ARTHRITIS ASSOCIATES

www.sebbaarthritis.com

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ANTHONY SEBBA, MD ANJALI SHETTY, MD ROHAN CHAWLA, MD SHREYA GOR, MD

Dear _____,

Welcome to Arthritis Associates.

This letter is to confirm your appointment for a consultation on _____ at _____.

Because we reserve more time for your first appointment, if you do not hear from us the day before your appointment, please call us at 727-773-9793, option one, to confirm your appointment time. There may be a charge for missed appointments or appointments cancelled without 24 hours' notice.

We are located in the Harbor Park building complex on the west side of US 19, corner of Nebraska. There are two entrances, one on US Highway 19 and one on Nebraska, across from Sprouts. The building is located behind the Verizon and Grain & Berry stores on US 19.

Normal office hours are 7am – 4:30pm, Monday through Thursday. We are closed on Friday.

Please fill out necessary paperwork prior to your appointment time:

- Patient History forms
- Patient Information form
- Patient Assessment forms
- Financial Agreement
- Patient Consent form

If your insurance company requires a referral or authorization to see a specialist, please make sure we receive this from your primary care physician before the date of your appointment.

Please make sure you or your referring physician provides us with all relevant medical records including labs, x-rays, MRI, and CAT scans.

Thank you for choosing Arthritis Associates.

Sincerely,

The staff of Arthritis Associates

Dear Patient:

The completion of forms represents an administrative service to patients beyond the provision of medical care. The time and effort involved in providing special requests results in significant costs especially when multiplied over the large number of patients our practice services.

Financial Assistance may be available for your medication, but it is also an added administrative burden requiring time and effort of our staff and physicians. Please be aware there is a fee for each application and renewals applications for each medication. For this fee:

- Arthritis Associates can direct you to the financial assistance/foundation based on medication
- Arthritis Associates will fill out physician portion of forms and obtain physician signature
- Arthritis Associates will fax appropriate documentation to program and maintain a copy in patient's chart
- **Patient will be responsible to follow-up with foundation/program and keeping track of renewals.**
- Arthritis Associates will provide any follow-up documentation required by foundation/program, such as insurance authorization or attempted authorization, including appeals.

Arthritis Associates
Financial Agreement

This is a financial agreement between you, the patient, and Arthritis Associates. Please review and initial each policy below:

_____Your insurance policy is a legal contract between you and your insurance company and it is your responsibility to know your medical benefits.

_____You will be responsible to provide current insurance information prior to each visit and bring your insurance card to each appointment. Even minor changes to your insurance may make a big difference. If we are not informed of changes in your insurance, you could be responsible for medical charges.

_____Under the terms of your contract with your insurance company, we must collect any Copay prior to you being seen. If you cannot pay the Copay upon checking in, you may be rescheduled.

_____Under the terms of your contract with your insurance company, and our agreement with them, all referrals and prior authorizations are required before we see you. We respectfully ask that you contact your primary care physician for this authorization. If we do not receive the authorization before your visit, we will need to reschedule your appointment.

_____You agree to pay our fee of $25 if you do not show for your scheduled appointment or cancel it within 24 hours.

_____ You are aware that there is a charge for special requests such as disabled parking applications, financial assistance forms (physician portion only), any letter written by physician/provider, FMLA forms, short/long term disability forms (functional capacity evaluations are not done here).

WE ARE NOT MEDICAID PROVIDERS. If you have a Medicaid plan, secondary or supplemental to your primary insurance plan, we cannot accept this insurance. By signing this Agreement, you agree to be responsible for copays, coinsurance, and/or deductibles. If you have Medicaid QMB eligibility, please let staff know.

The following name(s) are granted permission to discuss financial responsibility information:

Name	Relationship
_____	_____
_____	_____

By signing below, I agree to the policies above and I authorize the Practice to bill my insurance for services provided to me and request the payments for such services to be made to the Practice on my behalf.

_____

Patient's name (please print)

_____ _____

Patient's or legal guardian's signature Date

Arthritis Associates Patient Consent Form

Uses and Disclosures of Your Protected Health Information (PHI)

I understand that as part of my health care, the practice originates and maintains paper and electronic records describing my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my continued care
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually rendered
- To obtain authorizations for treatment, prescriptions, or financial assistance
- A tool for routine health care operation, such as assessing quality and reviewing the competence of staff
- A copy of our NOTICE OF PRIVACY PRACTICES is available upon request for a more complete description of information uses and disclosures.

I authorize Arthritis Associates to leave health information messages on my:

home answering machine Yes / No (please circle)

cell phone voice mail Yes / No (please circle)

I hereby authorize Arthritis Associates to discuss my protected health information with the following:

Name	Relationship
_____	_____
_____	_____

Permission to Treat

Permission is hereby granted for physicians, employees, or agents of the Practice to render the patient named below medical treatment as deemed necessary.

_____

Patient's name (please print)

_____ _____

Patient's or legal guardian's signature Date

Arthritis Associates
Patient Information

Name: _____ Today's Date: _____

Date of birth: _____ SSN _____

Address: _____ Marital Status: _____ Sex: ____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work/Other Phone: _____ Email: _____

Employer Name & Address: _____

Emergency Contact: _____

Relation to you: _____ Phone: _____

Pharmacy: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Address: _____

Referring Physician: _____ Phone: _____

Address: _____

Primary Insurance Company: _____

Who is the policy holder: _____ DOB: _____

Policy ID: _____ Group: _____

Secondary Insurance Company: _____

Who is the policy holder: _____ DOB: _____

Policy ID: _____ Group: _____

Seasonal address: _____

Usual months at this address: _____ Phone: _____

AMERICAN COLLEGE OF RHEUMATOLOGY
Patient History Form

Date of first appointment: _____ Time of appointment: _____ Birthplace: _____

Name: _____ Birthdate: _____
LAST FIRST MIDDLE INITIAL MAIDEN

Address: _____ Age: _____ Sex: ○ F ○ M
STREET APT#

_____ Telephone: Home _____
CITY STATE ZIP Work _____

MARITAL STATUS: ○ Never Married ○ Married ○ Divorced ○ Separated ○ Widowed

Spouse/Significant Other: ○ Alive/Age ____ ○ Deceased/Age ____ Major Illnesses _____

EDUCATION (select highest level attended):

Grade School ○7 ○8 ○9 ○10 ○11 ○12 College ○1 ○2 ○3 ○4 ○ Graduate School _____

Occupation _____ Number of hours worked/average per week _____

Referred here by: (check one) ○ Self ○ Family ○ Friend ○ Doctor ○ Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Do you have an orthopedic surgeon? ○ Yes ○ No If yes, Name: _____

Describe briefly your present symptoms:

Date symptoms began (approximate): _____

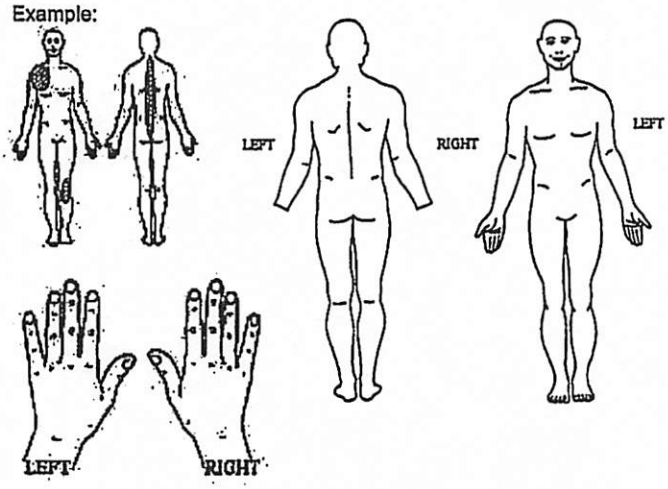
Diagnosis: _____

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later):

Please list the names of other practitioners you have seen for this problem:

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands.**

Example:



RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
☐	Arthritis (unknown type)		☐	Lupus or "SLE"	
☐	Osteoarthritis		☐	Rheumatoid Arthritis	
☐	Gout		☐	Ankylosing Spondylitis	
☐	Childhood arthritis		☐	Osteoporosis	
Other arthritis conditions:					

Patient's Name _____ Date _____ Physician Initials _____

SYSTEMS REVIEW

As you review the following list, please check any of those problems which have significantly affected you.

Date of last mammogram _____ Date of last eye exam _____ Date of last chest x-ray _____

Date of last Tuberculosis Test _____ Date of last bone densitometry _____

Constitutional

- ☐ Recent weight gain
  amount _____
- ☐ Recent weight loss
  amount _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever

Eyes

- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye
- ☐ Itching eyes

Ears-Nose-Mouth-Throat

- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Dryness in nose
- ☐ Runny nose
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness of mouth
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing

Cardiovascular

- ☐ Pain in chest
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat
- ☐ High blood pressure
- ☐ Heart murmurs

Respiratory

- ☐ Shortness of breath
- ☐ Difficulty in breathing at night
- ☐ Swollen legs or feet
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing (asthma)

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting of blood or coffee ground material
- ☐ Stomach pain relieved by food or milk
- ☐ Jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools
- ☐ Heartburn

Genitourinary

- ☐ Difficult urination
- ☐ Pain or burning on urination
- ☐ Blood in urine
- ☐ Cloudy, "smoky" urine
- ☐ Pus in urine
- ☐ Discharge from penis/vagina
- ☐ Getting up at night to pass urine
- ☐ Vaginal dryness
- ☐ Rash/ulcers
- ☐ Sexual difficulties
- ☐ Prostate trouble

For Women Only:

Age when periods began:_____

Periods regular? ☐ Yes ☐ No

How many days apart? _____

Date of last period? _____

Date of last pap?_____

Bleeding after menopause? ☐ Yes ☐ No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal

- ☐ Morning stiffness
  Lasting how long?
  _____ Minutes _____ Hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint swelling

List joints affected in the last 6 mos.

_____

_____

_____

_____

_____

Integumentary (skin and/or breast)

- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive (sun allergy)
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet in the cold

Neurological System

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle spasm
- ☐ Loss of consciousness
- ☐ Sensitivity or pain of hands and/or feet
- ☐ Memory loss
- ☐ Night sweats

Psychiatric

- ☐ Excessive worries
- ☐ Anxiety
- ☐ Easily losing temper
- ☐ Depression
- ☐ Agitation
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

Endocrine

- ☐ Excessive thirst

Hematologic/Lymphatic

- ☐ Swollen glands
- ☐ Tender glands
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Transfusion/when _____

Allergic/Immunologic

- ☐ Frequent sneezing
- ☐ Increased susceptibility to infection

Patient's Name _____ Date _____ Physician Initials _____

SOCIAL HISTORY

Do you drink caffinated beverages?

Cups/glasses per day? _____

Do you smoke? ☐ Yes ☐ No ☐ Past – How long ago? _____

Do you drink alcohol? ☐ Yes ☐ No Number per week _____

Has anyone ever told you to cut down on your drinking?

☐ Yes ☐ No

Do you use drugs for reasons that are not medical? ☐ Yes ☐ No
If yes, please list: _____

_____

Do you exercise regularly? ☐ Yes ☐ No

Type _____

Amount per week _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ☐ Yes ☐ No

Do you wake up feeling rested? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Do you now or have you ever had: *(check if "yes")*

☐ Cancer	☐ Heart problems	☐ Asthma
☐ Goiter	☐ Leukemia	☐ Stroke
☐ Cataracts	☐ Diabetes	☐ Epilepsy
☐ Nervous breakdown	☐ Stomach ulcers	☐ Rheumatic fever
☐ Bad headaches	☐ Jaundice	☐ Colitis
☐ Kidney disease	☐ Pneumonia	☐ Psoriasis
☐ Anemia	☐ HIV/AIDS	☐ High Blood Pressure
☐ Emphysema	☐ Glaucoma	☐ Tuberculosis

Other significant illness (please list) _____

_____

Natural or Alternative Therapies (chiropracty, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

Previous Operations

Type	*Year*	*Reason*
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ☐ No ☐ Yes Describe: _____

Any other serious injuries? ☐ No ☐ Yes Describe: _____

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number deceased _____

Number of children _____ Number living _____ Number deceased _____ List ages of each _____

Health of children: _____

_____

Do you know of any blood relative who has or had: (check and give relationship)

☐ Cancer _____	☐ Heart disease _____	☐ Rheumatic fever _____	☐ Tuberculosis _____
☐ Leukemia _____	☐ High blood pressure _____	☐ Epilepsy _____	☐ Diabetes _____
☐ Stroke _____	☐ Bleeding tendency _____	☐ Asthma _____	☐ Goiter _____
☐ Colitis _____	☐ Alcoholism _____	☐ Psoriasis _____	

Patient's Name _____ Date _____ Physician Initials _____

MEDICATIONS

Drug allergies: ☐ No ☐ Yes To what? _____

_____

Type of reaction: _____

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped? A Lot	Some	Not At All
1.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐

PAST MEDICATIONS Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, ***how long*** you were taking the medication, the ***results*** of taking the medication and list any ***reactions*** you may have had. Record your comments in the spaces provided.

Drug names/Dosage	Length of time	Please check: Helped? A Lot	Some	Not At All	Reactions
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		☐	☐	☐	
Circle any you have taken in the past Ansaid (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulindac) Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac) Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Naifon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac)					
Pain Relievers					
Acetaminophen (Tylenol)		☐	☐	☐	
Codeine (Vicodin, Tylenol 3)		☐	☐	☐	
Propoxyphene (Darvon/Darvocet)		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Auranofin, gold pills (Ridaura)		☐	☐	☐	
Gold shots (Myochrysine or Solganol)		☐	☐	☐	
Hydroxychloroquine (Plaquenil)		☐	☐	☐	
Penicillamine (Cuprimine or Depen)		☐	☐	☐	
Methotrexate (Rheumatrex)		☐	☐	☐	
Azathioprine (Imuran)		☐	☐	☐	
Sulfasalazine (Azulfidine)		☐	☐	☐	
Quinacrine (Atabrine)		☐	☐	☐	
Cyclophosphamide (Cytoxan)		☐	☐	☐	
Cyclosporine A (Sandimmune or Neoral)		☐	☐	☐	
Etanercept (Enbrel)		☐	☐	☐	
Infliximab (Remicade)		☐	☐	☐	
Prosorba Column		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	

Patient's Name _____ Date _____ Physician Initials _____