Arthritis & Rheumatology of GA, PC
980 Johnson Ferry Road NE, Suite 220
Atlanta, GA 30342
T: 404-255-5956 f: 404-255-3626

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Welcome to our practice!

We look forward to seeing you on this date:_____at this time:_____with Dr._____ at 980 Johnson Ferry Rd NE, Suite 220, Atlanta, GA.

We are delighted that you have chosen us for your medical needs. At ARG we take great pride in the relationships that we establish with our patients and the ability to provide a personalized approach to difficult problems.

As a patient of the Articularis Healthcare Group, Inc., we appreciate you following the guidelines of the practice to help us maintain our goals. Please read through our policies carefully and call us with any questions.

New patients:

Please arrive 30 minutes before your scheduled appointment time with the completed paperwork to allow for the registration process. Please do not mail paperwork.

- There is a $50 no-show and cancelation fee for all appointments not kept or not canceled within 24 hours prior to your appointment date, except for emergencies.

  Cash payments, deductibles and co-payments must be paid at the **time of service**.
- Payments for medical services not covered by insurance plans are the patient's responsibility.

  Self-Pay patients are required to bring $205 to their initial visit. Additional financial assistance is
- available; please ask our Front Desk Receptionist for details.

Please bring attached forms, your photo ID and insurance cards to your visit.

Please be aware that if you arrive over 15 minutes late to your appointment you will be asked to reschedule.

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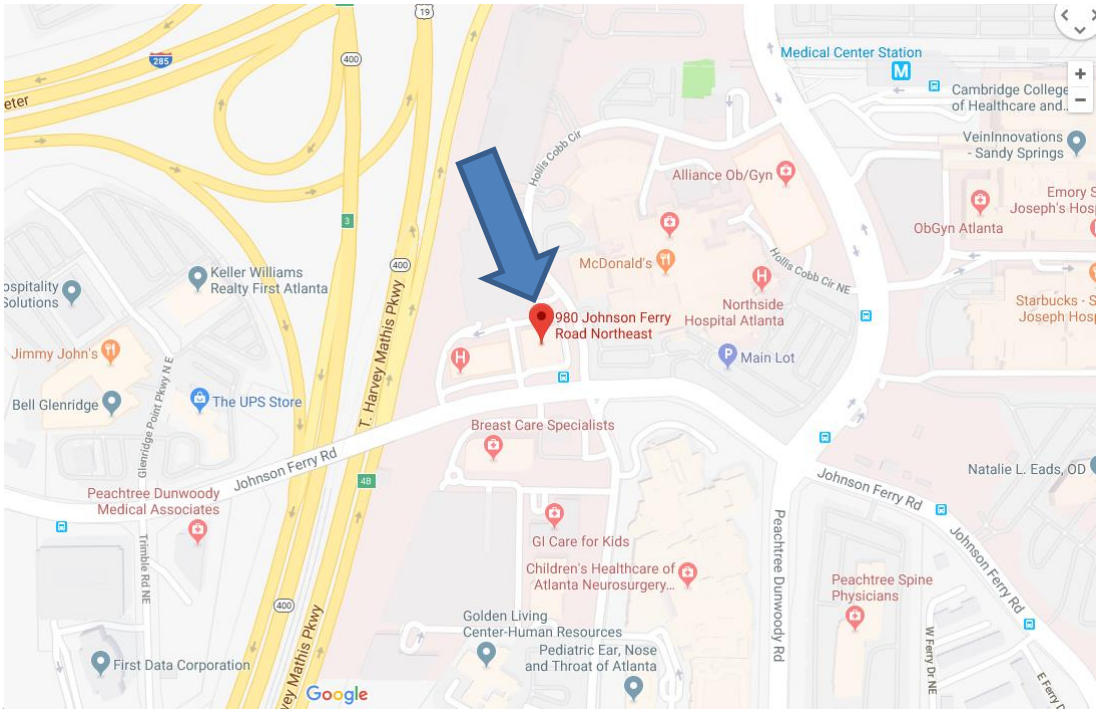

Directions Traveling East on I-285

Exit #26 at the Glenridge Connector and turn right at the foot onto Glenridge Drive. Merge into the left-hand turn lane, and turn left at the light onto Johnson Ferry Road. The Doctors Centre is on your left after crossing the bridge and before the next intersection. Turn left into the Doctors Centre, the 960 building is on the left and the 980 building is on your right. Parking is immediately ahead in the garage. The current cost to park is $6.00.

Directions Traveling West on I-285

Exit #28 at Peachtree-Dunwoody Road and turn left onto Peachtree Dunwoody Road. Turn right at the fourth traffic light onto Johnson Ferry Road, in front of Northside Hospital. Pass Northside Hospital on the right, Scottish Rite on your left. The Doctors Centre is on your right, passing through the next traffic light. Turn right into the Doctors Centre and drive straight ahead for the parking garage. The 980 building is on your right as your drive in. The current cost is $6.00.

Directions from GA 400 (North and South)

Traveling North- take exit 4A and turn left onto the Glenridge Connector. Turn right at the light onto Johnson Ferry Road. The Doctors Centre is on your left before the Hospital.

Traveling South- Take exit #3 and turn left onto the Glenridge Connector. Turn right at the light onto Johnson Ferry Road and the Doctors Centre is ahead on your immediate left. The parking deck is immediately ahead in the garage and the current cost to park is $6.00.

***PLEASE BE AWARE IT IS $6.00 **CASH, CHECK, OR CARD** TO PARK WITHIN THE PARKING DECK. THIS IS REGULATED BY A THIRD PARTY AND NOT UNDER OUR CONTROL. THANK YOU FOR YOUR UNDERSTANDING. ***

Arthritis & Rheumatology of GA, A Member of Articularis Healthcare, Inc.

Patient Information

Last Name	**First Name**	**Middle Initial**
Street Address		**Apt/Lot**
City	**State**	**Zip**
SSN	**DOB**	**Circle One:** ◯ **Mr.** ◯ **Mrs.** ◯ **Ms.**
Email	**Cell #**	**Home #**
Circle One: ◯ **Male** ◯ **Female**	**Marital Status** ◯ **S** ◯ **M** ◯ **W** ◯ **D**	**Student** ◯ **Yes** ◯ **No**

Employment (Circle One):
◯ **Full-Time** ◯ **Part-time** ◯ **Retired** ◯ **Disabled**

Referring Physician	**Phone #**
Primary Care Physician	**Phone #**
Spouse	**Phone #**
Emergency Contact	**Phone #**
Primary Insurance Name	**Policy #**
Policy Holder Name	**DOB**
Group #	**Group Name**
Secondary Insurance	**Policy #**
Policy Holder Name	**DOB**
Group #	**Group Name**

Authorization to Treat: I consent to examination, treatment and procedures which may be performed during my office visits including emergency treatment considered necessary by the physician and/or his designated provider. **Assignment of Insurance:** I hereby assign payment directly to Arthritis and Rheumatology of GA, P.C. for services covered by insurance or other health benefit plans.
Authorization for Release of Information: I authorize ARG to release to my insurance carrier and its designated agents any medical information, including information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS, necessary to process any healthcare related review or quality assurance activities. I also authorize the release of medical information to other healthcare providers who provide consultative services regarding my healthcare. This authorization remains in effect until revoked by me in writing. I agree that a photocopy of the same is as valid as the original.

Patient/Guardian: _____ Date: _____
Signature

Arthritis & Rheumatology of GA, A Member of Articularis Healthcare, Inc.

Patient Name: _____ Date of Birth: _____

Reason for visit: _____

Preferred Pharmacy: _____ Address: _____

City: _____ State: _____ Zip: _____

Current medications: Please list **name, strength,** and **frequency.**

1 _____/_____mg
2 _____/_____mg
3 _____/_____mg
4 _____/_____mg
5 _____/_____mg
6 _____/_____mg
7 _____/_____mg
8 _____/_____mg
9 _____/_____mg
10 _____/_____mg
11 _____/_____mg
12 _____/_____mg
13 _____/_____mg
14 _____/_____mg

Medications you have **tried in the past** for your arthritis condition.

1 _____
2 _____
3 _____
4 _____

Medical History: Please list any diseases or illnesses you have now or have had previously.

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____
10 _____

Medication or Latex allergies: _____

Prior Surgeries: _____

_____

Have you ever smoked cigarettes, or tobacco in other forms? ☐ Yes ☐ No

If yes, when you were smoking your heaviest, how many packs per day did you smoke, on average: _____

What year did you start smoking? _____ If you subsequently quit, what year did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, please circle: Beer Wine Liquor

On average, how many drinks per week? _____

What other physicians care for you, now and in the past?

1. _____ 3. _____
2. _____ 4. _____

Please indicate the history of arthritis or rheumatic disease in your family:

	Father	Mother	Sibling
Rheumatoid Arthritis			
Gout			
Psoriasis			
Lupus			
Other:			

Date of last DEXA Scan: _____

Is your arthritis a result of an accident or trauma? ☐ Yes ☐ No

*We **do not** provide care for problems related to accidents for which there is ongoing litigation for Workman's Compensation. Notify the office if you are unclear about your case.

*Disability forms **will not** be completed until you have received six months of established care from our practice.

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Authorization to Release/Obtain Medical Records

Patient Name:_____ DOB: _____

Previous Name (if applicable):_____ SSN: _____

Method of disclosure:

☐ I authorize Articularis Healthcare to **release** my medical records to:

Name: _____

Fax #: _____

☐ I authorize Articularis Healthcare to **obtain** my medical records from:

Name: _____

Fax #: _____

Health Information to disclose:

☐ ALL health information

☐ Healthcare information relating to the following:

Treatment, Condition, or Dates: _____

I understand I have the right to refuse to sign this form, and that I may revoke my authorization at any time (except to the extent that the information has already been released). When my information is disclosed, the federal HIPAA Privacy Rule may no longer protect it. This authorization will automatically expire one (1) year from the date of this request or on the following requested date:

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

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Medical Information Release Form (HIPAA Release Form)

I understand that Articularis Healthcare Group, Inc. maintains my personal records, medical history, symptoms, examinations, and test results as a part of my healthcare. This information is not to be given to any other person without my permission. Therefore, this is a written consent to authorize release of my medical information.

RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records, laboratory values, prescribed medications, treatment plan, examination rendered, and claims information. This information may be released to:

☐ Spouse:_____

☐ Child(ren):_____

☐ Other:_____

☐ Check if okay to leave detailed health information on voicemail

☐ Information is **NOT** to be released to anyone

Patient Signature:_____Date: _____

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We are committed to providing our patients with the best possible medical care and minimizing administrative costs. Please read through this policy thoroughly. If you have any questions, please call our Front Desk prior to your visit.

New Patients

- If you are unable to keep your appointment, kindly call our office at least 72 hours prior to your appointment time. We will work with you to reschedule you to a more convenient time.
- Self-pay patients are required to bring a payment in the amount of $205 to their initial visit, which will be collected prior to being seen by the physician. Additional financial assistance is available after the first visit; please ask the Front Desk Receptionist for details.

Follow-up Appointments

- Established patients with a balance greater than $100 must clear the outstanding balance with the billing department before scheduling any future appointments. Payment plans can be arranged if necessary.
- Any patient who no-shows or cancels 2 appointments without giving a 72-hour notice will receive a discharge warning letter in the mail.
- If a patient cancels or no-shows 3 times in a calendar year they will be discharged from the practice.
- It is the patient's responsibility to keep up with their appointment times. We send automated calls/text message appointment reminders as a courtesy.
- It is the patient's responsibility to obtain any referral needed for a Blue Choice/Tricare Prime insurance for their office visit.

Prescriptions and Refills

- All prescription refills will be done at your appointment time.
- **Additional refills will only be filled if patient has kept previous appointment and has follow up appointment scheduled.**
- Patients are required to provide name and contact information for their pharmacy.
- **WE DO NOT ACCEPT FAXES FROM YOUR PHARMACY.**
- ARG does not offer chronic pain management and will not dispense chronic pain medication. Patient will need to discuss referral options with their doctor.
- **ARG is not your primary care physician group.** Likewise, we cannot refill medications that we do not monitor or prescribe.
- **Please allow 2 business days for refills.**

Patient/Guardian Signature**:**_____ Date**:**_____

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Patient Financial Policy

- We will collect payments at the time of service based on the patient's insurance allowable amounts, deductible, co-payment, and any portion of charges as specified by the plan at the time of visit.
  - Payment for professional services can be made with cash, check, credit.
  - Statements must be paid within 30 days upon receipt via Patient Portal, over the phone, by mail, or in person.
  - Payment plans are available to those whose services rendered total greater than $200 after the new patient appointment. A credit, debit, HSA card, or bank account is required to be on file for all payment plans. For balances greater than $200, 1/3 of the balance will be drafted on the 1st day of each of the next 3 consecutive months.
- As the owner of the insurance policy, the patient is solely responsible for the policies regarding their plan, to provide us with current insurance information, to notify us with any changes to insurance coverage, and to bring his/her insurance card to each visit. If we do not have the correct insurance information, the patient is responsible for the bill.
- If the patient believes the insurance denied or processed the claim in error, please call us immediately. If the patient pays more than they are responsible for before insurance is processed, we will apply the credit to the patient's account and it may be used at the next visit or receive a refund of the overpayment.
- Our Billing Department will submit a claim for services rendered for patients who are beneficiaries of insurance companies our practice participates with. All necessary insurance information, including any forms, must be completed by the patient prior to leaving the office. If a patient has insurance in which we do not participate, our office will file the claim upon request; however, payment in full is expected at the time of service.
- If the patient's insurance company requests additional information from the patient, it is important to reply to their requests in a timely manner. If the insurance company does not pay the claim in 45 days, the balance is billed to and becomes the responsibility of the patient.
- Financial assistance is available for qualified patients. If a patient feels that he or she may qualify for assistance, the Front Desk Receptionist should be notified. Patients who do not have insurance are expected to pay for professional services at the time of service unless prior arrangements have been made with us.

Patient/Guardian Signature**:**_____ Date**:**_____

NAME:_____

DOB:_____

DATE:_____

RAPID3

ROUTINE ASSESSMENT OF PATIENT INDEX DATA

The RAPID3 includes a subset of core variables found in the Multi-dimensional HAQ (MD-HAQ). Page 1 of the MD-HAQ, shown here, includes an assessment of physical function (section 1), a patient global assessment (PGA) for pain (section 2), and a PGA for global health (section 3). RAPID3 scores are quickly tallied by adding subsets of the MD-HAQ as follows:

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

1. a-j FN (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. PN (0-10):

3. PTGE (0-10):

RAPID3 (0-30)

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 — 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 — 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