Arthritis Center of North Georgia

Gainesville Office
961A Smoky Mountain Springs Lane
Gainesville, GA 30501
P:770-531-3711/ F:770-531-3718

Athens Office
957 Baxter Street
Athens, GA 30606
P: 706-410-9270 / F: 706-410-9276

Last Name_____ First Name _____ MI ___Nickname _____

Date of Birth_____ Age _____ SS# _____ Sex M or F

Mailing Address _____

City _____ State _____ Zip Code _____ Marital Status: S M W Sep D

Home #: _____Work #: _____ Cell #: _____

Primary Physician_____ Referred By _____

Emergency Contact Name _____Phone # _____Relationship _____

Race: White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian, other Pacific Islander, prefer not to answer

Ethnicity: Hispanic or Latino, Not Hispanic or Latino, prefer not to answer

Preferred Language: English, Spanish or Other _____

Preferred Method of Contact for Preventative Care: Phone, Mail or web message thru the patient portal

Email Address (so that we may send you an invitation to join our patient portal website)_____

Employer Information

Employer Name _____Phone #_____

Address_____Occupation _____

Insurance Information

Insured's Name _____ DOB _____ SS# _____

Address (if different than above) _____

Phone #: _____ Relationship to patient _____

Primary Insurance _____ Policy ID #:_____Group #: _____

Secondary Insurance _____ Policy ID #:_____Group #: _____

Pharmacy Information

Pharmacy Name_____ Location/Street Name _____

Pharmacy Phone # _____ Prescription Insurance _____

I certify that the above information is correct and that I will notify this office of any changes.

Signature: _____Date: _____

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Dear Patient:

In the ever-changing world of health care and medical insurance companies, mergers have created fewer but larger companies that each offer many different plans. While we may be a provider on one plan of an insurance company, we may not be a provider on another one of their plans. **Therefore it is in your best interest to verify with your insurance company that the provider you are seeing is in-network.**

If you have an HMO or POS policy and a referral is needed to see a specialist, please contact your primary care physician to obtain the referral. **We must have this referral before your appointment. It is the patient's responsibility to make sure we have a referral on file for every visit.** If we do not have a referral on file, you will be held responsible for the charges.

Co-payments, Deductibles and Co-Insurance will be due at the time of your visits. It is also the patient's responsibility to pay for any non-covered services.

Self-Pay patients are responsible for paying $75.00 for office visit only. Cost of procedures will be discussed and payment is due before services are rendered.

We require a 24 hour notice for all appointment changes for established patients and a 72 hour notice for new patients. If a 24 or 72 hour notice is not given, there will be a $35.00 fee charged to your account.

By signing below, you give permission to have all insurance payments sent directly to our office, Arthritis Center of North Georgia and authorize the release of any information necessary to process an insurance claim.

I have read and understand the above policy.

Patient Signature _____ Date _____

Printed Name: _____ Date of Birth: _____

Arthritis Center of North Georgia

HIPAA CONSENT

Patient Name (please print): _____ Date of Birth:_____

I authorize my physician and office staff to discuss my private healthcare information with the following people (friends, family or caretakers):

Name	Relationship

I authorize my records be faxed to the following doctors upon request:

Doctor's Name	Doctor's Phone Number

☐ I authorize my records to be mailed to my home address at my request.

I understand that as part of my healthcare, Arthritis Center of North Georgia will need to contact me from time to time regarding my private healthcare information. I authorize my physician and office staff to leave a message regarding appointments, test results and billing questions or problems at the following numbers:

☐ Home Number ☐ Cell Number

☐ Work Number ☐ Other Number: _____

I understand that I have the right to revoke or amend this agreement at any time, in writing, with the Privacy Officer at Arthritis Center of North Georgia. Any revocation or change will not apply to communications already completed.

I understand that as part of my health care, Arthritis Center of North Georgia, originates and maintains paper and electronic records describing my health history. I understand that this information serves as:

- A basis of planning my care and treatment
- A means of communication among the healthcare professionals who contribute to my care
- A source of information for applying my diagnosis to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected healthcare information to another entity. I consent to such disclosure for these permitted uses as described in the Notice of Privacy Practice which is posted in the reception area and is available upon request.

I fully understand and accept the terms of this consent. Please sign and date below:

Patient Signature: _____ Date: _____

Patient Name: _____DOB: _____ Date: _____

This questionnaire includes information not available from blood tests, x-rays, or any other 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. There are no right or wrong answers. 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 O O O O O O O O O O O O O O O O O O O O O **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. 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 O O O O O O O O O O O O O O O O O O O O O **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

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. PN (0-10)

3. PTGL (0-10)

RAPID3 (0-30)

Cat:

HS = >12

MS = 6.1-12

LS = 3.1-6

R = ≤3

OFFICE USE ONLY

RAPID3 CUMULATIVE: _____ Weighted RAPID3: _____

Severity: _____ Modified HAQ:_____

Name of Scorer: _____ Date: _____