ARTHRITIS CENTER OF NORTH GEORGIA

A Member Of

Welcome to our practice!

We are looking forward to seeing you on this date: _________ at this time: _______ with Dr. __________ at our ______________ 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.
- 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 $303 to their initial visit towards services rendered.
- It is your responsibility to ensure we have a current and valid referral on file. Otherwise, you will be financially responsible for the visit charges in full.

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

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

Directions to Gainesville Office

Address: 961 A Smoky Mountain Springs Lane
Gainesville, GA 30501

FROM CORNELIA: Take 365 South to ext. 24 Turn right onto Jesse Jewell Pkwy. Go to the 6th light and turn right onto Downey Blvd. Go approximately 1 mile and you will pass the First Presbyterian Church on the right, past the church get into the right hand turning lane and turn into the driveway for Smoky Mountain Springs Retirement Home (You are turning onto Smokey Mountain Springs Lane). We are the 2nd brick office on the left.

FROM 985 NORTH: Take 985 North to exit 24. Turn left onto Jesse Jewell Pkwy. Go to the 7th light and turn right onto Downey Blvd. Go approximately 1 mile and you will pass the First Presbyterian Church on the right, past the church get into the right hand turning lane and turn into the driveway for Smoky Mountain Springs Retirement Home (You are turning onto Smokey Mountain Springs Lane). We are the 2nd brick office on the left.

FROM 129 / ATHENS HWY: Turn right onto Martin Luther King Jr. Blvd at the Burger King. Continue until you cross over Jesse Jewell Pkwy. onto Downey Blvd. Go approximately 1 mile and you will pass the First Presbyterian Church on the right, past the church get into the right hand turning lane and turn into the driveway for Smoky Mountain Springs Retirement Home (You are turning onto Smokey Mountain Springs Lane). We are the 2nd brick office on the left.

FROM CLEVELAND HWY: Turn left (at the light at CVS Pharmacy) onto South Enota Drive. Get into the middle turning lane and turn left into the driveway of Smoky Mountain Springs Retirement Home (You are turning onto Smokey Mountain Springs Lane). We are the 2nd brick office on the left.

FROM GA 400: Exit at Hwy 369/Browns Bridge Road. Browns Bridge turns into Jesse Jewell Pkwy. Continue on Jesse Jewell Pkwy until you pass Northeast Georgia Medical Center on your left. Right after you pass the hospital you will come to the intersection of Jesse Jewell Pkwy and Downey Blvd. Turn left onto Downey Blvd and go approximately 1 mile and you will pass the First Presbyterian Church on the right, past the church get into the right hand turning lane and turn into the driveway for Smoky Mountain Springs Retirement Home (You are turning onto Smokey Mountain Springs Lane). We are the 2nd brick office on the left.

Directions to Athens Office

Address: 957 Baxter Street
Athens, GA 30606

DIRECTIONS FROM PRINCE AVE: Athens Regional Medical Center should be on your right, stay straight until you reach Dunkin Donuts. Turn right onto Milledge Ave. Keep straight through several traffic lights, until you reach the intersection of Milledge and Baxter. Turn right onto Baxter Street. Our office will be on your left at 957 Baxter Street.

FROM ST. MARY'S: St. Mary's should be on your left, stay straight, approximately 1 mile you will cross over Rock Springs Rd. We are the 3rd building on the right. You will see the athletic field of Clarke Central High School on your left.

Arthritis Center of North Georgia a Member of Articularis Healthcare
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
Race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White	Ethnicity: Hispanic, Latino, Not Hispanic or Latino, or prefer not to answer	Preferred Language: English, Spanish, Other________________
Preferred Method of contact for appointment reminders: Cell Phone, Home Phone, Mail, Text Message (rates may apply), or web message via Patient Portal		

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

Referring Physician	Phone #
Primary Care Physician	Phone #
Spouse	Phone #
Emergency Contact/Relationship	Phone #
Primary Insurance Name	Policy #
Policy Holder Name	DOB
Group #	Group Name
Address:	Phone
Secondary Insurance	Policy #
Policy Holder Name	DOB
Group #	Group Name
Address:	Phone:

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 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

ARTHRITIS CENTER OF NORTH GEORGIA

HEALTH HISTORY QUESTIONNAIRE

DATE: ____________ NAME: ____ DATE OF BIRTH: ___________________

Which physician referred you to our clinic? ____

Which local pharmacy do you use? ____

Which mail order pharmacy do you use? ____

PLEASE LIST CURRENT MEDICAL PROBLEMS FOR WHICH YOU ARE CURRENTLY BEING TREATED:

1	5
2	6
3	7
4	8

PLEASE LIST ANY PREVIOUS SURGERIES:

1	3	5
2	4	6

PLEASE LIST ALL CURRENT MEDICATIONS (OR BRING A DETAILED MEDICATION LIST):

1	5	9
2	6	10
3	7	11
4	8	12

PLEASE LIST ANY DRUG ALLERGIES:

1	3	5
2	4	6

In which city do you reside? ____

Marital Status? Never Married_____ Married_____ Divorced_____ Separated_____ Widowed_____

Number of Children? ____________ Have you ever had any miscarriages? _______________ If so, what trimester? ______________________

Occupation? _____________________________ Place of Employment ____

Do you currently or have you ever smoked? __________If so, how much? ______________ If you have quit smoking, how long did you smoke and when did you quit? ___________________Do you currently consume alcohol? __________If so, how much and how often? ______________

Does anyone in your immediate family have a history of rheumatoid arthritis, lupus, Sjogren's syndrome, scleroderma, polymyositis, gout, Crohn's disease, ulcerative colitis, ankylosing spondylitis or psoriasis?

If so, what condition and who? ____

Does anyone in your family have osteoporosis? __________________ If so, who? ____

Have you ever had a bone density test? _________________________If so, when and where? ____________________________________

Patient Signature ____ Date _____________________________

ARTHRITIS CENTER OF NORTH GEORGIA

A Member Of

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 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:___________________

ARTHRITIS CENTER OF NORTH GEORGIA

A Member Of

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

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

PATIENT NAME (PLEASE PRINT):____ **DATE OF BIRTH:** ________________

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

NAME/RELATIONSHIP	PHONE NUMBER

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

DOCTOR'S NAME	DOCTOR'S PHONE NUMBER/FAX NUMBER

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 (Please initial all that apply):

________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 Office at Arthritis Center of North Georgia. Any revocation or change will not apply to communications already completed.

Patient Signature:_______________________________________Date: ___________________

Witness Signature:_______________________________________Date: ___________________

Articularis Healthcare, 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

- 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.
- Self-pay patients are required to bring a payment in the amount of $303 to their initial visit, which will be collected prior to being seen by the physician. This amount is for the office visit only, any additional testing or procedures will be an additional charge.

Follow-up Appointments

- Any patient who no-shows or cancels 2 appointments (in a calendar year) without giving a 72-hour notice will receive a discharge warning letter in the mail.
- If a patient cancels or no-shows 4 times in a calendar year they may 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.

Patient/Guardian Signature: ____________________________________ Date: _______________

Articularis Healthcare, Inc.
Patient Financial Policy

We thank you for choosing Arthritis Center of North Georgia (ACNG) as your healthcare provider. The ACNG team of physicians and healthcare professionals are committed to fulfilling our mission to provide a continuum of medical services to our patients. To support this goal, we have created this financial policy to communicate important financial aspects about our practice. Please read this policy thoroughly before your visit and contact our Business Office should you have questions or concerns. Our Business Office is available Monday – Thursday from 8:00am – 5:00pm, and you may reach them by dialing 770-531-3711 (select option 2).

Arriving for Your Visit. To provide exceptional care to every patient, ACNG has adopted guidelines around late arrivals, cancellations, and patients who fail to show for their appointments. We ask that every patient, regardless if you are new or established within our practice, arrive 15 minutes before their scheduled appointment time. If you do not arrive for your appointment, a $25 charge may be applied to your account or if you cancel within 24 hours of your appointment. ACNG reserves the right to discharge patients who arrive late, cancel within of 24 hours of their visit, and/or no show for their appointments three times within a 12-month period.

Referrals and Prior Authorizations. It is your responsibility to obtain referrals for the services provided within a Arthritis Center of North Georgia practice. However, ACNG will obtain any of the required prior authorizations for treatments or services provided within our practice.

Insurance and Billing. ACNG is pleased to bill your primary and secondary health care plans on your behalf. You are ultimately responsible for your co-pay and any co-insurance related to your deductible at check-in for your appointment, as well as any remaining balance after insurance payments. Ancillary services rendered in our clinic, like ultrasound, lab, and/or x-ray, will be billed to you after your visit. We accept most insurance policies, but please contact your insurance company to verify we are an in-network provider. As the owner of the insurance policy, you are solely responsible for coverage policies under the plan and the accuracy of information on file.

Self-Pay. If you choose to pay for your medical care without utilizing insurance coverage, you will be considered Self-Pay and charged for all services at our self-pay rate until we are notified otherwise.

Insurance Errors. If you believe your insurance company denied or processed a claim in error, please call us immediately. If your insurance company requests additional information from you, it is important to comply with their requests in a timely manner. If insurance does not pay a claim within 45 days of submission, the outstanding balance is billed to the patient and becomes the patient's responsibility. Should you pay more than what you are responsible, the overpayment will be applied as a credit on the account, and you may decide if the credit may be used at the next visit for services rendered or opt to receive a refund check.

Paying Your Bill. For your convenience, ACNG accepts multiple forms of payment, including personal checks (payable to Arthritis Center of North Georgia), money orders, Visa, MasterCard, Discover, American Express, and cash. Payment is accepted by phone, online, in person, and by mail. If we utilize lab processing through Quest Diagnostics or LabCorp, they will bill you directly for any outstanding out-of-pocket balances. Please contact them directly to discuss your bill.

Ability to Pay. Account balances should be paid in full by the statement due date. If you have circumstances that limit your ability to pay on your account balance and have exhausted other resources, please contact a member of the Billing Office. Failed attempts to contact patients by phone and/or mail about their unpaid balances to establish payment arrangements may lead to collections and/or discharge from the practice.

Articularis Healthcare, Inc.
Patient Financial Policy Continued

Accounts in Default. ACNG will attempt to bill and collect from patients who are responsible for all or part of the cost of services provided by an ACNG physician. After 90 days, if you have not made a payment on a bill or established a payment plan, ACNG may initiate pre-collections by sending the patient a pre-collections notice. If ACNG fails to collect or arrange payment from the patient, the patient may receive a final notice to pay. If ACNG decides it is unreasonable to try to collect balances, a certified letter discharging the patient from our practice will be sent and the account referred to a primary collection's agency.

Patient/Guardian Signature: ________________________________ Date: ______________

Articularis Healthcare, 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.
- All narcotic refill requests may 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. 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 { 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 PAIN AS BAD AS IT COULD BE

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 { 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 VERY POORLY

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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): ☐

4.PTGL (0-10): ☐

RAPID 3 (0-30) ☐

Cat:

HS = >12

MS = 6.1-12

LS = 3.1-6

R = ≤3

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

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5. ROS: ☐

__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

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

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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.
† **M**uch **B**etter † **B**etter † the **S**ame †**W**orse †**M**uch **W**orse

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.

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

Date: ______________________________ Signature____