VALLEY ARTHRITIS CARE

Peoria Office
13943 N. 91st Ave. Bldg. I, Peoria, AZ 85381

Sun City West Office
13613 W Camino Del Sol #4, Sun City West, AZ 85375

HEALTH HISTORY QUESTIONAIRE

All questions in this questionnaire are strictly confidential and will become part of your medical record.

FIRST NAME: _____ **LAST NAME:** _____ ☐ **MALE** ☐ **FEMALE**

PRIMARY CARE PHYSICIAN: _____ **DATE OF BIRTH:** _____

REASON FOR VISIT: _____ **OCCUPATION:** _____

PERSONAL HEALTH HISTORY

Surgeries	Hospital	Year

Other Hospitalizations

Reason	Hospital	Year

List your prescribed drugs and over the counter drugs, such as vitamins and inhalers.

Name of drug	Strength	Frequency taken

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Allergies To Medication

Name Of Drug	Reaction You Had

PHARMACY NAME:_____ **PHARMACY PHONE NUMBER:**_____

LOCATION:_____

Health Habits

Questions:	Response	
Do you drink alcohol? If yes, what kind? How many drinks per week?	Yes	No
Do you currently use tobacco? If yes, how often?	Yes	No
Do you currently use recreational or street drugs?	Yes	No
Have you ever given yourself street drugs with a needle?	Yes	No
Do you have a pacemaker?	Yes	No
Do you have dentures?	Yes	No
Do you have metal in your body? If yes , please explain:	Yes	No

Family Health History

Have any of your family members been diagnosed with any of the following:

Questions:	Response	
Rheumatoid Arthritis? If yes, explain:	Yes	No
Lupus? If yes, explain:	Yes	No
Gout? If yes, explain:	Yes	No
Osteoporosis? If yes, explain:	Yes	No
Diabetes? If yes, explain:	Yes	No
Cancer? If yes, explain:	Yes	No

Any other Family History?

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Your Health History

Have you been diagnosed with any of the following?

Hypertension?	Yes	No	High Cholesterol?	Yes	No	Lupus?	Yes	No
Emphysema?	Yes	No	Fibromyalgia?	Yes	No	Osteoarthritis?	Yes	No
Carpel Tunnel?	Yes	No	Irritable Bowel Syndrome?	Yes	No	Restless Leg Syndrome?	Yes	No
Sleep Apnea?	Yes	No	Degenerative Disc Disease?	Yes	No	Gout?	Yes	No
Diabetes?	Yes	No	Rheumatoid Arthritis?	Yes	No	Osteoporosis?	Yes	No
Asthma?	Yes	No	Cancer?	Yes	No	Crohn's Disease?	Yes	No
Migraines?	Yes	No	Psoriasis?	Yes	No	Ulcerative Colitis?	Yes	No
Sciatica?	Yes	No	Lupus?	Yes	No			

Have you had any of the following symptoms?

Shortness of breath?	Yes	No	Bloody Cough?	Yes	No	Cough?	Yes	No
Wheezing?	Yes	No	Sputum Production?	Yes	No	Fever?	Yes	No
Vomiting?	Yes	No	Fatigue?	Yes	No	Nausea?	Yes	No
Loss Of Appetite?	Yes	No	Sciatica?	Yes	No	Degenerative Disc Disease?	Yes	No
Bloody Stools?	Yes	No	Chest Pain on Exertion?	Yes	No	Palpitation?	Yes	No
Chills?	Yes	No	Night Sweats?	Yes	No	Abdomen Pain?	Yes	No
Leg Edema/Water Retention?	Yes	No	Frequent Urination?	Yes	No	Painful Urination?	Yes	No
Urgency Of Urination?	Yes	No	Urine Incontinence?	Yes	No	Easy Bruising?	Yes	No
Nosebleeds?	Yes	No	Swollen Glands?	Yes	No	Frequent Infections?	Yes	No
Seizures?	Yes	No	Visual Problems?	Yes	No	Depression?	Yes	No
Anxiety?	Yes	No	Numbness/Tingling?	Yes	No	Hallucinations?	Yes	No
Jaw Pain?	Yes	No	Mouth Sores?	Yes	No	Heartburn?	Yes	No
Rashes?	Yes	No	Dry Eyes?	Yes	No	Dry Mouth?	Yes	No
Photosensitivity/Rash In Sun?	Yes	No	Fingertip color change in cold temperature?	Yes	No	Temperature Intolerance?	Yes	No
Muscle Spasm/Ache?	Yes	No	Change in Bowel Habits?	Yes	No	Muscle Spasm/Ache?	Yes	No

OTHER?

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Patient Demographic Questionnaire

Please take a moment to answer the questions on this questionnaire. Please understand you can and may refuse to answer. We are asking for your race and ethnicity because some people have higher risks of developing certain diseases, such as high blood pressure, diabetes, and heart disease. It is also important that we know your preferred spoken language so that your health care team can communicate clearly. Our registration system also allows us to document your gender and sexual orientation for patients that want this information documented into their chart. We understand you may wish to speak with your physician directly regarding this subject during your office visit. We will keep this information confidential and will update your medical file. This information will assist us in continuing to provide you with the best health care. Thank you!

Patient Full Name:_____ Date of Birth:_____

Please provide the information below. We greatly appreciate your participation.

1. Race / Ethnicity:
   - White/Caucasian
   - Asian
   - Native Hawaiian or Pacific Islander
   - Native American
   - Black/ African
   - Hispanic/ Latino
   - Other
   - Prefer not to Answer

2. Please indicate your preferred spoken language:_____
3. Sex: ____Female _____Male
4. Gender Identity:
   - Male
   - Female
   - Transgender Male/ Female to Male
   - Transgender Female/ Male to Female
   - Genderqueer, neither exclusively Male nor Female
   - Other
   - Declined
5. Sexual Orientation:_____Straight _____Gay _____Lesbian ____Bisexual ____Other ___ unknown ____Declined

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Financial Policy

Our physicians appreciate the confidence you have shown in choosing them to provide for your health care needs. We are committed to provide you with the best treatment available. The service that you have elected implies a financial responsibility on your part. The responsibility obligates you to the ensure full payment for our service. All new patients must complete our patient registration as well as read and sign the financial policy before seeing the physician.

Please keep in mind that your insurance is a contract between you and the insurance carrier. We will bill your insurance on you behalf with the information you have provided to us. Please make sure to notify our office if there are any insurance changes to your plan. We will only provide services to you if we consider them medically necessary. In providing the best treatment for you, we will charge what is usual and customary. Please be aware that your insurance plan may consider our services as non-covered services and / or not medically necessary. We will offer our assistance to you in negotiating payment from the insurance for any dispute claims. However, as our patient, you are responsible for payment of all services provided in our office.

In the event you do not have medical insurance coverage you will be considered a self-pay patient and responsible for payment of all services provided on the date of service unless prior payment arrangement has bene made.

All co-pays and deductibles and / or co-insurance are due prior to treatment. We understand it may be necessary for you to make financial agreement plan with our billing department for deductibles and co- insurance. Please contact our billing department at (623)414-4053.

If a account becomes past due and is placed with an outside collection agency, you will be responsible for all the collection and legal fees.

Thank you for understanding our financial policy. If you have any questions or concerns, our billing department will be happy to assist you.

I have read and I understand this financial policy. I authorize my insurance company to pay and benefit directly to Valley Arthritis Care, LLC. I agree with this financial policy and understand I will be responsible for payment of services provided to me.

Print Full Name_____ **Date of Birth** _____

Patient Signature_____**Date** _____

Parent/LegalGuardianSigniture_____**Date** _____

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Thank you for choosing Valley Arthritis Care to provide your health care needs. In an effort to serve patients, we must use our time efficiently. We have implemented the following policy concerning treatment and records.

Medical Record Release

The patient must sign an authorization to release medical records. The allotted time frame for records to be released is approximately 7-10 business days. In the event a patient requested a copy of their entire chart, this can take up to 30days.

Disability Forms

Some physicians will require you to schedule an appointment in order to fill your disability form. While other physicians will not fill out disability forms at the patient's visit. Please check with the medical records department prior to leaving any forms. For physicians not requiring an appointment, all forms will be given to the medical records department and then dispersed to your physician. Physicians will review and complete the forms on a monthly basis. The patient must be establish with the same physician for a minimum of 1 year.

if the physician determines they cannot procced to fill out the form, the physician may recommend the patient to have a functional capacity evaluation. We do not perform these types of evaluations. Facilities that perform this type of evaluation do charge a fee for their services and you will need to contact them directly. If you choose to perform the type of evaluation, please bring those results to your physician. Valley Arthritis Care will charge a fee of $50.00 for all completed forms and letters. All fees will need to be paid prior to receiving any completed forms.

FMLA Leave Forms

Before the physician can fill out an FMLA form the patient must be establish with the physician and have at least been seen for two visits. FMLA forms may require an appointment and / or be filled out on a monthly basis. Please bring a job description of your daily required duties.

Cancellation/No Show Appointments

We understand there may be times when you miss an appointment due to emergencies of obligations to work or family.
However, we urge you to call our office 24 hours prior to cancelling your appointment. If you fail to call our office to cancel your appointment, it will be considered a no-show. If you no-show twice, you may be discharge from our practice.

Consent For Treatment

At each visit you will be require to review your information. Please make necessary changes at the that time. You will be consenting to treatment considered necessary for your medical condition.

Switching Physicians within the Practice

If you have preference of a physician, you must let our schedulers know prior to your first visit. We will make every reasonable attempt to accommodate your preference. Request to switch providers must be approved by the physicians and in general will be denied. There will be an exception if it is a geographical issue and / or language barrier.

Notice of Privacy Practice

I hereby acknowledge that I have been presented with a copy of Valley Arthritis Care's Notice of Privacy Practice.
I have read and understand the above policies.

Print Full Name_____ **Date of Birth** _____

Patient Signature_____**Date** _____

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Notice of Privacy Practice and Patient Consent for Use and Disclosure of Protected Health Information.

Patient's Full Name: _____Date:_____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Valley Arthritis Care, LLC may use or disclose my protected health information for treatment, payment or health care operations which means for providing health care for me, the patient; handling billing and payment; and taking care of other health care operations. Unless require by law, there will be no other uses and disclosures of this information without my authorization.

Valley Arthritis Care, LLC has a detailed document called the `Notice of Privacy Practices`. It contains a more complete description of your rights to privacy and how we use and disclose protected health information.

I understand that I have the right to read the `Notice of Privacy Practices`.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Valley Arthritis Care, LLC to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Valley Arthritis Care, LLC has taken action relaying on this consent.

Print Full Name_____ **Date of Birth** _____

Patient Signature_____**Date** _____

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting Valley Arthritis Care, LLC 13943 N 91ST AVE BUILDING I , Peoria , AZ 85381.(623) 815-2690

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Authorization to Disclose Health Information

Discuss/ Pick up Medical Information

I authorize Valley Arthritis Care to discuss my health care information records to the following persons:

FULL NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER

Types of Information

_____All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, DEXA's, history and laboratory findings, admission and discharge reports, treatment records, diagnosis and prognosis records, nurse and physician notes, and any other non-medical information in my file.

_____ PICK UP OF PRESCRIPTIONS.

_____ PICK UP OF ORDERS FOR LABS, X-RAY, MRI ETC.

_____ PICK UP OF SAMPLES MEDICATIONS.

_____ONLY THE FOLLOWING TYPES OF INFORMATION.

Patient Name:_____ Date of Birth:_____

Patient Signature:_____ Today's Date:_____

Parent/Legal Guardian:_____ Today's Date:_____

This authorization shall remain valid until revoked (voided) by me in writing or signed in the box below.
I wish to revoke this authorization as some or all of this information is incorrect or no longer valid. I understand I cannot make changes to this form, but I can fill out a new authorization form, I give permission for this form to be voided.

Patient Name:_____Today's Date: _____
Patient Signature: _____Today's Date: _____
Parent/Legal Guardian:_____ Today's Date: _____
Name of Employee voiding form:_____Today's Date: _____

This authorization must be given to the medical records department. The medical records department will be responsible for entering the data into the computer, setting an alert and scanning this form under HIPAA Authorization.

If the patient needs to make changes to this form for any reason, they will need to void this form and fill out a new form the employee must print this form from the chart and have patient sign in the revoke box. The word "VOIDED" must be written across the corner. The voided form must be given to the medical records department.

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AUTHORIZATION TO RELEASE MEDICAL RECORDS & DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Full Name: _____ Date of Birth:_____

Patient's Address:_____Telephone Number:_____

I AUTHORIZE THE RELEASE OF INFORMATION IN MY HEALTH CARE RECORD:
From: Valley Arthritis Care, LLC To: Self

□I will pick up records when ready at □MAIN □SCW □Please mail records to Patient's Address listed above.

INFORMATION TO RELEASE

- Patient records of the past three years of treatment.
- All medical records (I understand this requires approval from the privacy officer and may take up to 30days)
- Medical Records from:_____ TO_____
- Specific records: (from the past year) □Billing □Office Notes □Labs □X-Ray □Bone Density
- Other: (please explain and provide dates: _____

Purpose: □Patient Request □Continue Medical Care □Attorney Request □Other

I understand that my health records may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency; (AIDS), Human Immunodeficiency Virus (HIV), Hepatitis C, and other communicable disease, Behavioral Health Care, Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes the release of such information. I may refuse to sign this authorization and understand that Valley Arthritis Care will not condition or deny treatment on my signing this authorization.

I understand that I may revoke this authorization at any time in writing except to the extent that actions has taken based on this authorization, unless otherwise revoked this authorization is calid for one year.

I understand that once my information is released, Valley Arthritis Care will no longer be able to protect that information. I release Valley Arthritis Care and its employees from any legal liability that may arise from the disclosure of the above information.

I understand there is an administrative fee associated with to duplication of my records. Please allow 7-10 days for any duplication of records. For the release of all medical records please allow 30days.

Patient/Legally Authorized Representative Signature: _____ **Date:** _____

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Notice to all Patients:

Due to all the various HMO and PPO insurance plans and their individual requirements regarding payments, pre-certification, and claims, we are requesting that all patients seek out all the information needed and provide that information to the office staff.

Patients are responsible for following up on an authorization and referrals for their office visit and procedures. If your authorizations or referral must come from your primary care physician, please give them at least a ten-day notice. If your authorization or referral has not been received one day prior to the scheduled appointment time, the appointment may be rescheduled.

We have always filed and will continue to file claims for patient, but the patient must share equal responsibility for obtaining and giving the doctor and insurance company the necessary information needed to process and received payment within a reasonable amount of time. We are therefore requesting your cooperation, so that we may better serve you and give you the proper health care you deserve.

Thank you, we appreciate your help.

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Patient Online Services

As you know, few things in life matter more than your health and the health of your loved ones…now there's a new way to manage what's more important.

At MyHealthRecord.com, you can:

- Securely message your care team
- Review appointments
- Request prescription refills or view medication list
- View lab results and summary notes
- Send your records to other healthcare providers
- Receive secure messages from your provider regarding results.
- Make billing payments

Creating an account is quick and easy:

1. Ask a staff member to email you a registration link.
2. Open link
3. Answer a few data-verification questions
4. Visit MyHealthRecord.com to log in

My Health Record