Low Country Rheumatology

A MEMBER OF Articularis HEALTHCARE

Phone (843) 572-4840
New Patient Dept. Phone (843) 572-4852
www.lowcountryrheumatology.com

Gary E. Fink, M.D.
Gregory W. Niemer, M.D.
Alan N. Brown, M.D.
Colin C. Edgerton, M.D.
William M. Edwards, M.D.
Clarence W. Legerton III, M.D.
Jennifer K. Murphy, M.D.
Nicholas Holdgate, MD

Welcome to our practice!

We look forward to seeing you on this date: _____ at this time: _____ with Dr._____ at our **Mount Pleasant** location.

We are delighted that you have chosen us for your medical needs. At Articularis Healthcare 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 15 minutes before your schedule appointment time with the completed paperwork to allow for the registration process. Please do not mail paperwork.

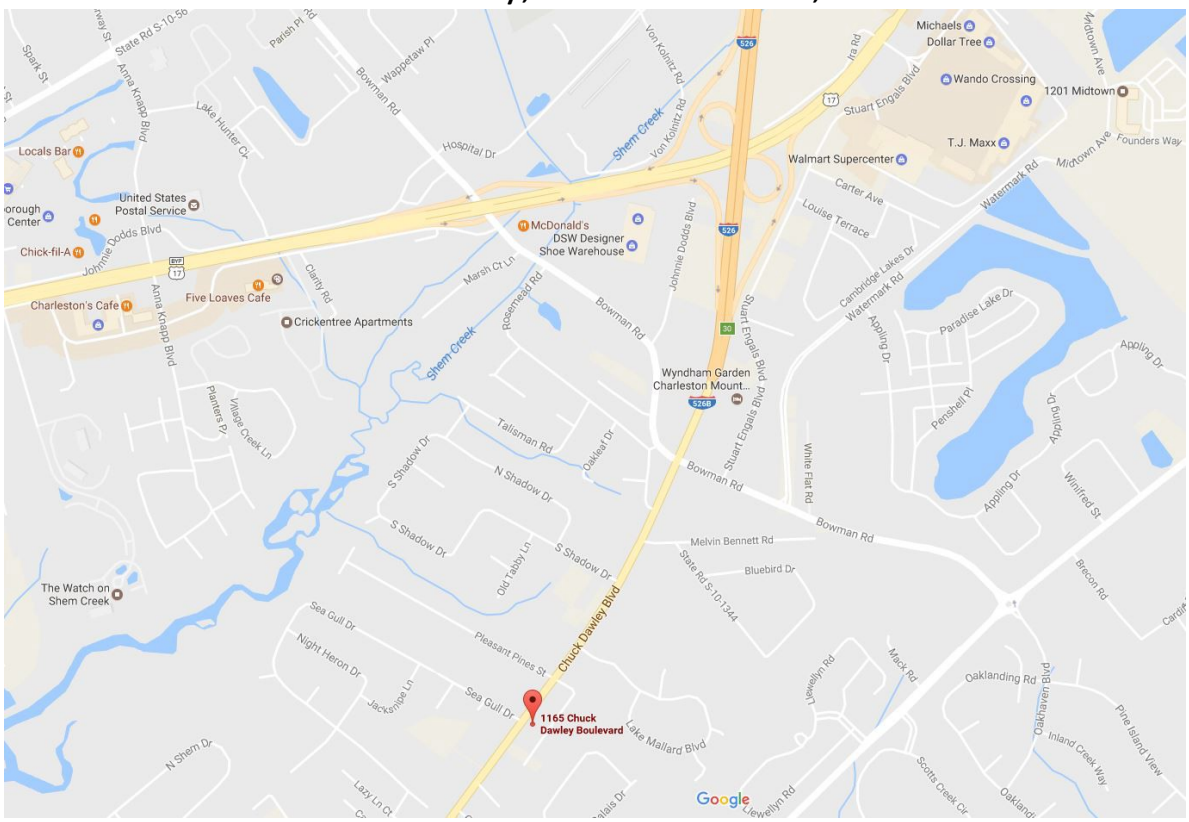
- There is a $25 no-show and cancelation fee for all appointments not kept or not canceled within 72 hours prior to your appointment date, except for emergencies. A credit/debit card number is required at the time of scheduling to secure all new patient appointments.
- Cash payments, deductibles and co-payments must be paid at the time of service. Payments for medical services not covered by insurance plans are the patient's responsibility.
- We do accept Medicaid as a secondary insurance to Medicare or Medicare Replacement plans.
- Self-Pay patients are required to bring $250 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.

Directions to Mount Pleasant Office

1165 Chuck Dawley, Mount Pleasant, SC 29464



From Myrtle Beach/Georgetown -Take US-17 South to Mount Pleasant. Exit 526 via SC 703 ramp to Chuck Dawley Blvd. Roughly 1 mile down, Low Country Rheumatology will be on the left.

From Downtown Charleston - Take exit 220B/17 North to Mount Pleasant/Georgetown. Stay in the right 2 lanes and continue across the Arthur Ravenel Jr. Bridge. Take exit 703 Coleman Blvd/Sullivan's Island. Keep left and continue on Coleman Blvd for roughly 2 miles. Use the left 2 lanes and turn left onto Chuck Dawley Blvd. Roughly 1 mile down, Low Country Rheumatology will be on your right.

From Daniel Island - Merge onto 1-526 East towards Mount Pleasant. Continue onto 526 to 1165 Chuck Dawley Blvd. Low Country Rheumatology will be on your left.

Low Country Rheumatology, 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**

Consent for treatment, payment and acknowledgement of receipt of notice of privacy practices: I request that payment under the medical insurance program be made payable to Articularis Healthcare Group, Inc. I authorize disclosure of my personal health information to carry out treatment, payment or health care procedures. I have received the privacy policy and notice of information practices that provides a more complete description of information uses and disclosures. I agree to pay any and all charges that exceed or not paid/covered by my insurance. In the event my account is turned over to a collection agency, I will be billed the additional collection fees.

Patient/Guardian: _____ Date: _____
Signature

Low Country Rheumatology, A Member of Articularis Healthcare, Inc.
Health Questionnaire

Patient Name: _____ Date of Birth: _____

Reason for visit:_____

Preferred Pharmacy: _____ Address: _____

City: _____ State: _____ Zip: _____

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

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 _____ 3 _____
2 _____ 4 _____

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

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

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: _____

* ***This authorization expires ONE year from the date of signature****

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 myinformation 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: _____

Witness Signature:_____Date: _____

Low Country Rheumatology, a Member of Articularis Healthcare Group, Inc.
Scheduling Policy

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

- A credit/debit card is required to be on file to schedule and reserve a new patient appointment.
  - A $25 fee will be charged to the card on file for all new patient appointments that are canceled less than 72 hours prior to the scheduled appointment date.
- If you care 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.
- We do accept Medicaid as a secondary insurance to Medicare or Medicare Replacement plans.
- Self-pay patients are required to bring a payment in the amount of $250 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.
- A physician will review the medical records of all Medicaid and self-referral patients before being scheduled.

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.

Patient/Guardian Signature: _____ Date: _____

Low Country Rheumatology, a Member of Articularis Healthcare Group, Inc.
Patient Financial Policy

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 Billing Department prior to your visit.

- We will no longer send paper statements in the mail; statements can be viewed online through our Patient Portal.
- 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, or Care Credit.
    - Patients that carry a balance after insurance is processed will receive a statement via Patient Portal.
        - Statements must be paid within 30 days upon receipt via Patient Portal, over the phone, by mail, or in person.
        - Patients that do not pay their first statement within 30 days will be required to store a credit, debit, HSA card or account on file.
    - 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.
        - We do not have access to the patient's credit/debit/HSA/bank information. It is stored and encrypted by a certified company that is compliant with all federal privacy laws as well as the Payment Card Industry Data Security Standards (PCI DSS). Additionally, each of our offices are PCI DSS compliant.
- 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**:** _____

Low Country Rheumatology, a Member of Articularis Healthcare Group, Inc.
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 an Articularis Healthcare Group, Inc. 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.
    - **We do not accept refill requests from pharmacies**.
- All narcotic refill requests will 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.

Patient/Guardian Signature: _____ Date: _____

Multi-Dimensional Health Assessment Questionnaire (R808-NP2)

This questionnaire includes information not available from blood tests, X-rays, or any 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. <u>There are no right or wrong answers.</u> 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 ○ 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. Please place a check (√) in the appropriate spot to indicate the amount of pain you are having today in each of the joint areas listed below:

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
a. LEFT FINGERS	□ 0	□ 1	□ 2	□ 3	i. RIGHT FINGERS	□ 0	□ 1	□ 2	□ 3
b. LEFT WRIST	□ 0	□ 1	□ 2	□ 3	j. RIGHT WRIST	□ 0	□ 1	□ 2	□ 3
c. LEFT ELBOW	□ 0	□ 1	□ 2	□ 3	k. RIGHT ELBOW	□ 0	□ 1	□ 2	□ 3
d. LEFT SHOULDER	□ 0	□ 1	□ 2	□ 3	l. RIGHT SHOULDER	□ 0	□ 1	□ 2	□ 3
e. LEFT HIP	□ 0	□ 1	□ 2	□ 3	m. RIGHT HIP	□ 0	□ 1	□ 2	□ 3
f. LEFT KNEE	□ 0	□ 1	□ 2	□ 3	n. RIGHT KNEE	□ 0	□ 1	□ 2	□ 3
g. LEFT ANKLE	□ 0	□ 1	□ 2	□ 3	o. RIGHT ANKLE	□ 0	□ 1	□ 2	□ 3
h. LEFT TOES	□ 0	□ 1	□ 2	□ 3	p. RIGHT TOES	□ 0	□ 1	□ 2	□ 3
q. NECK	□ 0	□ 1	□ 2	□ 3	r. BACK	□ 0	□ 1	□ 2	□ 3

4. 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

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1.a-j FN (0-10): ☐

1=0.3 2=0.7 3=1.0 4=1.3 5=1.7 6=2.0 7=2.3 8=2.7 9=3.0 10=3.3 11=3.7 12=4.0 13=4.3 14=4.7 15=5.0 16=5.3 17=5.7 18=6.0 19=6.3 20=6.7 21=7.0 22=7.3 23=7.7 24=8.0 25=8.3 26=8.7 27=9.0 28=9.3 29=9.7 30=10

2 .PN (0-10): ☐

4.PTGL (0-10): ☐

RAPID 3 (0-30) ☐

Cat:
HS = >12
MS = 6.1-12
LS = 3.1-6
R = ≤3

Please turn to the other side

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5. Please check (√) if you have experienced any of the following over the last month:

☐ Fever	☐ Lump in your throat	☐ Paralysis of arms or legs
☐ Weight gain (>10 lbs)	☐ Cough	☐ Numbness or tingling of arms or legs
☐ Weight loss (>10 lbs)	☐ Shortness of breath	☐ Fainting spells
☐ Feeling sickly	☐ Wheezing	☐ Swelling of hands
☐ Headaches	☐ Pain in the chest	☐ Swelling of ankles
☐ Unusual fatigue	☐ Heart pounding (palpitations)	☐ Swelling in other joints
☐ Swollen glands	☐ Trouble swallowing	☐ Joint pain
☐ Loss of appetite	☐ Heartburn or stomach gas	☐ Back pain
☐ Skin rash or hives	☐ Stomach pain or cramps	☐ Neck pain
☐ Unusual bruising or bleeding	☐ Nausea	☐ Use of drugs not sold in stores
☐ Other skin problems	☐ Vomiting	☐ Smoking cigarettes
☐ Loss of hair	☐ Constipation	☐ More than 2 alcoholic drinks per day
☐ Dry eyes	☐ Diarrhea	☐ Depression - feeling blue
☐ Other eye problems	☐ Dark or bloody stools	☐ Anxiety - feeling nervous
☐ Problems with hearing	☐ Problems with urination	☐ Problems with thinking
☐ Ringing in the ears	☐ Gynecological (female) problems	☐ Problems with memory
☐ Stuffy nose	☐ Dizziness	☐ Problems with sleeping
☐ Sores in the mouth	☐ Losing your balance	☐ Sexual problems
☐ Dry mouth	☐ Muscle pain, aches, or cramps	☐ Burning in sex organs
☐ Problems with smell or taste	☐ Muscle weakness	☐ Problems with social activities

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5. ROS: ☐

Please check (√) here if you have had none of the above over the last month:_____.

---

6. When you awakened in the morning OVER THE LAST WEEK, did you feel stiff? ☐ No ☐ Yes
If "No," please go to Item 7. If "**Yes**," **please indicate the number of minutes_____, or hours _____** until you are as limber as you will be for the day.

7. How do you feel TODAY compared to ONE WEEK AGO? Please check only one.
☐ Much Better ☐ Better ☐ the Same ☐ Worse ☐ Much Worse

8. How often do you exercise aerobically (sweating, increased heart rate, shortness of breath) **for at least one-half hour** (30 minutes)**? Please check only one.**
☐ 3 or more times a week ☐ 1-2 times per month
☐ 1-2 times per week ☐ Do not exercise regularly ☐ Cannot exercise due to disability/ handicap

9. How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK?

FATIGUE IS NO PROBLEM ○ FATIGUE IS A MAJOR PROBLEM
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

10. Over the last 6 months have you had: [Please check (√)]

☐ No	☐ Yes	An operation or new illness	☐ No	☐ Yes	Change(s) of arthritis or other medication
☐ No	☐ Yes	Medical emergency or stay overnight in hospital	☐ No	☐ Yes	Change(s) of address
☐ No	☐ Yes	A fall, broken bone, or other accident or trauma	☐ No	☐ Yes	Change(s) of marital status
☐ No	☐ Yes	An important new symptom or medical problem	☐ No	☐ Yes	Change job or work duties, quit work, retired
☐ No	☐ Yes	Side effect(s) of any medication or drug	☐ No	☐ Yes	Change of medical insurance, Medicare, etc.
☐ No	☐ Yes	Smoke cigarettes regularly	☐ No	☐ Yes	Change of primary care or other doctor

Please explain any "Yes" answer below, or indicate any other health matter that affects you:

_____

_____

SEX: ☐ Female, ☐ Male **ETHNIC GROUP:** ☐ Asian, ☐ Black, ☐ Hispanic, ☐ White, ☐ Other_____

Your Occupation _____

Work Status: ☐ Full-time, ☐ Part-time ☐ Disabled
☐ Homemaker, ☐ Self-Employed, ☐ Retired,
☐ Seeking work, ☐ Other_____

Please circle the number of years of school you have completed:
1 2 3 4 5 6 7 8 9 10
11 12 13 14 15 16 17 18 19 20

Please write your weight:_____lbs. height:_____inches

Your Name_____ **Date of Birth**_____ **Today's Date** _____

 Thank you for completing this questionnaire to help keep track of your medical care. **R808NP2**

FOR OFFICE USE ONLY: I have reviewed the questionnaire responses.
Date: _____ Signature_____