Appalachian Regional Rheumatology

a practice of Appalachian Regional Medical Associates
2146 Blowing Rock Road | Boone, NC 28607
(828) 386-2300 | fax (828) 386-2301
apprhs.org/apprheumatology

Thank you for choosing Appalachian Regional Rheumatology as your healthcare provider. We look forward to seeing you at your appointment.

This new patient information packet includes directions to our office and contact information for your records. Also enclosed is the paperwork that you will need for your upcoming appointment. Please complete the paperwork enclosed and bring it to your appointment. Our Billing & Insurance Information, Notice of Privacy Practices and Patient Bill of Rights & Responsibilities are available at the front desk or online at *apprhs.org*.

At Appalachian Regional Rheumatology, a practice of Appalachian Regional Medical Associates, we treat the whole person, not just the illness. Our services focus on diagnosis and treatment of rheumatic diseases including arthritis, autoimmune diseases and osteoporosis. Our rheumatologist develops a personalized treatment plan for each patient based on medical history, family history, physical exam, test results and the patient's symptoms to improve quality of life.

Our office is available to you by phone from 8:00 a.m. - 5:00 p.m. Monday - Friday. If you have any questions, please call our office manager at (828) 386-2300.

To learn about the providers at this location, visit *apprhs.org/apprheumatology*

_____
has an appointment with

_____

☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri.

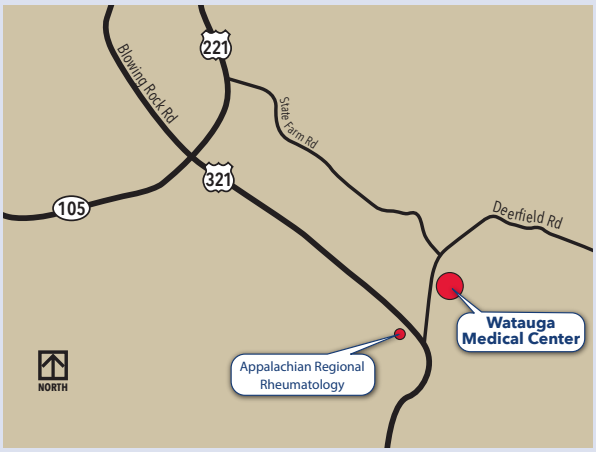
_____date _____a.m./p.m.

To reschedule your appointment, please call (828) 386-2300.

NEW PATIENT CHECKLIST:

For your first appointment please arrive 15 minutes early and bring the following:

☐ Insurance Card
☐ Pharmacy Information
☐ Medical Records
☐ Payment
☐ Current Medications/Prescription Bottles
☐ Questions for doctor
☐ Completed forms
☐ Photo ID



APPALACHIAN REGIONAL RHEUMATOLOGY
a practice of Appalachian Regional Medical Associates

Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Patient Registration

Please Print Patient Name: First M/I Last

Gender: ☐Male ☐ Female **Date of Birth:** ____/____/_____ **Social Security #:** _____-_____-_____

Mailing Address: Street-

City- State- Zip Code-

Home Phone #: _____ **Work Phone #:** _____

Cell #: _____ **E-mail:** _____

Employer/Occupation: _____

Marital Status: ☐Married ☐Single ☐Divorced ☐ Separated ☐Widowed ☐ Partner

How did you hear about us?
☐ Billboards ☐Doctor ☐Friends/Family ☐Magazine ☐Newspaper ☐Social Media ☐Radio ☐TV
☐ARHS Website ☐Other _____

What is your ethnicity? ☐Hispanic or Latino ☐ Not Hispanic or Latino

Select one or more races to indicate what you consider yourself to be: ☐Asian ☐ White
☐ American Indian or Alaskan Native ☐ Black or African American
☐Native Hawaiian or other Pacific Islander ☐ Other: _____

Preferred language? ☐English ☐Other: _____

Which Pharmacy do you use: _____

Emergency Contact Name and Relationship: _____
Emergency Contact Number: _____

If patient is a minor:
Please Print Guardian Name: First M/I Last

If someone else is responsible for the bill:
Patient's relationship to Guarantor: _____
Guarantor's Name: First M/I Last

Mailing Address: Street-

City- State- Zip Code-

Date of Birth: ____/____/_____ **Social Security #:** _____-_____-_____ **Phone #:** _____

Employer: _____ **Employer Phone#:** _____

Referring Doctor: _____ **Primary Care Provider:** _____

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Revised Date: 10/21/2020
Form Number: 11676

APPALACHIAN REGIONAL RHEUMATOLOGY
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Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Patient History Survey

Name: _____ Date: _____

Who is your regular physician? _____

Chief Complaint (briefly state reason for seeing us): _____

_____

How long have you had this problem? _____

Medications: (Please include both prescription medicines and over the counter medications such as those for headache, bowels, etc. as well as any herbal therapies, vitamins or injections):

Currently Taking (name, dose)	Taken within the past 6 months
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.

Drug Allergies (rash, fever, wheezing or other reaction):

Drug:	Reaction:	Year Occurred:

Surgeries:	Date (approx.)	Surgeon	City
Appendectomy:			
Hysterectomy:			
Tonsillectomy:			
Other: _____			

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T-11677

APPALACHIAN REGIONAL RHEUMATOLOGY a practice of Appalachian Regional Medical Associates	Patient Name_____ Date of Birth_____ Phone Number_____ Please Fill in or Affix a Patient Label

Patient History Survey

Injuries (broken bones, accidents): _____

_____

Recent Hospitalizations (within last three years):

Date (approx.) Reason:

_____ _____

_____ _____

Sleep Schedule: Retire: _____ Arise: _____

Childhood Diseases:

Rheumatic Fever	☐ Yes ☐ No	Date:
Hepatitis	☐ Yes ☐ No	Date:
Scarlet Fever	☐ Yes ☐ No	Date:
Other	☐ Yes ☐ No	Date:
Have you ever had a blood transfusion? ☐ Yes ☐ No Date:		

Have you or any of your relatives had any of these diseases? If so, please list your relationship to the person with the disease:

	Self	Relative		Self	Relative
Gout			High Blood Pressure		
Lupus			Fibromyalgia		
Rheumatoid Arthritis			Diabetes		
Osteoarthritis			Tuberculosis		
Psoriasis			Kidney Disease		
Epilepsy/Seizure			Kidney Stone		
Migraine			Thyroid Disease		
Cancer (kind?)			Osteoporosis		
Heart Disease			Other (specify)		

Social History: Marital Status: _____ Birth date: _____

Where were you born? _____ Education: High School _____

College/ Professional School: _____ Degree _____

Occupation (current): _____

Children:

Name	Age	Health Status

Have you traveled outside the Southeast in the past 3 years? _____

If so, when and where?_____

Rheumatic Systems Review:

Effective Date: Not Set
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Form Number: 11677

T-11677

APPALACHIAN REGIONAL RHEUMATOLOGY
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Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Patient History Survey

	Yes	No	Comments
Ever been told you have gout?			
Ever had tender joints?			
Any swollen joints?			
Any hot or red joints?			
Any nodules or lumps about any joints?			
Any prolonged morning stiffness?			
Any jaw pain with chewing?			
Any sudden change in vision?			
Any scalp tenderness?			
Any unusual headaches?			
Any muscle pain?			
Any difficulty with climbing stairs?			
Difficulty using arms?			
Trouble thinking?			
Persistent sadness or irritability?			
Have you been told that you snore?			
Any trouble with swallowing?			
Any thickness or tightening of skin?			
Do your fingers blanche or turn white on exposure to cold?			
Does sun exposure give you fever, rash or make you ill?			
Any large loss of scalp hair lately?			
Is your mouth persistently dry?			
Any persistent sandy or gritty sensation in your eyes?			
Have you ever had a blood clot?			
Do you have recurrent ulcers/sores of the mouth or genitals?			
Any episode(s) of painful/bloodshot eyes?			
Any problem with heel pain?			
Ever had bloody diarrhea?			
Any hot flashes / flushing or nightsweats?			
Any tick bites?			
Rheumatic Systems Review Continued	Yes	No	Comments

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Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Patient History Survey

Have you ever had pleurisy (hurting when you take a deep breath)?			
Have you had hepatitis?			
Do you have frequent back pain?			
Have you ever had a TB skin test?			
Have you ever had psoriasis?			
Do you smoke?			
Do you drink alcohol?			
Do you exercise regularly?			
Women: Regular menstrual periods?			
Menopause? If so, at what age?			
Using birth control pills?			
Ever had a miscarriage?			
Men: History of penile discharge?			
Penile rash or ulcers?			
Patients with Rheumatoid Arthritis:			
Have you taken:			
Plaquenil?			
Azulfidine			
Methotrexate (Rheumatrex)?			
Imuran (Azathioprine)?			
Leflunomide (Aava)?			
Remicade?			
Back pain patients only:			
Did your back pain begin shortly after an injury?			
Did your back pain begin suddenly?			
Has your back pain ever persisted for more than three months?			
Has your back been especially stiff in the morning?			
Is your back pain better relieved by rest or by exercise?			
At what age did your back pain begin?			

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APPALACHIAN REGIONAL RHEUMATOLOGY
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Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Patient Evaluation

Patient Name: _____ DOB: ___/___/___ Date: ___/___/___

Instructions: This brief form provides a record of your health status today. Please try and answer each question even if you've already answered a similar question before. There are no right or wrong answers – just answer exactly as you think or feel.

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 kilometer, 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

For Office Use Only

1.a-j FH (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. PH (0-10): _____

4. PTGL (0-10): _____

RAPID 3 (0-30): _____

2. How much pain have you had because of your condition **over the past week**? Please indicate how severe your pain has been on a scale of 1 to 10:
_____

3. How much of a problem has **unusual** fatigue or tiredness been for you **over the past week** on a scale of 1 to 10?
_____

4. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing on a scale of 1 to 10: _____

Pharmacy: _____ Date: _____

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Revised Date: 10/14/2020
Form Number: 11671

T-11671

APPALACHIAN REGIONAL HEALTHCARE SYSTEM Appalachian Regional Rheumatology	**Affix a Patient Label**

Authorization to Release and Consent

Consent for Diagnostic and Treatment

I hereby request and consent to diagnostic and medical treatment given to me at Appalachian Regional Rheumatology, a physician practice of Appalachian Regional Medical Associates, Inc. (hereinafter "ARMA"), which may include routine diagnostic procedures and medical treatment which my physician or another practitioner involved in my care considers necessary. I am aware that the practice of medicine (including surgery) is not an exact science, and no one has made any guarantees about the results of my treatments, examinations, or procedures.

Certification, Assignment of Insurance Benefits, and Guaranty of Payment

I certify that the information I have given in applying for payment under Medicare, Medicaid, or any other government or private insurance program is correct. I hereby authorize payment of surgical and medical benefits directly to my physician and/or directly to ARMA, as applicable. I authorize ARMA to bill my insurer directly, and I assign to ARMA the right to receive all health and liability insurance benefits otherwise payable to me. I understand that I am financially responsible for, agree to pay, and guarantee payment in full of all charges for services provided to me by ARMA and my physician, even if such services are not covered by insurance. I also understand that my insurer may not pay the full amount of my charges, and I may be responsible (as the patient, spouse, or the parent of a minor child) for the amount not paid. I understand that my bill will be sent to my address on file unless I request my bill to be sent to a different address. I acknowledge that in addition to receiving a bill from ARMA, if I receive pathology, laboratory, or imaging services, I will receive a separate bill from the respective provider of those services. I authorize ARMA to act as attorney-in-fact (act with authority from me) for the limited purposes of: (1) billing directly and collecting benefits from any responsible third party through whatever means necessary; and (2) endorsing benefit checks made payable to me and/or ARMA or my physician. If collection efforts are needed to obtain payment from me for the services and supplies provided, I agree to pay the costs of such collection efforts, including reasonable attorneys' fees. I authorize payment of any refund of any overpaid insurance benefits to be made to the appropriate insurer in accordance with my insurance policy conditions or any applicable benefit provisions. If any refund is due to me, I authorize the application of such refund to any amount that I am personally legally obligated to pay for services provided by ARMA. I understand that any remaining credit due after payment of these outstanding amounts will be refunded to me.

Use and Release of Health Information

I acknowledge that licensed physicians and other health care professionals involved in my care at ARMA may use and release my health information obtained during this visit for purposes of treatment, payment, and health care operations as stated in the ARMA Notice of Privacy Practices.

My health information, or information about payment for my medical treatment, may be shared with the following friends, family members, or authorized representatives:

Name: _____ Relationship: _____ Phone: _____

Limitations to disclosure (if any):_____

Name: _____ Relationship: _____ Phone: _____

Limitations to disclosure (if any):_____

Name: _____ Relationship: _____ Phone: _____

Limitations to disclosure (if any):_____

Note: A separate form must be completed by the patient to release written health information (e.g., medical records) to family members, friends, or other authorized representatives.

Effective Date: Not Set
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Form Number: 11672

T-11672

APPALACHIAN REGIONAL HEALTHCARE SYSTEM Appalachian Regional Rheumatology	**Affix a Patient Label**

Acknowledgment of Receipt of Notice of Privacy Practices and Financial Information

If I am a first-time patient, I certify that I have received a copy of the ARMA Notice of Privacy Practices. If I am a returning patient, I understand that a copy is available to me upon request. I have had the opportunity to review the ARMA financial information brochure.

Appointment No-Shows and Late Cancellations- $25.00 Fee

Any patient who fails to arrive for a scheduled appointment, without prior notification 24 hours in advance, is considered a "no-show." Patients must contact the office with at least 24 hours' notice to cancel or reschedule their appointment to avoid being charged a $25.00 fee. New patients that "no-show" two consecutive times to an appointment will be excluded from making future appointments with that provider. Established patients who "no-show" three consecutive times, or three times within a 12-month period, may be discharged from the practice.

I understand that this consent will automatically expire in one year. I also understand that I may revoke or withdraw my consent at any time by notifying ARMA in writing, but my withdrawal will not be effective for actions already taken based upon my consent. I understand and agree to the above releases, authorizations, consents, and assignments of benefits.

Signature: _____ **Date:** _____ **Time:** _____
(Patient or legal guardian/authorized representative, if patient unable to sign)

Printed Name: _____ **Relationship, if not patient:** _____

Guardian or Representative, if any: *(Please print name)* _____

Signature: _____ **Date:** _____ **Time:** _____
(Insured/Guarantor, if different from Guardian/Representative)

Insured/Guarantor, if any: *(Please print name)* _____

Effective Date: Not Set
Revised Date: 10/15/2020
Form Number: 11672

T-11672