

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 scheduled appointment time with the completed paperwork to allow for the registration process. Please do not mail paperwork.

- There is a \$25 no-show and cancellation 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.

Patient Registration



Patient Information

Patient Last Name		First Name	Middle Initial	Date of Birth	Sex
Mailing Address			City	State	Zip Code
Primary Telephone	Other Telephone	Activate Patient Portal? <input type="checkbox"/> Yes <input type="checkbox"/> No		Email Address	
Primary Language	Do You Need an Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	Ethnicity	Hearing Impaired? <input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Impaired? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employer Name			Employer Telephone		
Employer Address		Employer City	Employer State	Employer Zip Code	
Primary Care Physician			Referring Physician		

Emergency Contact Information

Last Name	First Name	Relationship to Patient	Primary Telephone	Legal Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Responsible Party If Other Than Patient

Last Name	First Name	Relationship to Patient	Primary Telephone	
Street Address		City	State	Zip Code

Medical Insurance Policy Holder

Check Here if Uninsured

Primary Insurance Company		Policy Holder Last Name	Policy Holder First Name
Relationship to Patient	Subscriber ID	Group Number	Date of Birth
Secondary Insurance Company		Policy Holder Last Name	Policy Holder First Name
Relationship to Patient	Subscriber ID	Group Number	Date of Birth

Assignment of Benefits / Consent for Treatment

I do hereby assign all medical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I acknowledge receipt of the Financial Policy and I understand that I am responsible for all charges not paid by insurance. I authorize this practice to release all information necessary to secure payment. I hereby voluntarily consent to treatment at this office and authorize such treatments, examinations, medications, and diagnostic procedures (including, but not limited to the use of lab and radiographic studies) as ordered by attending providers. I hereby voluntarily consent to the taking of photographic images for treatment purposes only (wound care progression, documentation of rashes, etc.) as ordered by the attending providers.

Signature of Patient / Legal Guardian	Date
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**Arthritis Center of North Georgia
a Member of Arthritis Healthcare
Patient Information**



Referring Physician	Phone #
Primary Care Physician	Phone #
Spouse	Phone #
Emergency Contact/Relationship	Phone #

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 _____

Articularis Healthcare Group, Inc. Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Contact the Privacy Officer 843-572-4840 with any questions.

Effective: November 13, 2019

We are committed to protect the privacy of your personal health information (PHI). This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. You will be notified of any breach of unsecured PHI. We will follow the terms outlined in this Notice. We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- Providing a copy of the new Notice in our office or by mail, upon request.
- Posting the revised Notice on our website, www.articularishealthcare.com.

Uses and Disclosures of Your PHI

The law permits or requires us to use or disclose your PHI for various reasons, which we explain in this Notice. We have included some examples, but we have not listed every permissible use or disclosure. When using or disclosing PHI or requesting your PHI from another source, we will make reasonable efforts to limit our use, disclosure, or request about your PHI to the minimum we need to accomplish our intended purpose.

Uses and Disclosures for Treatment, Payment or Health Care Operations

- **Treatment.** We may use or disclose your PHI and share it with other professionals who are treating you, including doctors, nurses, technicians, medical students, or hospital personnel involved in your care. For example, we might disclose information about your overall health condition with physicians who are treating you for a specific injury or condition.
- **Payment.** We may use and disclose your PHI to bill and get payment from health plans or others. For example, we share your PHI with your health insurance plan so it will pay for the services you receive.
- **Health Care Operations.** We may use and disclose your PHI to run our practice and improve your care. For example, we may use your PHI to manage the services you receive or to monitor the quality of our health care services.

Other Uses and Disclosures of Your PHI

We may share your information in other ways, usually for public health or research purposes or to contribute to the public good. For example, these other uses and disclosures may involve:

- **Our Business Associates.** We may use and disclose your PHI to our business associates that perform services on our behalf, such as auditing, legal, or transcription. The law requires our business associates and their subcontractors to protect your PHI in the same way we do. We also contractually require these parties to use and disclose your PHI only as permitted and to appropriately safeguard your PHI.
- **Health Information Exchanges.** We participate in health information exchanges (HIEs), which support electronic information sharing among members for treatment, payment, and health care operations purposes. Individuals may opt-out of HIEs. We will use reasonable efforts to limit the sharing of PHI in these electronic sharing activities for individuals who have opted out. If you would like to opt out, please contact our Privacy Officer.
- **Legal Compliance.** For example, we will share your PHI if the Department of Health and Human Services requires it when investigating our compliance with privacy laws.
- **Public Health and Safety Activities.** For example, we may share your PHI to report injuries, births, and deaths; prevent disease; report adverse reactions to medications or medical device product defects; report suspected child neglect or abuse or domestic violence; or avert a serious threat to public health or safety.
- **Responding to Legal Actions.** For example, we may share your PHI to respond to a court or administrative order or subpoena; discovery request; or another lawful process.
- **Research.** For example, we may share your PHI for some types of health research that do not require your authorization, such as if an institutional review board (IRB) has waived the written authorization requirement [because the disclosure only involves minimal privacy risks].
- **Medical Examiners or Funeral Directors.** For example, we may share PHI with coroners, medical examiners, or funeral directors when an individual dies.
- **Organ or Tissue Donation.** For example, we may share your PHI to arrange an authorized organ or tissue donation from you or a transplant for you.

- Workers' Compensation. We may use and disclose your PHI for workers' compensation claims; health oversight activities by federal or state agencies; law enforcement purposes or with a law enforcement official; or specialized government functions, such as military and veterans' activities, national security and intelligence, presidential protective services or medical suitability.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, please contact us and we will make reasonable efforts to follow your instructions. You have both the right and choice to tell us whether to:

- Share information such as your PHI, general condition or location, with friends or family members, or other persons involved in your care.
- Share information in a disaster relief situation, such as to a relief organization to assist with locating or notifying your family, close friends or others involved in your care.

We may share your information if we believe it is in your best interest, according to our best judgement, and:

- If you are unable to tell us your preference, for example, if you are unconscious.
- When needed to lessen a serious and imminent threat to health or safety.

Your Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing.

Inspect and obtain a copy of your protected health information. You may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested, we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost-based fee for a copy of the records.

Request Additional Restrictions. You have the right to ask us to limit what we use or share about your PHI. You can contact us and request us not to use or share certain PHI for treatment, payment, or operations or with certain persons involved in your care. For these requests:

- we are not required to agree;
- we may say "no" if it would affect your care; but
- we will not agree to disclose information to a health plan for purposes of payment or health care operations if the requested restriction concerns a health care item or service for which you or another person, other than the health plan, paid in full out-of-pocket, unless otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations. We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

Make Amendments. You may ask us to correct or amend PHI that we maintain about you that you think is incorrect or inaccurate. For these requests:

- You must submit requests in writing, specify the inaccurate or incorrect PHI and provide a reason that supports your request.
- We will generally decide to grant or deny your request within 60 days. If we cannot act within 60 days, we will give you a reason for the delay in writing and include when you can expect us to complete our decision.
- We may deny your request for an amendment if you ask us to amend PHI that is not part of our record, that we did not create, that is not part of a designated record set, or that is accurate and complete.

Request an Accounting of Disclosures. This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12-month period, you may be charged a reasonable fee.

Additional Privacy Rights

You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency we will give you this Notice as soon as possible. You have a right to receive notification of any breach of your protected health information.

Complaints

You have the right to complain if you feel we have violated your rights. We will not retaliate against you for filing a complaint. You may either file a complaint:

- directly with us by contacting the Privacy Officer. All complaints must be submitted in writing.
- with the Office for Civil Rights at the US Department of Health and Human Services (HHS). Send a letter to U.S. HHS at 200 Independence Ave., S.W., Washington, D.C. 20201; call 1-800-368-1019; or visit www.hhs.gov/ocr/privacy/hipaa/complaints/.

Acknowledgment of Receipt
"NOTICE OF PRIVACY PRACTICES"



I acknowledge that I have received a copy of the "Notice of Privacy Practices" for protected health information on the date set forth below.

Date of Receipt

Patient Date of Birth

Print Patient Name

Print Name of Authorized Personal Representative

Patient Signature

Signature of Authorized Personal Representative

Please Indicate Relationship to Patient

FOR USE BY PRACTICE PERSONNEL ONLY

(Complete only if patient acknowledgement is not obtained)

An Acknowledgement of Receipt of Notice of Privacy Practices was not received because:

Patient refused to sign Acknowledgment

Unable to gain signed Acknowledgment due to communication / language or another barrier

Patient was unable to sign Acknowledgment due to emergency treatment situation

Other *(please indicate reason):* _____

Staff Signature

Medical Records Release



Patient Information (*please print clearly*):

_____	_____	_____	_____	_____
<i>Last Name</i>	<i>First Name</i>	<i>Middle Initial</i>	<i>Date of Birth</i>	<i>(Month/Day/Year)</i>
_____	_____		_____	
<i>Street Address</i>	<i>Apt #/P.O. Box # (Please include complete mailing address)</i>		<i>Medical Record Number/SSN</i>	
_____	_____		_____	
<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>Primary Contact Number</i>	

I authorize Arthritis Center of North Georgia to disclose the above-named individual's health information to:

Another Facility:

Name

Street Address

City *State* *Zip Code*

I would like to pick up my records in person.

I authorize _____ to pick up my medical records in person.
(Name of person authorized to receive the record)

The information to be disclosed:

- All Billing Records
- Complete Medical Record

OR

Partial Medical Record (*please specify records below*)

<u>Information</u>	<u>Dates</u>
<input type="checkbox"/> Office Notes	_____
<input type="checkbox"/> Lab Results	_____
<input type="checkbox"/> X-Rays	_____
<input type="checkbox"/> Other	_____

The purpose of the disclosure:

- My personal records
- Disability
- Attorney
- Other _____

I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees. The fee is \$0.65 per page for the first 30 pages and \$0.50 for each page after 30.

I authorize Arthritis Center of North Georgia to obtain the above-named individual's health information on their behalf from:

Name

Street Address

City

State

Zip Code

Information to be obtained*:

- Referral Clinical notes Recent labs and imaging reports Demographics
 All of the Above Other: _____

*Please fax information above to our Medical Records department at (770) 531-3718

If you have questions, please call (770) 531-3711

Expiration of Authorization:

Unless I request in writing otherwise, this authorization will expire on _____. If I do not specify an expiration date or (insert date or event) event, this authorization will expire ninety (90) days from the date on which it was signed.

Right to Revoke Authorization:

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present written revocation to Arthritis Center of North Georgia. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

Refusal to Authorize Use and/or Disclosure:

I understand that authorizing the use or disclosure of the information above is voluntary. I need not sign this form to ensure healthcare treatment

Re-Disclosure

I understand that if my health information is disclosed to a party other than a healthcare provider, health plan, or healthcare clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

Release and Waiver

If the health information that I have requested Arthritis Center of North Georgia to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), Immunodeficiency Syndrome Related Complex (ARC), human immunodeficiency virus (HIV), venereal disease, tuberculosis, or hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Arthritis Center of North Georgia from any and all liabilities, damages, and claims which might arise from the release of the health information authorized by me above.

Signature of Patient or Patient's Legal Representative

Month/Day/Year

Description of Authority to Act for Patient

NOTE: A COPY OF THIS COMPLETED, SIGNED, AND DATED FORM MUST BE PROVIDED TO THE PATIENT AND/OR THE PATIENT'S REPRESENTATIVE, AND A COPY MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD

Patient Authorization for Use and Disclosure of Protected Health Information



This information is used to facilitate our communications with you as we strive to provide you with excellent service.

Patient Information (please print clearly):

_____	_____	_____	_____	_____
<i>Last Name</i>	<i>First Name</i>	<i>Middle Initial</i>	<i>Date of Birth</i>	<i>(Month/Day/Year)</i>
_____			_____	
<i>Street Address</i>	<i>Apt #/P.O. Box # (Please include complete mailing address)</i>		<i>Medical Record Number/SSN</i>	
_____			_____	
<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>Primary Contact Number</i>	

If we cannot reach you at the telephone number listed above, Arthritis Center of North Georgia may contact you (including leaving messages) regarding appointments or normal lab results at the following number(s):

_____	_____	_____
<i>Business Number</i>	<i>Cell Phone Number</i>	<i>Other Phone Number</i>

I authorize Arthritis Center of North Georgia to disclose Protected Health Information to the following persons:

Spouse: _____

_____	_____
<i>Name</i>	<i>Phone Number</i>

Child(ren): _____

_____	_____
<i>Name</i>	<i>Phone Number</i>

Other: _____

_____	_____
<i>Name</i>	<i>Phone Number</i>

Information to be disclosed:

All Medical Information Laboratory Results All Billing / Account Information

Authorization Statement: I understand that Protected Health Information (PHI) used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my revocation to the Arthritis Center of North Georgia location where I received care. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that Arthritis Center of North Georgia cannot require me to sign this authorization as a condition of treatment unless the provision of health care by Arthritis Center of North Georgia is solely for the purpose of creating PHI for disclosure to a third party legally authorized to receive such information. I understand that I will be given a copy of this authorization.

Signature/Date: (date authorization signed by patient or Legal Guardian/Personal Representative) _____
Month/Day/Year

_____ _____
Print Patient Name or Name of Legal Guardian/Personal Representative *Signature of Patient or Legal Guardian/Personal Representative*

Indicate relationship to patient (required)

Expiration Date: *This authorization is valid until written notice is provided to revoke this authorization.*

Last Updated: 1/27/2020

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 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 \$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.

Disability Forms: There are many factors that are taken into account when completing a disability form. Therefore, it is at the discretion of the provider of whether it is appropriate for them to complete a disability form. **Note: Dr. Chafin does not typically complete disability paperwork.**

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: _____

This questionnaire includes information not available from blood tests, x-rays, or any other 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.

Patient Name: _____ **DOB:** _____ **Date:** _____

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 AS BAD AS
 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 IT COULD BE

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 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 POORLY

FOR OFFICE USE ONLY
1. a-j FN (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=4.1 28=9.3
- 14=4.7 29=9.7
- 15=5.0 30=10

2. PN (0-10)

3. PTGL (0-10)

RAPID3 (0-30)

OFFICE USE ONLY

RAPID3 CUMULATIVE: _____

Weighted RAPID3: _____

Severity: _____

Modified HAQ: _____

Name of Scorer: _____

Date: _____

Cat:

HS = >12

MS = 6.1-12

LS = 3.1-6

R = ≤3

