# EMERALD COAST RHEUMATOLOGY

**3890 Jenks Avenue**
**Lynn Haven, FL 32444**

## Patient History Form

Date of first appointment: ____/____/____ Time of appointment: _____ Birthplace: _____
MONTH DA Y YEAR

Name: _____ Birthdate: ____/____/____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

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

_____ Telephone: Home (____) _____
CITY STATE ZIP Work (____) _____

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): _____

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

_____

_____

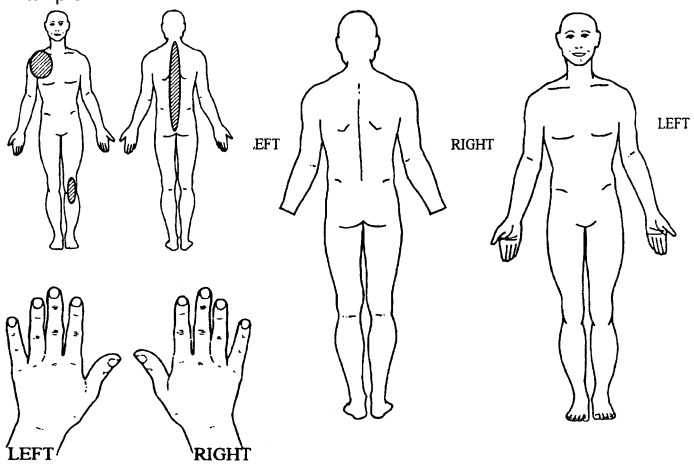
Please list the names of other practitioners you have seen for this problem:

_____

Diagnosis given: _____

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

Example:




Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

**RHEUMATIC DISEASE (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 | |
| | Fibromyalgia | | | Chronic fatigue syndrome | |
| Other arthritis conditions: | | | | | |

## REVIEW OF SYSTEMS

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

**Musculoskeletal**

❑ Morning stiffness
Lasting how long?
_____Minutes _____Hours
❑ Joint pain
❑ Joint swelling
List joints affected in the last 6 mos.
_____
_____
_____
_____
_____
❑ Muscle weakness
❑ Muscle tenderness

**Constitutional**

❑ Generalized weakness
❑ Fatigue
❑ Fever or chills
❑ Night sweats
❑ Recent weight loss
amount _____
❑ Recent weight gain
amount _____

**Eyes**

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

**Dermatology**

❑ Thickness
❑ Tightness
❑ Rash
❑ Unexpected hair loss
❑ Sun sensitive (sun allergy)
❑ Redness
❑ Hives
❑ Nodules/bumps
❑ Nail pits

**Psychiatric**

❑ Excessive worries
❑ Anxiety
❑ Panic attacks
❑ Easily losing temper
❑ Depression
❑ Agitation
❑ Difficulty falling asleep
❑ Difficulty staying asleep

**Gastrointestinal**

❑ Nausea
❑ Vomiting
❑ Abdominal pain
❑ Heartburn
❑ Diarrhea
❑ Mucus in stools
❑ Unusual constipation
❑ Blood in stools
❑ Black/tarry stools

**Genitourinary**

❑ Difficulty urinating
❑ Blood in urine
❑ Pain or burning on urination
❑ Pus in urine
❑ Cloudy urine
❑ Sexual difficulties
❑ Genital rash/ulcers
*For Women Only:*
❑ Vaginal dryness
❑ Vaginal discharge
Date of last period? ____/____/____/
Number of pregnancies? _____
Number of miscarriages? _____
*For Men Only:*
❑ Discharge from penis
❑ Prostate trouble

**Respiratory**

❑ Shortness of breath
❑ Cough
❑ Difficulty breathing at night
❑ Coughing of blood
❑ Wheezing (asthma)

**Neurological System**

❑ Numbness or tingling in hands
❑ Numbness or tingling in feet
❑ Headaches
❑ Dizziness
❑ Fainting
❑ Muscle spasm
❑ Cramping in legs at night
❑ Memory loss

**Endocrine**

❑ Excessive thirst

**Hematologic/Lymphatic**

❑ Blood clot in artery, vein, or lung
❑ Bleeding tendency
❑ Enlarged lymph nodes
❑ Anemia
❑ Transfusion/when _____

**Allergic/Immunologic**

❑ Frequent sneezing
❑ Increased susceptibility to infection

**Ears–Nose–Mouth–Throat**

❑ Dryness of mouth
❑ Sinus pain
❑ Difficulty swallowing
❑ Sores in mouth
❑ Ringing in ears
❑ Loss of hearing
❑ Nosebleeds
❑ Loss of smell
❑ Bleeding gums
❑ Loss of taste
❑ Frequent sore throats
❑ Hoarseness

**Cardiovascular**

❑ Chest pain
❑ Difficulty in breathing at night
❑ Cramping in calves when walking
❑ Swollen legs or feet
❑ Color changes of hands in the cold
❑ Irregular heart beat
❑ Sudden changes in heart beat
❑ Heart murmurs

**Please state the date of your last:**

Bone Densitometry ____/____/_____ Mammogram ____/____/_____ Eye exam____/____/_____ Chest x–ray____/____/_____

Tuberculosis Test ____/____/_____ Flu Vaccine ____/____/_____ Pneumonia Vaccine____/____/_____

Tetanus Vaccine____/____/_____ Shingles Vaccine____/_____/_____ Hepatitis B Vaccine____/_____/_____

Patient's Name _____ Date _____ Physician Initials _____

**YOUR PAST MEDICAL HISTORY:** Have **YOU** ever been diagnosed with any of the following diseases?

| | | | | | |
|---|---|---|---|---|---|
| ❑ Cancer/Leukemia/Lymphoma | ❑ Heart Disease | ❑ Diabetes | ❑ High blood pressure | ❑ High Cholesterol | ❑ Stroke |
| ❑ Emphysema/COPD/Asthma | ❑ Kidney disease | ❑ Thyroid disease | ❑ Jaundice/Hepatitis | ❑ Tuberculosis | ❑ Pneumonia |
| ❑ HIV/ AIDS | ❑ Headaches/Migraines | ❑ Depression | ❑ Nervous Breakdown | ❑ Glaucoma | ❑ Anemia |
| ❑ Rheumatic Fever | ❑ Epilepsy | ❑ Psoriasis | ❑ Colitis | ❑ Iritis/Uveitis | ❑ Sarcoidosis |

**Other significant illness** (not listed above):_____

**Previous Operations/ Surgical History**

| ***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** | |
|---|---|---|---|---|
| | Year of Birth | Health | Age at Death | Cause |
| Father | | | | |
| Mother | | | | |

Number of sisters ____Number living _____Number deceased____Number of brothers _____Number living _____Number deceased____

Number of daughters ____Number living _____Number deceased ___Number of sons _____Number living _____Number deceased____

Health of children: _____

Do you know of any close blood relative (parent, sibling or child) 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 _____

**SOCIAL HISTORY:**

**Marital Status:** ❑ Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse/Significant Other: ❑ Alive/Age _____ ❑ Deceased/Age _____Major Illnesses_____

How many people in household? _____Relationship and age of each _ **Education** (circle 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 _____

**Do you drink caffeinated beverage?** ❑ No ❑ Yes Cups/glasses per day?_____

**Do you smoke?** ❑No ❑Yes Amount per day_____ ❑ Previous smoker? How long ago?_____

**Do you drink alcohol?** ❑ No ❑ Yes Number per week_____Has anyone ever told you to cut down on your drinking? ❑ No ❑ Yes

**Recreational drug use?** ❑ No ❑ Yes If yes please list_____

**Do you exercise regularly?** ❑ **No** ❑ **Yes** Frequency_____Please describe _____

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** Over the Counter Medications as well, 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)** | | | | | |
| Ansaid (flurbiprofen) | | ❑ | ❑ | ❑ | |
| Arthrotec (diclofenac + misoprostil) | | ❑ | ❑ | ❑ | |
| Aspirin (including coated aspirin) | | ❑ | ❑ | ❑ | |
| Celebrex (celecoxib) | | ❑ | ❑ | ❑ | |
| Daypro (oxaprozin) | | ❑ | ❑ | ❑ | |
| Dolobid (diflunisal) | | ❑ | ❑ | ❑ | |
| Feldene (piroxicam) | | ❑ | ❑ | ❑ | |
| Indocin (indomethacin) | | ❑ | ❑ | ❑ | |
| Lodine (etodolac) | | ❑ | ❑ | ❑ | |
| Mobic (meloxicam) | | ❑ | ❑ | ❑ | |
| Motrin (ibupoprofen) | | ❑ | ❑ | ❑ | |
| Naprosyn (naproxen) | | ❑ | ❑ | ❑ | |
| Oruvail (ketoprofen) | | ❑ | ❑ | ❑ | |
| Voltaren (diclofenac) | | ❑ | ❑ | ❑ | |
| Other_____ | | ❑ | ❑ | ❑ | |
| **Pain Relievers** | | | | | |
| Acetaminophen (Tylenol) | | ❑ | ❑ | ❑ | |
| Codeine (Tylenol 3) | | ❑ | ❑ | ❑ | |
| Hydrocodone (Vicodin, Lortab, Norco) | | ❑ | ❑ | ❑ | |
| Ultram/Ultracet (tramadol) | | ❑ | ❑ | ❑ | |
| **Corticosteroids** | | | | | |
| Decadron (dexamethasone) | | ❑ | ❑ | ❑ | |
| Medrol dose pack (methylprednisolone) | | ❑ | ❑ | ❑ | |
| Prednisone | | ❑ | ❑ | ❑ | |
| Cortisone injection (where)_____ | | ❑ | ❑ | ❑ | |
| **Disease Modifying Antirheumatic Drugs (DMARDS)** | | | | | |
| Arava (leflunomide) | | ❑ | ❑ | ❑ | |
| Atabrine (quinacrine) | | ❑ | ❑ | ❑ | |
| Azulfidine (sulfasalazine) | | ❑ | ❑ | ❑ | |
| CellCept (mycophenolate mofetil) | | ❑ | ❑ | ❑ | |

| | | | | | |
|---|---|---|---|---|---|
| **DMARDS - Continued** | | | | | |
| Cytoxan (cyclophosphamide) | | ❑ | ❑ | ❑ | |
| Imuran (azathioprine) | | ❑ | ❑ | ❑ | |
| Methotrexate (rheumatrex) | | ❑ | ❑ | ❑ | |
| Neoral or Sandimmune (Cyclosporine A) | | ❑ | ❑ | ❑ | |
| Plaquenil (hydroxychloroquine) | | ❑ | ❑ | ❑ | |
| **Biologics** | | | | | |
| Actemra (tocilizumab) | | ❑ | ❑ | ❑ | |
| Cimzia (certolizumab) | | ❑ | ❑ | ❑ | |
| Enbrel (etanercept) | | ❑ | ❑ | ❑ | |
| Humira (adalimumab) | | ❑ | ❑ | ❑ | |
| Kineret (anakinra) | | ❑ | ❑ | ❑ | |
| Orencia (abatacept) | | ❑ | ❑ | ❑ | |
| Remicade (Infliximab) | | ❑ | ❑ | ❑ | |
| Rituxan (rituximab): | | ❑ | ❑ | ❑ | |
| Simponi (golimumab) | | ❑ | ❑ | ❑ | |
| **Osteoporosis Medications** | | | | | |
| Actonel (risedronate) | | ❑ | ❑ | ❑ | |
| Boniva (ibandronate) | | ❑ | ❑ | ❑ | |
| Estrogen (Premarin, etc.) | | ❑ | ❑ | ❑ | |
| Evista (raloxifene) | | ❑ | ❑ | ❑ | |
| Forteo (teriparatide) | | ❑ | ❑ | ❑ | |
| Fosamax (alendronate) | | ❑ | ❑ | ❑ | |
| Miacalcin nasal spray (calcitonin) | | ❑ | ❑ | ❑ | |
| Prolia (denosumab) | | ❑ | ❑ | ❑ | |
| Reclast (zoledronic acid) | | ❑ | ❑ | ❑ | |
| **Gout Medications** | | | | | |
| Zyloprim (allopurinol) | | ❑ | ❑ | ❑ | |
| Colcrys (colchicine) | | ❑ | ❑ | ❑ | |
| Benemid (probenecid) | | ❑ | ❑ | ❑ | |
| Uloric (febuxostat) | | ❑ | ❑ | ❑ | |
| Krystexxa (pegloticase) | | | | | |
| **Others** | | | | | |
| Hyalgan/Synvisc/Orthovisc/Euflexxa injections | | ❑ | ❑ | ❑ | |
| Cymbalta (dyloxetine) | | ❑ | ❑ | ❑ | |
| Lyrica (pregabalin) | | ❑ | ❑ | ❑ | |
| Neurontin (gabapentin) | | ❑ | ❑ | ❑ | |
| Savella (milnacipran) | | ❑ | ❑ | ❑ | |
| Muscle Relaxers | | ❑ | ❑ | ❑ | |
| Sleep Medication | | ❑ | ❑ | ❑ | |
| Other anti-depressants: | | | | | |

Have you participated in any clinical trials for new medications? ❑ Yes ❑ No If yes, list:

Patient's Name _____ Date _____ Physician Initials _____

## ACTIVITIES OF DAILY LIVING

Who does most of the housework?_____Who does most of the shopping? _____Who does most of the yard work? _____

| **Because of health problems do you have difficulty**: (Please check the appropriate response for each question.) | **Without ANY difficulty** | **With SOME difficulty** | **With MUCH difficulty** | **UNABLE to do** |
|---|---|---|---|---|
| 1. Dress yourself, including tying shoelaces and doing buttons? | ___0 | ___1 | ___2 | ___3 |
| 2. Get in and out of bed? | ___0 | ___1 | ___2 | ___3 |
| 3. Lift a full cup or glass to your mouth? | ___0 | ___1 | ___2 | ___3 |
| 4. Walk outdoors on flat ground? | ___0 | ___1 | ___2 | ___3 |
| 5. Wash and dry your entire body? | ___0 | ___1 | ___2 | ___3 |
| 6. Bend down to pick up clothing from the floor? | ___0 | ___1 | ___2 | ___3 |
| 7. Turn regular faucets on and off? | ___0 | ___1 | ___2 | ___3 |
| 8. Get in and out of a car, bus, train, or airplane? | ___0 | ___1 | ___2 | ___3 |
| 9. Reaching behind your head? | ___0 | ___1 | ___2 | ___3 |
| 10. Reaching behind your back? | ___0 | ___1 | ___2 | ___3 |
| 11. Going to sleep? | ___0 | ___1 | ___2 | ___3 |
| 12. Staying asleep due to pain? | ___0 | ___1 | ___2 | ___3 |
| 13. Obtaining restful sleep? | ___0 | ___1 | ___2 | ___3 |
| 14. Climbing stairs? | ___0 | ___1 | ___2 | ___3 |
| 15. Descending stairs? | ___0 | ___1 | ___2 | ___3 |
| 16. Working? | ___0 | ___1 | ___2 | ___3 |
| 17. Getting along with family members? | ___0 | ___1 | ___2 | ___3 |
| 18. Engaging in leisure time activities? | ___0 | ___1 | ___2 | ___3 |

What is the hardest thing for you to do?_____

Do you use a cane, crutches, as walker or a wheelchair? (circle one)

Are you receiving disability?..... Yes ❑ No ❑ Are you applying for disability?.....Yes ❑ No ❑

Do you have a medically related lawsuit pending?.....Yes ❑ No ❑

**Considering that all of the ways your arthritis has affected you over the past week, please place a vertical mark on the line below to show how you are feeling**:

VERY GOOD 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 VERY POOR

**How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK? Please circle on line below.**

NO PROBLEM 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 MAJOR PROBLEM

**How much pain have you had because of your condition OVER THE PAST WEEK? Please circle on the line below.**

NONE 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 AS BAD AS IT COULD BE

Patient's Name _____Date _____Physician Initials _____

# PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY DATE:_____

PATIENT NAME:_____AGE:_____SEX:_____

ADDRESS:_____SS#:_____

CITY:_____STATE:_____ZIP CODE:_____

HOME PHONE:_____DOB:_____DRIVER'S LICENSE:_____

EMPLOYER:_____OCCUPATION:_____

ADDRESS:_____PHONE #:_____CALLS ALLOWED: __Y__N

CITY:_____STATE:_____ZIP CODE:_____

SPOUSE NAME:_____

EMPLOYER:_____OCCUPATION:_____

ADDRESS:_____PHONE #:_____CALLS ALLOWED: __Y__N

CITY:_____STATE:_____ZIP CODE:_____

PRIMARY INSURANCE:_____INSURED:_____

POLICY NO._____ID#:_____PHONE:_____

ADDRESS:_____CITY,STATE:_____ZIP CODE:_____

SECONDARY INSURANCE:_____INSURED:_____

POLICY NO._____ID#:_____PHONE:_____

ADDRESS:_____CITY,STATE:_____ZIP CODE:_____

REFERRING PHYSICIAN:_____

REFERRING PHYSICIAN ADRESS & TELEPHONE:_____

EMERGENCY CONTACT:_____

I HEREBY AUTHORIZE ANY AND ALL INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN AND ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ANY UNPAID BALANCE. I UNDERSTAND THAT IF MY ACCOUNT SHOULD BE TURNED OVER TO A COLLECTION AGENCY THAT I WILL BE RESPONSIBLE FOR ANY FEES INCURRED, UP TO AND INCLUDING 35% OF THE UNPAID BALANCE. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED BY THE ABOVE INSURANCE COMPANY.

PATIENT SIGNATURE:_____

**EMERALD COAST RHEUMATOLOGY**

**3890 Jenks Avenue**
**Lynn Haven, FL 32444**
**Main Phone: 850-215-6400; Main Fax: 850-215-4440**

**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

By signing this authorization, I authorize **EMERALD COAST RHEUMATOLOGY** to use and/or disclose certain protected health information (PHI) about me to Dr. _____ at _____.

Patient's Name_____Date of Birth _____.
This authorization permits **EMERALD COAST RHEUMATOLOGY** to use and/or disclose the following individually identifiable health information (IIHI) and PHI about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.), or all records [if not specifically described, all records will be sent]:

_____
_____.

The information will be used or disclosed for the following purpose:
_____, or [ ] at the request of the individual.

This authorization shall be in force and effect until I revoke it, at which time this authorization to use or disclose this IIHI and PHI expires.

The information may include information about HIV, AIDS, alcohol use, drugs, and mental health.

I do not have to sign this authorization in order to receive treatment from Emerald Coast Rheumatology. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: 2202 State Avenue, Suite 104, Panama City, FL 32405.

Signed by:_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION

**EMERALD COAST RHEUMATOLOGY**

**3890 Jenks Avenue**
**Lynn Haven, FL 32444**
**Main Phone: 850-215-6400; Main Fax: 850-215-4440**

## PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize **Dr.**_____to disclose certain protected health information (PHI) about me to **EMERALD COAST RHEUMATOLOGY.**

Patient's Name_____Date of Birth _____.

This authorization permits **Dr.**_____to use and/or disclose the following individually identifiable health information (IIHI) and PHI about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.), or all records [if not specifically described, all records will be sent]:

_____
_____.

The information will be used or disclosed for the following purpose:
_____, or [ ] at the request of the individual.

This authorization shall be in force and effect until I revoke it, at which time this authorization to use or disclose this IIHI and PHI expires.

The information may include information about HIV, AIDS, alcohol use, drugs, and mental health.

I do not have to sign this authorization in order to receive treatment. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

Signed by:_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION

**Effective Date of this Notice: Sept. 5, 2013**

# EMERALD COAST RHEUMATOLOGY

## NOTICE OF PRIVACY PRACTICES
## FOR PROTECTED HEALTH INFORMATION

**NOTICE EFFECTIVE ON OCTOBER 11,2011**
**REVISED: SEPTEMBER 2013**
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

OUR PRACTICE IS DEDICATED TO MAINTAINING THE PRIVACY AND CONFIDENTIALITY OF YOUR PROTECTED HEALTH INFORMATION (PHI). IN CONDUCTING OUR BUSINESS, WE WILL CREATE RECORDS REGARDING YOU; THIS INCLUDES THE TREATMENT AND SERVICES WE PROVIDE TO YOU. WE ARE REQUIRED BY LAW TO MAINTAIN THE CONFIDENTIALITY OF HEALTH INFORMATION THAT IDENTIFIES YOU. WE ALSO ARE REQUIRED BY LAW TO PROVIDE YOU WITH THIS NOTICE OF OUR LEGAL DUTIES AND THE PRIVACY PRACTICES THAT WE MAINTAIN IN OUR PRACTICE CONCERNING YOUR PHI, AND TO NOTIFY YOU FOLLOWING A BREACH OF UNSECURED PHI. BY FEDERAL AND STATE LAW, WE MUST FOLLOW THE TERMS OF THE NOTICE OF PRIVACY PRACTICES THAT WE HAVE IN EFFECT AT THIS TIME.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

**The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all times.**

### A. PROTECTED HEALTH INFORMATION (PHI) MAY BE USED OR DISCLOSED IN THE FOLLOWING WAYS:

1. **Treatment.** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we

may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. **Payment**. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
3. **Health Care Operations.** Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
4. **Appointment Reminders.** Our practice may use and disclose your PHI to contact you and remind you of an appointment.
5. **Treatment Options.** Our practice may use and disclose your PHI to obtain information of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your PHI to obtain information on health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.
8. **Disclosures Required By Law**. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

**B. UNIQUE SCENARIOS IN WHICH WE MAY USE AND DISCLOSE YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES DESCRIBED AS FOLLOWS:**

1. **Public Health Risks.** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
    - maintaining vital records, such as births and deaths
    - reporting child abuse or neglect
    - preventing or controlling disease, injury or disability
    - notifying a person regarding potential exposure to a communicable disease

- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities.** Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement.** We may release PHI if asked to do so by a law enforcement official:
    - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
    - Concerning a death believed to be as a result of criminal conduct
    - Regarding criminal conduct at our offices
    - In response to a warrant, summons, court order, subpoena or similar legal process
    - To identify/locate a suspect, material witness, fugitive or missing person
    - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)
5. **Deceased Patients**. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. **Organ and Tissue Donation**. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
7. **Research**. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an IRB or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to the individual's privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.
8. **Serious Threats to Health or Safety**. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. **Military**. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
10. **National Security**. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
11. **Inmates**. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
12. **Workers' Compensation**. Our practice may release your PHI for workers' compensation and similar programs.

**C. YOUR RIGHTS REGARDING YOUR PHI:**

1. **Confidential Communications**. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home,

rather than work. In order to request a type of confidential communication, we have a form that we require you to complete. If we have not provided you with a form please bring this to our attention and we will provide one immediately. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. **Requesting Restrictions**. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; unless the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and the PHI pertains solely to a health care item or service for which you, or someone other than the health plan on behalf of you, has paid us in full. If we agree to restrictions, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to our privacy officer at our address. Your request must describe in a clear and concise fashion:
    - the information you wish restricted;
    - whether you are requesting to limit our practice's use, disclosure or both; and
    - To whom you want the limits to apply.
3. **Inspection and Copies**. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to your specific Doctor here, in order to inspect and/or obtain a copy of your PHI. Our practice may impose a reasonable charge for inspections and copies (the copying charge for paper copies will not exceed $.75 per page). Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. **Amendment**. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to your specific Doctor at our address. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; (d) not

created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures**. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. We are not required to document use of your PHI as part of the routine patient care in our practice. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to your specific Doctor at our office. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. **Right to a Paper Copy of This Notice**. You are entitled to receive a paper copy of our notice of privacy practices. We can provide copies at request.
7. **Right to File a Complaint**. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact The Privacy Officer, Arthritis Health Associates, PLLC at 310 S. Crouse Avenue, Syracuse, NY 13210. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.
8. **Right to Provide an Authorization for Other Uses and Disclosures**. The use and disclosure of your PHI for other purposes or activities, not listed in this Notice, will be made only with your written authorization (permission). –Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note we are required to retain records of your care.

# EMERALD COAST RHEUMATOLOGY

**RECEIPT OF NOTICE OF PRIVACY PRACTICES**
**WRITTEN ACKNOWLEDGEMENT FORM.**

I, _____, have received a copy of EMERALD COAST RHEUMATOLOGY's
Patient's Name Name of Practice

Notice of Privacy Practices.

_____ _____
Signature of Patient Date

Emerald Coast Rheumatology

# OFFICE INFORMATION

## APPOINTMENTS

Our phone number is 850-215-6400. We see patients by appointment Monday through Thursday from 8 am to 12 pm and from 1pm to 5 pm, and Friday from 7:30 am to 12:30 pm. Please notify us within 72 hours of your scheduled appointment if you must cancel. Please call 850.215.6400 Ext 202 to cancel.

## APPOINTMENT CONFIRMATION

A recorded message will be confirming your appointment 3 business days prior to your visit. Patients more than 15 minutes late for an appointment may have to reschedule. You will always receive a confirmation call. Please contact the office if you do not receive a call 24 hours prior to your scheduled appointment. You may confirm or cancel an appointment at any time by calling our automated line at 1-850-215-6400.

## INSURANCE COVERAGE VERIFICATION

If you are a new patient, or have a new insurance carrier, please call 850.215.6400 Ext. 201 so we can verify your insurance coverage before your visit. Patients cannot be seen unless benefits are verified.

## TELEPHONE CALLS

If you need to leave a message for one of the staff, please include your name, phone number, doctor's name and reason for the call.

Please call during office hours. This will allow us to pull your medical chart for review by the doctor and/or nurse before returning your call. As we see patients throughout the day, we do our best to return calls as quickly as possible. If we receive your call after 2 pm, we may not return your call until the next business day.

## TELEPHONE EXTENSIONS

Scheduling .....Ext. 202
New Patient Appt .....Ext. 201
Insurance .....Ext. 201
Nurses.....Ext. 203
Refills.... .....Ext. 204
Medical Records.....Ext. 202
Infusion .....Ext 206

CONTINUED >

## LAB RESULTS

***Lab results will be reviewed with you at the next visit unless a change is required in your medical protocol, and you will be contacted***

## PRESCRIPTION REFILLS

***Have your pharmacy call our office at 850-215-6400 Ext. 202***

We do not take prescription refills directly from patients.

Often times the doctor or nurse will want to review your chart before prescribing more medication, so it is faster if you ***call your pharmacy at least 5 days before your prescription runs out***.

## EMERGENCIES

***If you are experiencing shortness of breath, chest pain and/or fever, call us immediately.*** Be sure to leave your name, phone number and the nature of the emergency. If you feel it is critical, call 911 or go to the nearest Emergency Room where they will contact us.

## PAYMENTS

**It is necessary for patients to pay deductibles and co-payments at the time of their visit. To make payment more convenient, we accept, cash, check, MasterCard, VISA and Discover.**

Emerald Coast Rheumatology

OFFICE LOCATION
3890 Jenks Avenue
Lynn Haven, Florida
32444

850.215.6400 PHN 850.215.4440 FAX

**www.DrKenawy.com**