AOCC Arthritis & Osteoporosis Consultants of the Carolinas

Authorization for Release of Information

Name of Patient_____ Date of Birth_____

Arthritis and Osteoporosis Consultants of the Carolinas is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/xrays ☐ Other
☐ Other Person (s) (provide name and phone number)(i.e. Spouse, Friend, Family etc.) ☐ _____ ☐ _____ ☐ _____	☐ Financial ☐ Medical as follow(s)_____
☐ Email Communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical as follow(s)_____ ☐ Appointment reminders ☐ Breach notification
☐ Text communication - Provide cell number* _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder Other:_____
☐ **For email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately, I still elect to receive email and/or text communication as selected.	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____Date_____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

_____

Revised Feb 2016

Arthritis & Osteoporosis Consultants of the Carolinas
New Patient Form

Name_____ Date of Birth _____
Name of referring physician _____ Primary Care Physician _____

Reason for your visit today _____
Current medications: _____
_____
Name of Practitioners seen in last 5 years (Names of doctors)
_____
ALLERGIES(medication and reaction)_____
When did your symptoms begin- approximately _____
Please describe your Rheumatologic symptoms _____
_____
Prior Diagnosis of your symptoms _____
Previous Treatments for this problem (physical therapy, medications etc.)
_____

Past Medical History: (check if you have had)

☐ Alcoholism	☐ Cancer	☐ Hepatitis	☐ Diverticulitis	☐ Systemic lupus
☐ Anemia	☐ COPD	☐ High blood pressure	☐ Tuberculosis	☐ Rheumatoid Arthritis
☐ Arthritis	☐ Depression	☐ Heart attack	☐ Shingles	☐ Psoriasis
☐ Asthma	☐ Diabetes	☐ Osteoporosis	☐ Stomach Ulcer	☐ Gout
☐ Blood Clots	☐ Heartburn	☐ Thyroid trouble	☐ Fracture	

☐ Other- Please list below
_____

Past Surgical History:

Year	Hospitalization or Surgery	Year	Hospitalization or Surgery
_____	_____	_____	_____
_____	_____	_____	_____

Obstetrical history: Age at first period _____Age of last period (menopause) ____Hysterectomy ☐ Yes ☐ No Ovaries Removed? ☐ Yes ☐ No
# of Pregnancies _____ # of abortions _____ # of miscarriages_____ # of living children _____

Family History:

At any point has a blood relative had any of the following: (check those that apply)

	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Child
Alcoholism						
Arthritis						
Bleeding disorder						
Cancer						
Heart Attack						
Diabetes						
High Cholesterol						
High Blood pressure						
Stroke						
Osteoporosis						
Ankylosing Spondylitis						
Behcet's						
Crohn's Disease/ Ulcerative Colitis						
Lupus						
Psoriasis/ psoriatic arthritis						
Rheumatoid Arthritis						
Hip Fracture						
Other (list)						

Mother living ? ☐ Yes ☐ No Cause of death? _____
Father living ? ☐ Yes ☐ No Cause of death? _____

Social History:

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Occupation/ Prior jobs _____
Who lives at home with you? _____

Habits:
Have you ever smoked? ☐ Yes ☐ No How many packs/ day ? ____ How many years? ___ Quit? ___ years
Any other tobacco use? _____
Do you drink alcohol ☐ Yes ☐ No How often? _____ How much ? _____
Do you exercise? ☐ Yes ☐ No How often ?_____ How much ?_____
Are you at risk of HIV infection? ☐ Yes ☐ No

Please check any symptoms that you have had in the past (outside of an acute infection)

Yes	No	Check each Item	Yes	No	Check each Item	Yes	No	Check Each Item	Yes	No	Check Each Item
		GENERAL			**HEART**			**METABOLIC**			**SKIN**
		Chills			Chest pain			Cold intolerance			Bruising
		Fatigue			Leg pain with walking			Hair loss			Discoid rash
		Fever			Lower extremity swelling			Heat intolerance			Hives
		Night Sweats			Fingers turning white, blue or red			Excess hair growth			Nail changes
		Weight gain			Fast heart rate			Hot flashes			Sensitivity to the sun
		Weight Loss			Varicose veins			Increased thirst			Psoriasis
		Eyes, Ears and mouth			**GASTROINTESTINAL**			**NEUROLOGIC**			Rash
		Vision changes			Abdominal pain			Confusion/ disorientation			Scalp tenderness
		Vision loss			Bloating			Dizziness			**Musculoskeletal**
		Dental cavities			Blood in stools			Extremity numbness			Back pain
		Double vision			Constipation			Extremity weakness			Height loss
		Dry mouth			Diarrhea			Changes in gait			Joint pain
		Dry eyes			Difficulty swallowing			Headache			Joint swelling
		Nose bleeds			Heartburn			Memory loss			Joint tenderness
		Hearing loss			Loss of appetite			Seizures			Low back pain
		Hoarseness			Nausea			Fainting			Morning stiffness
		Jaw pain			Vomiting			Tingling			Muscle cramping
		Nose sores			**GENITOURINARY**			Tremors			Muscle weakness
		Mouth sores			Genital ulcers			**PSYCHIATRIC**			Muscle pain
		Red eye			Blood in urine			Anxiety			Neck pain
		Sinus infections			Kidney stones			Depression			Neck stiffness
		RESPIRATORY			Urination at night			Worry			**BLOOD**
		Sleep apnea			Pelvic pain			Insomnia			Easy bruising
		Cough			Scrotum or testicular pain			**IMMUNOLOGIC**			Easy bleeding
		Frequent respiratory infections			Urinary frequency			Allergic Rhinitis			Enlarged lymph nodes
		Coughing up blood			Urinary incontinence			Frequent infections			
		Chest pain with deep breaths						Food allergies			
		Shortness of breath									

Other (Please list)_____

PATIENT INFORMATION / CONSENT TO TREAT

Date		Referring Dr	PCP
Patient Name		Date of Birth	Social Security #
Address		Gender (please circle) M F	Marital Status
City/State/Zip		Home Phone	Work Phone
Emergency Contact	Phone #	Relationship to Patient	
Responsible Party	Phone #	Relationship to Patient	
Responsible Party Address		Date of Birth	
		Email:	

PRIMARY INSURANCE

Insurance_____ Subscriber Name_____ Subscriber SSN_____

Subscriber Date of Birth _____ Subscriber ID # _____Patient Relationship to Subscriber _____

Subscriber Group # _____ Subscriber Employer/Group Name_____

SECONDARY INSURANCE

Insurance_____ Subscriber Name_____ Subscriber SSN_____

Subscriber Date of Birth _____ Subscriber ID # _____Patient Relationship to Subscriber _____

Subscriber Group # _____ Subscriber Employer/Group Name_____

TO BE COMPLETED IN OFFICE

FINANCIAL RESPONSIBILITY

- I understand that it is my responsibility to verify my benefits in regard to AOCC with my insurance company.
- I understand it is my responsibility to obtain the necessary approval(s), authorization(s), and/or referral(s) from my insurance company.
- I acknowledge that if my insurance or HMO/PPO network does not participate or contract with AOCC I am responsible for the balance of services rendered.
- I understand that I am financially responsible for any non-covered services and/or if my insurance does not pay.
- I understand that filing of insurance is a courtesy only, not a guarantee of payment; I am responsible for my bill.
- If covered by Medicare or Medicaid, I certify that the information I provide for payment under Titles V, XVII, and/or the Social Security Act is correct.

CONSENT TO TREAT

I am asking for care and I agree to be offered all necessary diagnostic tests, examinations, surgical, and medical treatments prescribed by the treating physician(s). No one has given me a guarantee of how these examinations and treatments will affect me. or my condition.

Signature of Patient / Responsible Party: _____ Date: _____

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

I acknowledge that a copy of the NPP has been made available to me. I understand this NPP is subject to change at any time. I may obtain a revised copy of the NPP by request.

Signature of Patient / Responsible Party: _____ Date: _____

FOR STAFF USE ONLY

Patient declined to sign after NPP was made available.

Staff Signature: _____ Date: _____

ARTHRITIS AND OSTEOPOROSIS CONSULTANTS OF THE CAROLINAS
NOTICE OF NONDISCRIMINATION

Arthritis and Osteoporosis Consultants of the Carolinas ("AOCC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AOCC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

AOCC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages
- If you need these services, contact Tracy Moye

If you believe that AOCC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Tracy Moye, AOCC Civil Rights Coordinator, 1918 Randolph Rd. Suite 600, Charlotte NC 28207, 704-342-0252 , civilrights@aocc.md. You can file a grievance in person or by mail, or email. If you need help filing a grievance, Tracy Moye, AOCC Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Signature: _____

Name (Print): _____

Date: _____