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<br>☐ Other |
| ☐ Other Person (s) (provide name and phone number)(i.e. Spouse, Friend, Family etc.)<br>☐ _____<br>☐ _____<br>☐ _____ | ☐ Financial<br>☐ Medical as follow(s)_____ |
| ☐ Email Communication-Provide email address*<br>_____<br>*For email communication to occur, please accept the disclosure below: | ☐ Financial<br>☐ Medical as follow(s)_____<br>☐ Appointment reminders<br>☐ Breach notification |
| ☐ Text communication - Provide cell number*<br>_____<br>*For text communication to occur, accept the disclosure below: | ☐ Appointment reminder<br>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 Capers

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 Capers, AOCC Civil Rights Coordinator, 1918 Randolph Road, 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 Capers, 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: _____