

**PATIENT REGISTRATION INFORMATION**

Date of Birth

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Sex \_\_\_\_\_ Month / Day / Year (xxxx)

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Primary Telephone Number \_\_\_\_\_ Other Telephone \_\_\_\_\_ Email Address \_\_\_\_\_

Primary Language: \_\_\_\_\_ Do You Need An Interpreter?  Yes  No Ethnicity: \_\_\_\_\_

Hearing Impaired?  Yes  No Vision Impaired?  Yes  No

Primary Care Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Telephone Number \_\_\_\_\_ Legal Guardian?  Yes  No

**RESPONSIBLE PARTY IF OTHER THAN PATIENT**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Telephone Number \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**MEDICAL INSURANCE POLICY HOLDER**

**PRIMARY INSURANCE INFORMATION**

**SECONDARY INSURANCE INFORMATION**

Primary Insurance Company: _____	Secondary Insurance: _____
Policy Holder Last Name: _____	Policy Holder Last Name: _____
Policy Holder First Name: _____	Policy Holder First Name: _____
Subscriber Date of Birth: _____	Subscriber Date of Birth: _____
Relationship to Patient: _____	Relationship to Patient: _____
Subscriber ID: _____	Subscriber ID: _____
Group ID: _____	Group ID: _____

**ASSIGNMENT OF BENEFITS / CONSENT FOR TREATMENT**

I do hereby assign all medical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I acknowledge receipt of the Financial Policy and I understand that I am responsible for all charges not paid by insurance. I authorize this practice to release all information necessary to secure payment. I hereby voluntarily consent to treatment at this office and authorize such treatments, examinations, medications, and diagnostic procedures (including, but not limited to the use of lab and radiographic studies) as ordered by attending providers. I hereby voluntarily consent to the taking of photographic images for treatment purposes only (wound care progression, documentation of rashes, etc.) as ordered by the attending providers.

\_\_\_\_\_  
*Signature of Patient or Patient's Legal Representative*

\_\_\_\_\_  
*Month / Day / Year*

\_\_\_\_\_  
*Printed Name of Patient or Legal Representative*

\_\_\_\_\_  
*Relationship to Patient*



## HIPAA PATIENT AUTHORIZATION AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

### PATIENT INFORMATION

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_ <sup>Date of Birth</sup> \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month / Day / Year (xxxx)  
Primary Contact Number \_\_\_\_\_

### ALTERNATE CONTACT NUMBERS

If we cannot reach you at the primary number above, we may contact you (including leaving messages) at:

\_\_\_\_\_ **Business Number**      \_\_\_\_\_ **Cell Phone Number**      \_\_\_\_\_ **Other Phone Number**

### PERSONS AUTHORIZED TO RECEIVE INFORMATION

I authorize Southeastern Rheumatology Alliance (SERA) to disclose my Protected Health Information (PHI) to the following individuals:

_____ <b>Name</b>	_____ <b>Phone Number</b>
_____ <b>Name</b>	_____ <b>Phone Number</b>
_____ <b>Name</b>	_____ <b>Phone Number</b>

### INFORMATION TO BE DISCLOSED

**Complete** Medical Records     **Specific** Records (describe below)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### AUTHORIZATION STATEMENT

I understand that the PHI disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand I have the right to revoke this authorization at any time by providing written notice to Southeastern Rheumatology Alliance (SERA), except to the extent that action has already been taken. I understand I am not required to sign this authorization as a condition for treatment unless the sole purpose of the treatment is to create health information for a third party. I will be provided a copy of this authorization.

\_\_\_\_\_  
**Signature of Patient or Patient's Legal Representative**

\_\_\_\_\_  
**Month / Day / Year**

\_\_\_\_\_  
**Printed Name of Patient or Legal Representative**

\_\_\_\_\_  
**Relationship to Patient**

### EXPIRATION DATE OF AUTHORIZATION

Indefinite until revoked in writing     Expires on (MM/DD/YYYY):

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

## NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Effective: January 1, 2025**

We are committed to protecting the privacy of your personal health information (PHI). This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment, or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. You will be notified of any breach of unsecured PHI. We will follow the terms outlined in this Notice. We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- Providing a copy of the new Notice in our office or by mail, upon request.
- Posting the revised Notice on our Uses and Disclosures of Your PHI.

The law permits or requires us to use or disclose your PHI for various reasons, which we explain in this Notice. We have included some examples, but we have not listed every permissible use or disclosure. When using or disclosing PHI or requesting your PHI from another source, we will make reasonable efforts to limit our use, disclosure, or request about your PHI to the minimum we need to accomplish our intended purpose.

### **Uses and Disclosures for Treatment, Payment, or Health Care Operations**

- We may use or disclose your PHI and share it with other professionals who are treating you, including doctors, nurses, technicians, medical students, or hospital personnel involved in your care. For example, we might disclose information about your overall health condition to physicians who are treating you for a specific injury or condition.
- We may use and disclose your PHI to bill and get payment from health plans or others. For example, we share your PHI with your health insurance plan so it will pay for the services you receive.
- We may use and disclose your PHI to run our practice and improve your care. For example, we may use your PHI to manage the services you receive or to monitor the quality of our health care services.

## **Other Uses and Disclosures of Your PHI**

We may share your information in other ways, usually for public health or research purposes or to contribute to the public good. For example, these other uses and disclosures may involve:

- **Our Business Associates:** We may use and disclose your PHI to our business associates that perform services on our behalf, such as auditing, legal, or transcription. The law requires our business associates and their subcontractors to protect your PHI in the same way we do. We also contractually require these parties to use and disclose your PHI only as permitted and to appropriately safeguard your PHI.
- **Health Information Exchanges:** We participate in health information exchanges (HIEs), which support electronic information sharing among members for treatment, payment, and health care operations purposes. Individuals may opt out of HIEs. We will use reasonable efforts to limit the sharing of PHI in these electronic sharing activities for individuals who have opted out. If you would like to opt out, please contact our Privacy Officer.
- **Legal Compliance:** For example, we will share your PHI if the Department of Health and Human Services requires it when investigating our compliance with privacy laws.
- **Public Health and Safety Activities:** For example, we may share your PHI to report injuries, births, and deaths; prevent disease; report adverse reactions to medications or medical device product defects; report suspected child neglect or abuse or domestic violence; or avert a serious threat to public health or safety.
- **Responding to Legal Actions:** For example, we may share your PHI to respond to a court or administrative order or subpoena, discovery request, or other lawful process.
- **Research:** For example, we may share your PHI for some types of health research that do not require your authorization, such as if an institutional review board (IRB) has waived the written authorization requirement [because the disclosure only involves minimal privacy risks].
- **Medical Examiners or Funeral Directors:** For example, we may share PHI with coroners, medical examiners, or funeral directors when an individual dies.
- **Organ or Tissue Donation:** For example, we may share your PHI to arrange an authorized organ or tissue donation from you or a transplant for you.
- **Workers' Compensation:** We may use and disclose your PHI for workers' compensation claims; health oversight activities by federal or state agencies; law enforcement purposes or with a law enforcement official; or specialized government functions, such as military and veterans' activities, national security and intelligence, presidential protective services, or medical suitability.

## **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, please contact us and we will make reasonable efforts to follow your instructions. You have both the right and choice to tell us whether to:

- Share information such as your PHI, general condition, or location with friends or family members or other persons involved in your care.
- Share information in a disaster relief situation, such as with a relief organization to assist with locating or notifying your family, close friends, or others involved in your care.

We may share your information if we believe it is in your best interest, according to our best judgment, and:

- If you are unable to tell us your preference, for example, if you are unconscious.
- When needed to lessen a serious and imminent threat to health or safety.

## **Your Rights**

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing.

- **Inspect and obtain a copy of your protected health information:** You may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested, we will provide you with a copy of your records in an electronic format. There are some exceptions to records that may be copied and the request may be denied. We may charge you a reasonable cost-based fee for a copy of the records.
- **Request Additional Restrictions:** You have the right to ask us to limit what we use or share about your PHI. You can contact us and request us not to use or share certain PHI for treatment, payment, or operations or with certain persons involved in your care. For these requests:
  - We are not required to agree.
  - We may say “no” if it would affect your care; but
  - We will not agree to disclose information to a health plan for purposes of payment or health care operations if the requested restriction concerns a health care item or service for which you or another person, other than the health plan, paid in full out-of-pocket, unless otherwise required by law.
- **You have the right to request for us to communicate in different ways or in different locations:** We will agree to reasonable requests. We may also request an alternative address or other method of contact, such as mailing information to a post office box. We will not ask for an explanation from you about the request.

- **Make Amendments:** You may ask us to correct or amend PHI that we maintain about you that you think is incorrect or inaccurate. For these requests:
  - You must submit requests in writing, specify the inaccurate or incorrect PHI and provide a reason that supports your request.
  - We will generally decide to grant or deny your request within 60 days. If we cannot act within 60 days, we will give you a reason for the delay in writing and include when you can expect us to complete our decision.
  - We may deny your request for an amendment if you ask us to amend PHI that is not part of our record, that we did not create, that is not part of a designated record set, or that is accurate and complete.
- **Request an Accounting of Disclosures:** This right applies to disclosures for purposes other than treatment, payment, or healthcare operations. You may request them for the previous six years or a shorter time frame. If you request more than one list within a 12-month period, you may be charged a reasonable fee.

### **Additional Privacy Rights**

You have the right to obtain a paper copy of this notice from us, upon request. We will provide you with a copy of this Notice the first day we treat you at our facility. In an emergency, we will give you this Notice as soon as possible. You have a right to receive notification of any breach of your protected health information.

### **Complaints**

You have the right to complain if you feel we have violated your rights. We will not retaliate against you for filing a complaint. You may either file a complaint:

- Directly with us by contacting the Privacy Officer. All complaints must be submitted in writing.
- With the Office for Civil Rights at the US Department of Health and Human Services (HHS). Send a letter to U.S. HHS at 200 Independence Ave., S.W., Washington, D.C. 20201; call 1-800-368-1019; or visit [www.hhs.gov/ocr](http://www.hhs.gov/ocr)

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*Signature of Patient or Patient's Legal Representative*

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*Month / Day / Year*

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*Printed Name of Patient or Legal Representative*

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*Relationship to Patient*

## FINANCIAL POLICY

We thank you for choosing ***Southeastern Rheumatology Alliance (SERA)*** as your healthcare provider. The SERA team of physicians and healthcare professionals are committed to fulfilling our mission to provide a continuum of medical services to our patients. To support this goal, we have created this financial policy to communicate important financial aspects about our practice. Please read this policy thoroughly before your visit and contact our Business Office should you have questions or concerns. Our Business Office is available Monday-Thursday from 8:00am - 5:00pm, and you may reach them by dialing:

**Arthritis Center of North Georgia:** 706-410-9270

**Arthritis and Rheumatology of Georgia:** 404-255-5956

**Coastal Rheumatology Associates of Georgia:** 912-349-4227

### **Arriving for Your Visit**

To provide exceptional care to every patient, SERA has adopted guidelines around late arrivals, cancellations, and patients who fail to show for their appointments. We ask that every patient, regardless if you are new or established within our practice, arrive 15 minutes before their scheduled appointment time.

## **ESTABLISHED PATIENT POLICY**

### **Cancellation Policy**

- Patients must provide at least 48 hours' notice if they need to cancel or reschedule an appointment.
- After three or more cancellations within a 12-month period, patients may be charged a cancellation fee (e.g., \$25 or a percentage of the visit cost).
- Exceptions may be made for emergencies or extenuating circumstances at the provider's discretion.

### **No-Show Policy**

- A patient is considered a no-show if they fail to arrive for a scheduled appointment without 48 hours notice of cancellation.
- A no-show fee (e.g., \$50) may be charged. (excludes Medicaid and Tricare patients)
- After three or more no-shows, patients may be required to prepay for future visits or may be subject to dismissal from the practice.

### **Late Arrivals**

- Patients arriving more than 15 minutes late may be asked to reschedule to avoid disrupting other appointments.
- If the provider can still accommodate the patient, the visit may be shortened to stay on schedule.

## **NEW PATIENT POLICY:**

To reserve your initial appointment, our practice requires a \$50 deposit for all new patients. This deposit will be applied toward the cost of your first visit.

Deposit Terms:

- The \$50 deposit is **non-refundable** if you cancel with less than 48 business hours' notice or do not show for your appointment.
- If you cancel or reschedule at least 48 hours in advance, the deposit will be **fully refunded** or applied to your rescheduled appointment.
- Payment will be collected when appointment is scheduled.
- Exceptions may be made for emergencies or extenuating circumstances at the provider's discretion.

## **Referrals and Prior Authorizations**

It is your responsibility to obtain referrals for the services provided within the Southeastern Rheumatology (SERA) practices. However, SERA will obtain any of the required prior authorizations for treatments or services provided within our practice.

## **Insurance and Billing**

SERA is pleased to bill your primary and secondary health care plans on your behalf. You are ultimately responsible for your co-pay and any co-insurance related to your deductible at check-in for your appointment, as well as any remaining balance after insurance payments. Ancillary services rendered in our clinic, like ultrasound, lab, and/or x-ray, will be billed to you after your visit. We accept most insurance policies, but please contact your insurance company to verify we are an in-network provider. As the owner of the insurance policy, you are solely responsible for coverage policies under the plan and the accuracy of information on file.

## **Self-Pay**

If you choose to pay for your medical care without utilizing insurance coverage, you will be considered Self Pay and charged for all services at our self-pay rate until we are notified otherwise.

## **Insurance Errors**

If you believe your insurance company denied or processed a claim in error, please call us immediately. If your insurance company requests additional information from you, it is important to comply with their requests in a timely manner. If insurance does not pay a claim within 45 days of submission, the outstanding balance is billed to the patient and becomes the patient's responsibility. Should you pay more than what you are responsible, the overpayment will be applied as a credit on the account, and you may decide if the credit may be used at the next visit for services rendered or opt to receive a refund check.

**Paying Your Bill**

For your convenience, SERA accepts multiple forms of payment, including personal checks, money orders, Visa, MasterCard, Discover, American Express, and cash. Payment is accepted by phone, online, in person, and by mail. If we utilize lab processing through Quest Diagnostics or LabCorp, they will bill you directly for any outstanding out-of-pocket balances. Please contact them directly to discuss your bill.

**Ability to Pay**

Account balances should be paid in full by the statement due date. If you have circumstances that limit your ability to pay on your account balance and have exhausted other resources, please contact a member of the Billing Office. Failed attempts to contact patients by phone and/or mail about their unpaid balances to establish payment arrangements may lead to collections and/or discharge from the practice.

**Accounts in Default**

SERA will attempt to bill and collect from patients who are responsible for all or part of the cost of services provided by an SERA physician. After 90 days, if you have not made a payment on a bill or established a payment plan, SERA may initiate pre-collections by sending the patient a pre-collections notice. If SERA fails to collect or arrange payment from the patient, the patient may receive a final notice to pay. If SERA decides it is unreasonable to try to collect balances, a certified letter discharging the patient from our practice will be sent and the account referred to a primary collection's agency.

**Disability Forms**

There are many factors that are taken into account when completing a disability form. Therefore, it is at the discretion of the provider of whether it is appropriate for them to complete a disability form.

\_\_\_\_\_  
*Signature of Patient or Patient's Legal Representative*

\_\_\_\_\_  
*Month / Day / Year*

\_\_\_\_\_  
*Printed Name of Patient or Legal Representative*

\_\_\_\_\_  
*Relationship to Patient*

## PRESCRIPTION REFILL POLICY

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

- Your prescription can only be discussed with a physician, nurse, or medical assistant.
- The requested medication must have been ordered previously by a Southeastern Rheumatology Alliance (SERA) physician.
- Physicians will not accept refill requests after hours or on the weekends (**Friday-Sunday**).
- 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 may take 48 hours to process. You may pick up your prescription at our office no sooner than 48 hours after it was called in.
- 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.
- 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.
- The patient has kept the last scheduled appointment or has been rescheduled for a date within the next 4 weeks.
- 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.

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*Signature of Patient or Patient's Legal Representative*

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*Month / Day / Year*

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*Printed Name of Patient or Legal Representative*

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*Relationship to Patient*

## MEDICAL RECORDS RELEASE FORM

### PATIENT INFORMATION

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date of Birth  
 Street Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Phone Number \_\_\_\_\_

### I AUTHORIZE

Name of Provider/Facility \_\_\_\_\_  
 Street Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_

to **RELEASE** my medical records **TO/FROM** (select below) the following Southeastern Rheumatology Alliance Practices:

**Arthritis Center of North Georgia**  
 700 South Enota Drive, NE  
 Gainesville, GA 30501  
**Phone:** (770) 531-3711  
**Fax:** (770) 531-3718

**Arthritis Center of North Georgia**  
 1715 Resurgence Drive • Suite 201  
 Watkinsville, GA 30677  
**Phone:** (706) 410-9270  
**Fax:** (706) 410-9276

### INFORMATION TO BE RELEASED

Select all that apply:

**ALL** Medical Records    Office Visit Notes    Laboratory Reports    Imaging/X-Ray Reports    Medication List

Other (specify): \_\_\_\_\_

### PURPOSE OF RELEASE

Continuity of Care    Personal Use    Legal    Insurance

Other (specify): \_\_\_\_\_

### DATES OF SERVICE TO BE RELEASED (IF APPLICABLE)

From: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### AUTHORIZATION STATEMENT

I understand that:

- I may revoke this authorization at any time by submitting a written request to the releasing provider.
- Revocation will not apply to records already released in reliance on this authorization.
- This authorization will expire one year from the date signed unless otherwise specified: \_\_\_\_\_.
- I understand that once the records are released, they may no longer be protected by HIPAA.
- I may be charged a fee for copies of records as permitted by law.

\_\_\_\_\_  
*Signature of Patient or Patient's Legal Representative*

\_\_\_\_\_  
*Month / Day / Year*

\_\_\_\_\_  
*Printed Name of Patient or Legal Representative*

\_\_\_\_\_  
*Relationship to Patient*

### FOR OFFICE USE ONLY

Date Received: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Released By: \_\_\_\_\_

Date Released: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Select One:    Faxed    Mailed    Picked Up

## HEALTH HISTORY QUESTIONNAIRE

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_ Date of Birth  
 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Month Day Year (xxxx)

Which physician referred you to our practice? \_\_\_\_\_

Name of Local Pharmacy \_\_\_\_\_ Local Pharmacy Phone \_\_\_\_\_

Name of MAIL ORDER Pharmacy \_\_\_\_\_ Mail Order Pharmacy Phone \_\_\_\_\_

**PLEASE LIST ALL CURRENT MEDICAL CONDITIONS FOR WHICH YOU ARE RECEIVING TREATMENT:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PLEASE LIST ANY PREVIOUS SURGERIES:**

_____	Date: _____	_____	Date: _____
_____	Date: _____	_____	Date: _____
_____	Date: _____	_____	Date: _____

**PLEASE LIST ALL CURRENT MEDICATIONS, OR BRING A DETAILED MEDICATION LIST:**

_____	_____	_____
_____	_____	_____
_____	_____	_____

**PLEASE LIST ANY DRUG ALLERGIES:**

\_\_\_\_\_  
 \_\_\_\_\_

In which city do you reside? \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Separated  Widowed

Number of children: \_\_\_\_\_ Pregnancies: \_\_\_\_\_ Miscarriages and if so, what trimester: \_\_\_\_\_

Occupation: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Smoking History:  Current  Former  Never If so, how many packs? \_\_\_\_\_ If former, date you quit: \_\_\_\_\_

Do you currently consume alcohol?  Yes  No If yes, how much? \_\_\_\_\_ How often: \_\_\_\_\_

Does anyone in your immediate family have a history of rheumatoid arthritis, lupus, Sjögren's syndrome, scleroderma, polymyositis, gout, Crohn's disease, ulcerative colitis, ankylosing spondylitis, or psoriasis?

If yes, please list the condition(s) and the family member(s): \_\_\_\_\_

Does anyone in your family have osteoporosis?  Yes  No If yes, who? \_\_\_\_\_

Have you ever had a bone density test?  Yes  No If yes, when and where? \_\_\_\_\_

**RHEUMATOLOGY MEDICATION HISTORY**

<b>MEDICATION NAME</b>	<b>DID IT HELP?</b>	<b>DESCRIBE ANY SIDE EFFECTS OR PROBLEMS</b>
Actemra	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Azathioprine (Imuran)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bimzelx	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cellcept / Mycophenolate / Olumiant	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cimzia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cosentyx	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Enbrel	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Humira or Biosimilar	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ibuprofen or other NSAIDs (e.g., Naproxen, Mobic, Celebrex, Aleve)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ketvara	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Kineret	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Leflunomide (Arava)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Methotrexate	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Orencia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Otezla	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Plaquenil (Hydroxychloroquine)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Remicade / Renflexis / Inflectra / Avsola	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Rinvoq	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Rituxan / Ruxience / Truxima	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Simponi	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Simponi Aria	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Skyrizi	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Stelara	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sulfasalazine	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Taltz	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tremfya	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Xeljanz	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Medications (Please List):		

\_\_\_\_\_  
**Signature of Patient or Patient's Legal Representative**

\_\_\_\_\_  
**Month / Day / Year**

\_\_\_\_\_  
**Printed Name of Patient or Legal Representative**

\_\_\_\_\_  
**Relationship to Patient**

## MDHAQ FORM

Date of Birth

This questionnaire includes information not available from blood tests, x-rays, or any other source 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. There are no wrong or right answers. Please answer exactly as you think or feel. Thank you.

Date of Birth

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Month / Day / Year (xxxx)

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

OVER THE LAST WEEK, were you able to:

	Without <b>ANY</b> Difficulty	With <b>SOME</b> Difficulty	With <b>MUCH</b> Difficulty	<b>UNABLE</b> 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	_____ 2	_____ 3
l. Deal with feelings of anxiety or being nervous?	_____ 0	_____ 1	_____ 2	_____ 3
m. Deal with feelings of depression or feeling blue?	_____ 0	_____ 1	_____ 2	_____ 3

**FOR OFFICE USE ONLY**

1. a-j FN (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 = 4.1	28 = 9.3
14 = 4.7	29 = 9.7
15 = 5.0	30 = 10

2. How much pain have you had because of your condition OVER THE PAST WEEK?

Please indicate below how severe your pain has been:

	0	0.5	1	1.5	2	2.5	3	3.5	4	4.5	5	5.5	6	6.5	7	7.5	8	8.5	9	9.5	10
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PAIN AS BAD  
AS IT COULD  
BE

2. PN (0-10)
3. PTGL (0-10)

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

	0	0.5	1	1.5	2	2.5	3	3.5	4	4.5	5	5.5	6	6.5	7	7.5	8	8.5	9	9.5	10
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VERY  
POORLY

RAPID3 (0-30)
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Cat: HS = >12 MS = 6.1 - 12 LS = 3.1 - 6 R = < 3
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**OFFICE USE ONLY**

RAPID3 CUMULATIVE: _____	Weighted RAPID3: _____
Severity: _____	Modified HAQ: _____
Name of Scorer: _____	Date: _____