light after taking the exit. Low Country Rheumatology will be on the right.

From Summerville – Take I-26 toward Charleston. Exit 205-B to Highway 78 (University Blvd.) Turn right on Tricom Street. It will be the second traffic light after taking the exit. Low Country Rheumatology will be on the right.

From Moncks Corner – Take U.S. 52 East. Take the exit toward Highway 78/Charleston Southern University/I-26. Turn left onto Tricom Street. Low Country Rheumatology will be on the right.

Articularis Healthcare Group, Inc
Patient Information

Last Name	**First Name**	**Middle Initial**
Street Address	**Apt/Lot #**	
City	**State**	**Zip**
SSN#	**D.O.B.**	**Circle One** **Mr. Mrs. Ms. Dr.**
Home Phone #	**Alt. Phone #**	
Email	**Employment** **Full-time Part-time Retired Disabled**	
Sex **M F**	**Marital Status** **S M W D**	**Student** **Yes No Full-Time Part-Time**
Referring Physician	**Phone #**	
Primary Care Physician	**Phone #**	
Spouse	**Phone #**	
Emergency Contact	**Phone #**	
Primary Insurance Name		
Policy Holder Name	**D.O.B.**	
Policy #	**Group#**	**Group Name**
Secondary Insurance Name		
Policy Holder Name	**D.O.B.**	
Policy #	**Group#**	**Group Name**

Consent for Treatment, Payment, and Acknowledgement of Receipt of Notice of Privacy Practices: I request that payment under the medical insurance program be made payable to Articularis Healthcare Group, Inc. for services rendered. I understand that I am financially responsible for all charges incurred at Articularis Healthcare Group, Inc. I authorize disclosure of my personal health information to carry out treatment, payment, or health care procedures. I have received the privacy policy and Notice of Information Practices that provides a more complete description of information uses and disclosures. I agree to pay any and all charges that exceed or not paid/covered by my insurance. In the event my account is turned over to a collection agency, I will be billed the additional collection fees.

Patient/ Guardian:_____ Date: _____

Signature

HEALTH QUESTIONNAIRE

Patient Name: _____Date of Birth: _____

Reason for visit: _____

Preferred Pharmacy: _____ Address:_____

City: _____Zip: _____

Current medications: Please list **Name** and **Strength**

1 _____/_____mg
2 _____/_____mg
3 _____/_____mg
4 _____/_____mg
5 _____/_____mg
6 _____/_____mg
7 _____/_____mg
8_____/_____mg
9_____/_____mg
10_____/_____mg
11_____/_____mg
12_____/_____mg
13_____/_____mg
14_____/_____mg

Medications you have **tried in the past** for your arthritis condition.

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____

Allergies: _____

Prior surgeries: _____

Past medical history: Please list any other diseases or illnesses you have now or have had previously.

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____

Have you ever smoked cigarettes or tobacco in other forms? YES or NO. If yes, when you were smoking your heaviest, how many packs per day did you smoke on average: _____ pack(s). What year did you start smoking? _____. If you subsequently quit, what year did you quit? _____.

Do you drink alcohol? YES NO If yes, BEER WINE LIQUOR On average, how many drinks per week? _____.

What other physicians care for you; now or in the past?

1 _____
2_____
3_____
4_____

Is there a history of arthritis or rheumatic disease in your family? Please indicate Father, Mother, or Grandparent.

Rheumatoid Arthritis_____ Gout_____

Lupus_____ Psoriasis_____

Other_____

Is your arthritis problem a result of an accident or trauma? YES NO

* We **DO NOT** provide care for problems related to accidents for which there is ongoing litigation for Workman's Compensations. Notify the office if you are unclear about your case.

*** Disability forms will NOT be completed until you have received six months of established care from our practice.**

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Authorization to Release/Obtain Medical Records

Patient Name:_____DOB: _____

Previous Name (if applicable): _____SSN: _____

* ***This authorization expires ONE year from the date of signature****

Method of disclosure:

☐ I authorize Articularis Healthcare to **release** my medical records to:

Name: _____

Fax #: _____

☐ I authorize Articularis Healthcare to **obtain** my medical records from:

Name: _____

Fax #: _____

Health Information to disclose:

☐ ALL health information

☐ Healthcare information relating to the following:

Treatment, Condition, or Dates: _____

I understand I have the right to refuse to sign this form, and that I may revoke my authorization at any time (except to the extent that the information has already been released). When my information is disclosed, the federal HIPAA Privacy Rule may no longer protect it. This authorization will automatically expire one (1) year from the date of this request or on the following requested date:

Patient Signature:_____Date:_____

Witness Signature:_____Date:_____

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Medical Information Release Form (HIPAA Release Form)

I understand that Articularis Healthcare Group, Inc. maintains my personal records, medical history, symptoms, examinations, and test results as a part of my healthcare. This information is not to be given to any other person without my permission. Therefore, this is a written consent to authorize release of my medical information.

RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records, laboratory values, prescribed medications, treatment plan, examination rendered, and claims information. This information may be released to:

- ☐ Spouse:_____
- ☐ Child(ren):_____
- ☐ Other:_____
- ☐ Check if okay to leave detailed health information on voicemail
- ☐ Information is **NOT** to be released to anyone

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Articularis Healthcare Group, Inc.
Patient Scheduling Policy

We are committed to providing our patients with the best possible medical care while also minimizing administrative costs. This scheduling policy has been established with these objectives in min to avoid any misunderstanding or disagreement concerning payment for professional services.

New Patients

- Due to an increased number of no-shows and cancellation of New Patient appointments, we are now charging a $25 fee for all appointments that have not been cancelled 72 hours prior to the scheduled appointment date. A payment of $25 will be required to schedule and secure all New Patient appointments. This payment will be taken over the phone when scheduling the appointment and can be applied to your account for usage of a co-payment upon check-out.
- If you care unable to keep your appointment, kindly call our office at least 72 hours prior to your appointment time. We will work with you to reschedule you to a more convenient time. The $25 fee will be applied and charged to all appointments cancelled and NOT rescheduled 72 hours prior to the appointment date. If you fail to cancel your appointment within 72 hours, your $25 deposit will be forfeited.
- Cash Payments and co-payments must be paid at the time of service. If requested, the $25 deposit can be applied to your account for usage of a co-payment upon check-out.
- We do NOT accept Medicaid as a secondary insurance. If Medicaid is secondary, you will be required to sign an agreement understanding that Medicaid will not be accepted.
- Self-pay patients are required to bring a payment in the amount of $250 to their initial visit, which will be collected prior to being seen by the physician. Additional financial assistance is available.
- A physician will review the medical records of all Medicaid and self-referral patients before being scheduled.

Follow-up Appointments

- Established patients with a balance greater than $100 must clear the outstanding balance with the billing department before scheduling any future appointments. Payment plans can be arranged if necessary.
- Any patient who no-shows or cancels 2 appointments without giving a 72-hour notice cannot be rescheduled without a $50 deposit by credit card.
- If a patient cancels or no-shows 3 times in a calendar year, they will be discharged from the practice.
- It is the patient's responsibility to keep up with their appointment times. We send automated calls as a courtesy.
- It is the patient's responsibility to obtain any referral needed for a Medicaid/Tricare Prime insurance for their office visit. If a patient shows up for their office visit without an updated referral, they can pay a $25 fee for our office to obtain the referral or reschedule after they receive the referral

Our practice firmly believes that a good physician-patient relationship is based upon understands and good communications. Questions about financial arrangement should be directed to the medical practice. We are here to help you

Patient/Guardian Signature: _____

Date: _____

Articularis Healthcare Group, Inc.
Patient Financial Policy

We are committed to providing our patients with the best possible medical care and minimizing administrative costs. This financial policy has been established with these objectives in mind and avoid any misunderstanding disagreement concerning payment for professional services.

- As the owner of your insurance policy, you are solely responsible for the policies regarding your plan.
- Our practice participates with numerous insurance companies. For patients who are beneficiaries of one of these insurance companies, our billing office will submit a claim for services rendered. All necessary insurance information, including any forms, must be completed by the patient prior to leaving the office.
- If a patient has insurance in which we do not participate, our office is happy to file the claim upon request; however, payment in full is expected at the time of service.
- There is a mandatory deposit of $50 for all existing non-insured patients and $250 for new non-insured patients. This deposit will be applied to all charges incurred during your visit. If you are unable to make a deposit, your visit may be rescheduled.
- It is the patient's responsibility to pay any deductible, copayment, or any portion of the charges as specified by the plan at the time of visit. Payments for medical services not covered by an individual's insurance plan are the patient's responsibility and payment in full is due at the time of visit.
- Payment for professional services can be made with cash, check, or credit card.
- Financial assistance is available for qualified patients. If a patient feels that he or she may qualify for assistance, the practice receptionist should be notified for referral to the appropriate individual. Patients who do not have insurance are expected to pay for professional services at the time of service unless prior arrangements have been made with us.
- It is the patient's responsibility to ensure that any required referrals or pre-certifications for treatment are provided to the practice prior to the visit. Visits may be rescheduled, or the patient may be financially responsible due to lack of the referral or authorization from their insurance company
- It is the patient's responsibility to provide us with current insurance information and bring his/her insurance card to each visit.
- Any patient who no-shows 2 appointments or cancels 2 without giving a 72-hour notice cannot be rescheduled without a $50 deposit by credit care. Make sure we have proper documentation in the notes screen.
- Our staff is happy to help with insurance questions relating to how a claim was filed or regarding any additional information the payer might need to process the claim. Specific coverage issues, however, can only be addressed by the insurance company member services department. *(Telephone number is printed on the insurance card.)*
- If your insurance company requests additional information from you, it is important to reply with their requests in a timely manner considering that the balance of your claim and bill is ultimately the patient's responsibility whether your insurance company pays your claim or not. If the insurance company does not pay your claim in 45 days, the balance is billed to and becomes the responsibility of the patient.
- It is the patient's responsibility to notify us with any changes to insurance coverage and to make sure Articularis Healthcare has the proper insurance information. If we do not have the correct insurance information, the patient is responsible for the total bill.

Our practice firmly believes that a good physician-patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the medical practice. We are here to help you.

Patient/Guardian Signature: _____

Date: _____

Articularis Healthcare Group, Inc.
Patient Refill Policy

We are committed to providing our patients with the best possible medical care and minimizing administrative costs. This prescription refill policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for professional services.

Refill requests will only be accepted if the following appropriate criteria have been met:

- Physicians will not accept refill requests after hours or on the weekends.
- Refill requests will be submitted to your pharmacy. Please allow 24 hours for this process. You may call our offices only after you have spoken with your pharmacy.
- All narcotic refill requests will take 48 hours to process. You may pick up your prescription at our office no sooner than 48 hours after it was called in.
- Your prescription can only be discussed with a physician, nurse, or medical assistant.
- Our office is closed on Fridays. No prescription request will be taken Friday, Saturday, or Sunday.
- The requested medication has been ordered previously by an Articularis Healthcare Group, Inc. physician.
- The patient has been seen by the physician in the last **6 months** or it is documented that the physician has order a **1 year follow up**.
- The patient has kept the last scheduled appointment or has been rescheduled for a date within the next 4 weeks.
- A patient requesting DMARDS must have had the **required** blood work within the last **6 – 8 weeks**. The nurse may arrange for the patient to get blood work completed if necessary.
- All prescriptions will be written for periods no longer than your next scheduled appointment.
- If a patient misses their appointment and calls in for a prescription, the nurse may only authorize enough medication to meet the patient's dosing requirement until the next scheduled appointment. If possible, patients may be worked in within 1 week.
- No further refills can be authorized unless the next scheduled appointment is kept.

Our practice firmly believes that a good physician-patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the medical practice. We are here to help you.

Patient/Guardian Signature**:** _____

Date**:** _____

Multi-Dimensional Health Assessment Questionnaire (R808-NP2)

This questionnaire includes information not available from blood tests, X-rays, or any source other than you. Please try to answer each question, even if you do not think it is related to you at this time. Try to complete as much as you can yourself, but if you need help, please ask. <u>There are no right or wrong answers.</u> Please answer exactly as you think or feel. Thank you.

1. Please check (√) the ONE best answer for your abilities at this time:

OVER THE LAST WEEK, were you able to:	Without **ANY** Difficulty	With **SOME** Difficulty	With **MUCH** Difficulty	**UNABLE** To Do
a. Dress yourself, including tying shoelaces and doing buttons?	0	1	2	3
b. Get in and out of bed?	0	1	2	3
c. Lift a full cup or glass to your mouth?	0	1	2	3
d. Walk outdoors on flat ground?	0	1	2	3
e. Wash and dry your entire body?	0	1	2	3
f. Bend down to pick up clothing from the floor?	0	1	2	3
g. Turn regular faucets on and off?	0	1	2	3
h. Get in and out of a car, bus, train, or airplane?	0	1	2	3
i. Walk two miles or three kilometers, if you wish?	0	1	2	3
j. Participate in recreational activities and sports as you would like, if you wish?	0	1	2	3
k. Get a good night's sleep?	0	1.1	2.2	3.3
l. Deal with feelings of anxiety or being nervous?	0	1.1	2.2	3.3
m. Deal with feelings of depression or feeling blue?	0	1.1	2.2	3.3

2. How much pain have you had because of your condition OVER THE PAST WEEK? Please indicate below how severe your pain has been:

NO PAIN ○ PAIN AS BAD AS IT COULD BE
0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

3. 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
a. LEFT FINGERS	☐ 0	☐ 1	☐ 2	☐ 3	i. RIGHT FINGERS	☐ 0	☐ 1	☐ 2	☐ 3
b. LEFT WRIST	☐ 0	☐ 1	☐ 2	☐ 3	j. RIGHT WRIST	☐ 0	☐ 1	☐ 2	☐ 3
c. LEFT ELBOW	☐ 0	☐ 1	☐ 2	☐ 3	k. RIGHT ELBOW	☐ 0	☐ 1	☐ 2	☐ 3
d. LEFT SHOULDER	☐ 0	☐ 1	☐ 2	☐ 3	l. RIGHT SHOULDER	☐ 0	☐ 1	☐ 2	☐ 3
e. LEFT HIP	☐ 0	☐ 1	☐ 2	☐ 3	m. RIGHT HIP	☐ 0	☐ 1	☐ 2	☐ 3
f. LEFT KNEE	☐ 0	☐ 1	☐ 2	☐ 3	n. RIGHT KNEE	☐ 0	☐ 1	☐ 2	☐ 3
g. LEFT ANKLE	☐ 0	☐ 1	☐ 2	☐ 3	o. RIGHT ANKLE	☐ 0	☐ 1	☐ 2	☐ 3
h. LEFT TOES	☐ 0	☐ 1	☐ 2	☐ 3	p. RIGHT TOES	☐ 0	☐ 1	☐ 2	☐ 3
q. NECK	☐ 0	☐ 1	☐ 2	☐ 3	r. BACK	☐ 0	☐ 1	☐ 2	☐ 3

4. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

VERY WELL ○ VERY POORLY
0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

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1.a-j FN (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): ☐

4.PTGL (0-10): ☐

RAPID 3 (0-30) ☐

Cat:
HS = >12
MS = 6.1-12
LS = 3.1-6
R = ≤3

Please turn to the other side

5. Please check (√) if you have experienced any of the following over the last month:

__Fever	__Lump in your throat	__Paralysis of arms or legs
__Weight gain (>10 lbs)	__Cough	__Numbness or tingling of arms or legs
__Weight loss (>10 lbs)	__Shortness of breath	__Fainting spells
__Feeling sickly	__Wheezing	__Swelling of hands
__Headaches	__Pain in the chest	__Swelling of ankles
__Unusual fatigue	__Heart pounding (palpitations)	__Swelling in other joints
__Swollen glands	__Trouble swallowing	__Joint pain
__Loss of appetite	__Heartburn or stomach gas	__Back pain
__Skin rash or hives	__Stomach pain or cramps	__Neck pain
__Unusual bruising or bleeding	__Nausea	__Use of drugs not sold in stores
__Other skin problems	__Vomiting	__Smoking cigarettes
__Loss of hair	__Constipation	__More than 2 alcoholic drinks per day
__Dry eyes	__Diarrhea	__Depression - feeling blue
__Other eye problems	__Dark or bloody stools	__Anxiety - feeling nervous
__Problems with hearing	__Problems with urination	__Problems with thinking
__Ringing in the ears	__Gynecological (female) problems	__Problems with memory
__Stuffy nose	__Dizziness	__Problems with sleeping
__Sores in the mouth	__Losing your balance	__Sexual problems
__Dry mouth	__Muscle pain, aches, or cramps	__Burning in sex organs
__Problems with smell or taste	__Muscle weakness	__Problems with social activities

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5. ROS: ☐

Please check (√) here if you have had none of the above over the last month: _____.

---

6. When you awakened in the morning OVER THE LAST WEEK, did you feel stiff? ☐ No ☐ Yes
If "No," please go to Item 7. If "**Yes**," **please indicate the number of minutes**_____, **or hours** _____ until you are as limber as you will be for the day.

7. How do you feel TODAY compared to ONE WEEK AGO? Please check (✓) **only one.**
Much **B**etter ☐ (1), **B**etter ☐ (2), the **S**ame ☐ (3), **W**orse ☐ (4), **M**uch **W**orse ☐ (5) than one week ago

8. How often do you exercise aerobically (sweating, increased heart rate, shortness of breath) **for at least one-half hour** (30 minutes)**? Please check** (✓) **only one.**
☐ 3 or more times a week (3) ☐ 1-2 times per month (1)
☐ 1-2 times per week (2) ☐ Do not exercise regularly (0) ☐ Cannot exercise due to disability/ handicap (9)

9. How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK?

FATIGUE IS NO PROBLEM	○ 0	○ 0.5	○ 1.0	○ 1.5	○ 2.0	○ 2.5	○ 3.0	○ 3.5	○ 4.0	○ 4.5	○ 5.0	○ 5.5	○ 6.0	○ 6.5	○ 7.0	○ 7.5	○ 8.0	○ 8.5	○ 9.0	○ 9.5	○ 10	FATIGUE IS A MAJOR PROBLEM

10. Over the last 6 months have you had: [Please check (√)**]**

☐No	☐Yes	An operation or new illness	☐No	☐Yes	Change(s) of arthritis or other medication
☐No	☐Yes	Medical emergency or stay overnight in hospital	☐No	☐Yes	Change(s) of address
☐No	☐Yes	A fall, broken bone, or other accident or trauma	☐No	☐Yes	Change(s) of marital status
☐No	☐Yes	An important new symptom or medical problem	☐No	☐Yes	Change job or work duties, quit work, retired
☐No	☐Yes	Side effect(s) of any medication or drug	☐No	☐Yes	Change of medical insurance, Medicare, etc.
☐No	☐Yes	Smoke cigarettes regularly	☐No	☐Yes	Change of primary care or other doctor

Please explain any "Yes" answer below, or indicate any other health matter that affects you:

_____

_____

SEX: ☐ Female, ☐ Male **ETHNIC GROUP:** ☐ Asian, ☐ Black, ☐ Hispanic, ☐ White, ☐ Other_____

Your Occupation _____
Work Status: ☐ Full-time, ☐ Part-time, ☐ Disabled
☐ Homemaker, ☐ Self-Employed, ☐Retired,
☐ Seeking work, ☐ Other_____

Please circle the number of years of school you have completed:
1 2 3 4 5 6 7 8 9 10
11 12 13 14 15 16 17 18 19 20

Please write your weight: _____ lbs. height: _____ inches

Your Name_____ **Date of Birth** _____ **Today's Date** _____

 Thank you for completing this questionnaire to help keep track of your medical care. **R808NP2**

FOR OFFICE USE ONLY: I have reviewed the questionnaire responses.
Date: _____ Signature_____