Welcome to the Carolina Center for Rheumatology and Arthritis Care! The New Patient Pack gives our doctors detailed information to assess your condition and we ask that you pay particular attention when completing each page. Please bring the completed packet with you to your appointment along with your Insurance I.D. cards and a picture I.D. Also, you have the opportunity to join our Patient Portal to send us emails, view labs, etc. Just ask us how!

Prior to your appointment, the doctor will need to review your pertinent medical records. Please contact any physicians you have seen in the past 12 months or any rheumatologist you have seen in the past and have them mail or fax relevant office notes, lab reports and x-rays at least one week prior to your appointment. If any authorizations are needed for your visits, you will be responsible for getting them to our office prior to your appointment. If we do not receive your records or authorizations, your appointment may be rescheduled. You may wish to hand deliver your records and authorization to our office to ensure their timely arrival.

PLEASE CONTACT OUR OFFICE AT 803-329-1660 TO CONFIRM OR CANCEL YOUR APPOINTMENT 48 HOURS IN ADVANCE so that we may offer the visit to another patient. Our office will try to contact you to confirm your appointment as well. If we are unable to confirm with you personally, or with your legal guardian, it will be necessary to cancel your appointment and you may be charged $50 for the doctor's time.

ALL COPAYS, COINSURANCE AND/OR DEDUCTIBLES MUST be paid at time of visit. Depending on whether you have met your yearly deductible or not, these cost could be $500 to $700 approximately. Please contact your insurance company to find out if you have a deductible for a specialist visit and/or labs and be prepared for your payment. We do offer CARE CREDIT as an option. If you desire to apply for this special payment card which offers a Promotional Option of No Interest if Paid in Full within 6 months, please see Lori upon check in. The application process is simple and we should have an answer as to whether you qualify or not, by the time you check out.

Your first appointment with the doctor will consist of a review of your medical history and current complaints, as well as, a complete rheumatologic examination. Depending upon the complexity of your problems, you will be spending 45 minutes to 1 hour with the doctor. Blood work may be necessary and it can be done in our office at this time, so drink plenty of water before your appointment.

We look forward to your visit and appreciate the opportunity to participate in your rheumatologic care.

744 Arden Lane, Suite 225
Rock Hill, SC 29732
Phone: 803-329-1660 Fax: 803-329-4118

Patient Name: ______________________________ ________________________________
First Name MI Last Name

DOB: _____/_____/_____ Sex: M/F SS#: _______-_______-_______ Age: _________

Marital Status: S/M/D/W Spouse's Name: ____________________________________

Spouse SS#: _______-_____-_______ Spouse DOB: ______/______/______ Living/Deceased

Patient Mailing Address: ____

City: ____________________________ State: _________ Zip Code: __________________________

Home Phone: (______) _________-____________ Cell Phone: (______) __________-_____________

Work Phone: (______) _______-_________ Best # to Contact You: Home/Cell/Work (circle one)

Email: ______________________________________ Do you want to join our Patient Portal?: Y / N

Emergency Contact: ____
Name Phone Relationship

Employer Name and Address: ____

____ How many years?: _____________

Responsible Party for Billing: Self/Spouse/Parent/Legal Guardian (Please circle one)

____
Name DOB Relationship

____
Phone Employer Name Employer Phone

Who is your Primary Care Physician: ____
Name of Physician Practice Name

____
Address Phone Fax

Who referred you to our office: ____
Name of Physician/Referral Source Phone

Primary Insurance: ____
Company Name ID# Group#

Policy Holder: ____
Name SS# DOB

Secondary Insurance: ____
Company Name ID# Group#

Policy Holder: ____
Name SS#

I have received a copy of The Carolina Center for Rheumatology & Arthritis Care, P.A.'s Privacy Practices and authorize the release of protected health information for the purpose of treatment, payment or any other healthcare operations. I understand that I have the right to review my protected health information and to restrict and/or revoke consent. I authorize payment of medical insurance benefits directly to The Carolina Center for Rheumatology & Arthritis Care, P.A. I permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible if my insurance company does not pay within 90 days and for any deductible, co-insurance, co-pay or non-covered services as determined by my insurance carrier. In the event that any bill goes to collection I will be responsible for all cost associated with collection, including attorney fees. **ANY PAYMENTS DUE FROM PATIENT WILL BE COLLECTED AT THE TIME SERVICES ARE RENDERED.**

Patient or Legal Guardian Signature: ____Date: _____________

THE CAROLINA CENTER FOR RHEUMATOLOGY & ARTHRITIS CARE, P.A.

PATIENT HISTORY

NAME ____________________________

Reason for today's visit: ____

____

____

Is this problem related to a work injury or worker's compensation claim? _____Yes _____No

MEDICAL HISTORY Please check if you have ever had a problem with the following:

( ) Diabetes
( ) Stroke
( ) High Blood Pressure
( ) Heart Disease
( ) Heart Murmur
( ) Anemia
( ) Heart Burn/Reflux
( ) Stomach Ulcers
( ) Liver Disease
( ) Bleeding Disorder
( ) Blood Clots
( ) Lung Disease/Asthma
( ) Cancer
( ) HIV/AIDS
( ) Mental Health
( ) Drug or Alcohol Abuse
( ) Thyroid Disorder
( ) Other______________________

LIST PREVIOUS SURGERIES **DATE/YEAR OF SURGERY**

1. ____
2. ____
3. ____
4. ____
5. ____

LIST/DESCRIBE MEDICATION ALLERGIES

____

____

____

LIST CURRENT MEDICATIONS AND DOSAGE INCLUDING VITAMINS/OVER THE COUNTER

1. __________________________________
2. __________________________________
3. __________________________________
4. __________________________________
5. __________________________________
6. __________________________________
7. __________________________________
8 __________________________________

FAMILY HISTORY

	If Living:		If Deceased:	
	Age	Health	Age at Death	Cause
Mother				
Father				

Number of Brothers _________ Number Living _________ Number Deceased _________
Number of Sisters ___________ Number Living _________ Number Deceased _________
Number of Children __________ Serious illnesses of children ______________________________

PATIENT HISTORY PAGE 2 **NAME** ____________________________

Any other blood relatives who have or had: (Check and give relationship)

( ) Rheumatoid Arthritis ( ) Lupus (SLE) ( ) Gout ( ) Osteoporosis
( ) Osteoarthritis ( ) Scleroderma ( ) Fibromyalgia

SOCIAL HISTORY

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed
Occupation: ____________________________________ Level of Education: ________________________
Do you smoke? ( ) Yes ( ) No Have you ever smoked? ( ) Yes ( ) No Packs per day: _______
Alcohol use: ( ) Beer ( ) Wine ( ) Liquor How much? __________________
Amount of Exercise: _______________________ Type of Exercise: _______________________________

SYSTEMS REVIEW (Have you had problems with any of the following)

	YES	NO
General:		
Fatigue	____	____
Sleep Difficulty	____	____
Fever	____	____
Weight Loss	____	____
Eyes:		
Dryness	____	____
Double Vision	____	____
Blurring	____	____
Red or Pink Eye	____	____
ENT:		
Dry Mouth	____	____
Mouth Ulcers	____	____
Hoarseness	____	____
Cardiovascular:		
Chest Pain	____	____
Irregular Heart Beat	____	____
Shortness of Breath	____	____
Swollen Legs or Feet	____	____
Respiratory:		
Wheezing	____	____
Cough	____	____
Coughing Blood	____	____
Gastrointestinal:		
Nausea	____	____
Vomiting	____	____
Reflux (Heartburn)	____	____
Diarrhea	____	____
Blood in Stools	____	____

	YES	NO
Kidney/Bladder:		
Burning on Urination	____	____
Blood in Urine	____	____
Frequent Urination	____	____
Sexual Difficulties	____	____
Musculoskeletal:		
Morning Stiffness	____	____
(if yes how long?)	__________	
Muscle Weakness	____	____
Joint Swelling	____	____
Skin:		
Rash	____	____
Sun Sensitivity	____	____
Hair Loss	____	____
Nodules/Bumps	____	____
Cold-induced Color Change	____	____
Nervous System:		
Headaches	____	____
Seizures	____	____
Dizziness	____	____
Numbness or Tingling	____	____
Mental/Emotional:		
Memory Loss	____	____
Poor Concentration	____	____
Depression	____	____
Blood/Lymphatics:		
Swollen Lymph Nodes	____	____
Low Blood Counts	____	____
Endocrine/Hormonal:		
Infertility	____	____
Cold or Heat Intolerance	____	

The Carolina Center For Rheumatology & Arthritis Care, P.A.

Our practice is now collecting new demographic data to aid health agencies understand healthcare disparities, improve quality of care, and strengthen research and outreach. We appreciate your assistance in meeting these new national standards. The Carolina Center for Rheumatology & Arthritis Care is dedicated to being your partner in improving patient care.

Please place a check mark next to appropriate answer. Thank you

Race:

__ ***American Indian or Alaska Native***

__ ***Asian***

__ ***Black or African American***

__ ***Native Hawaiian or Other Pacific Islander***

__ ***Caucasian/White***

__ ***Multiracial***

__ ***Refused/Declined***

Preferred Language:

__ ***English***

__ ***Spanish***

__ ***Other***

Ethnicity:

__ ***Hispanic or Latino***

__ ***Not Hispanic or Latino***

__ ***Refused/Declined***

THE CAROLINA CENTER FOR RHEUMATOLOGY & ARTHRITIS CARE, P.A.

Name of Patient: ______________________________

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I acknowledge that I have been presented with a copy of The Carolina Center for Rheumatology and Arthritis Care, P.A. Notice of Privacy Practices which can be found on their website at www.carolinasarthritiscare.com or at check-in. I also acknowledge that I had the opportunity to ask questions concerning said Privacy Practices.

_________________________________   ____________

Signature of Patient or Legal Guardian   Date

AUTHORIZATION

I authorize the office staff of The Carolina Center for Rheumatology and Arthritis Care, P.A. to discuss my treatment plan with my spouse/partner/parents/children listed below, if they call the office with questions on my behalf or the staff calls my home.

( ) YES   ( ) NO

Name of Person	Relation to Patient	Phone Number

_________________________________   ____________

Signature of Patient or Legal Guardian   Date

PAYMENT POLICY

All co-pays, coinsurance and/or deductibles MUST be paid at check-in. We accept cash, checks and most major credit cards. We do NOT accept post-dated checks. Should you owe additional monies after your insurance has processed your claim, the balance should be paid within 30 days of receiving our statement to avoid being sent to collections. If necessary, we will try to reach an agreeable payment plan with you; it is important for you to call our office manager to set up this payment plan shortly after you receive your first statement.

There will be a $25.00 charge for all checks returned by the bank for non-payment. We will only try to deposit your check once.

Please understand that your insurance plan is a contract between you and your insurance company. If we are contracted with your insurance company, we will always file the claim for your office visit, laboratory and/or infusion visit on your behalf. We cannot guarantee that all services will be paid. If all or part of your claim is denied by your insurance, you will be held responsible for any charges not paid after 90 (ninety) days from the date of service by your insurance company.

It is imperative that you keep us informed of any changes in your insurance. Each time you receive a new insurance card, you should bring it with you to your appointment. If you are changing insurance, it is critical to call us PRIOR to your appointment to ensure that we are contracted with your new insurance company and verify your benefits if necessary.

I HAVE READ AND AGREE TO ABIDE BY THE TERMS OF THIS PAYMENT POLICY. I FURTHER UNDERSTAND THAT FAILURE TO DO SO MAY RESULT IN DISMISSAL FROM THIS PRACTICE AND POSSIBLY BE SENT TO A COLLECTIONS COMPANY.

______________________________ Print Name of Patient

______________________________ If Not the Patient, Print Name of Responsible Party

______________________________ Signature of Patient or Responsible Party

____________ Date

THE CAROLINA CENTER FOR RHEUMATOLOGY & ARTHRITIS CARE, P.A.

OFFICE POLICIES

APPOINTMENTS

To keep waiting time to a minimum, the doctors see patients by appointment only.

- All patients are requested to arrive 15 minutes prior to your appointment time. Late arrivals may have to be rescheduled.
- Routine follow-up visits are scheduled for 15 minutes. The doctor also uses this time to review your chart and record your progress.
- Our policy is to confirm appointments by an automated system two days before your appointment. If you cannot be reached, please call us to confirm your appointment.
- **New patients must contact us 48 hours prior to your scheduled appointment time to confirm or cancel. Returning patients are required to call 24 hours prior to your appointment time to cancel.**
- Please be advised that there may be a $50 fee for new patients and a $25 fee for returning patients for failure to notify us 48 hours or 24 hours respectively, that you are unable to keep your scheduled appointment. Frequent no show or cancelled appointments may be cause for dismissal from the practice.

TEST RESULTS

- It may take 2 weeks or more before we receive results of specialized laboratory studies.
- **If your test results or x-rays are abnormal and necessitate prompt intervention, you will be notified immediately.**
- If normal, new patients will receive a letter from us; for patients with scheduled future appointments, the doctor will discuss your results with you at your next office visit.

PHONE CALLS

- Our office hours are 8:30 am to 5:00 pm Monday – Thursday with lunch from 12:00 to 1:00. Fridays we are open from 8:30 am to 1:00pm. We ask that you only call during those hours.
- In most cases the person answering your call will consult with the doctor and call you back.
- In the case of an emergency, please call 911.
- **While we try to return your call the same day, it may take up to 24 hours to do so unless it is an emergency. Please be patient.**

PRESCRIPTION REFILLS

- **At your appointment, have the doctor refill any medications that you will need to last until your next office visit.**
- If you require a 90-day refill, please tell the doctor.
- If you need a refill between office visits, contact your pharmacist, they will call our office for approval.
- Do not wait until you are completely out of a medication to contact your pharmacist. **It may take 4 business days to get your prescription refilled.**
- If you are having problems with a medication, please call our office as early in the day as you can.
- Controlled substance drugs will not be called in over the phone. Refills will be given only at time of office visit.

MEDICAL RECORDS/FORMS

- Please allow 14 to 21 business days to obtain your medical records. Please allow 7 to 10 days for completion of forms or letters. An office visit may be required to do so. There may be a charge for these services. Please ask our front desk staff.

OFFICE LOCATION

- **Our office, located at 744 Arden Lane, Suite 225, Hunter at Millwood Building, Rock Hill, SC is in the Millwood Shopping Plaza behind Talbots and Chico's clothing stores off of Herlong Avenue, ¼ mile from the intersection of Ebenezer and Herlong and the 3rd light from the corner of Celanese Road and India Hook Road (India Hook Road turns into Herlong Avenue). Our office is in the 2nd brick medical office building on the right, (the door and parking lot are in the rear). Take the elevator to the second floor and Suite 225 is at the end of the hall.**

From 77

- **Take exit 82C towards York onto Celanese Road. Go approximately 1.2 miles and turn left onto India Hook Road. (A Dunkin Donuts and a Burger King will be on the left at this intersection) Go approximately .8 miles. (India Hook Road will become Herlong Road) At the 3rd light, turn right onto Arden Lane into the Millwood Shopping Center. (There are Talbots and Chicos Clothing Stores at this light) Go straight back to the second 2-story brick office building on the right called Hunter at Millwood. (LA Fitness will be on the left) Park in the back. Take elevator to second floor to Suite 225. Please call us at 803-329-1660 should you need further directions.**