Oregon Rheumatology
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OREGON RHEUMATOLOGY PATIENT POLICIES

Oregon Rheumatology Clinic strives to provide high quality care for patients in a compassionate, thorough, and time-efficient manner. We appreciate our patients and hope to exceed your expectations for care.

In order to serve you, we would like to provide some guidelines to help you understand our practice.

Please review some of the clinic polices:

Appointments: Please arrive 15 minutes early to your scheduled appointment time.

If you are 15 minutes late for your appointment, we will need to reschedule.

No shows: If you miss your scheduled appointment three times in a year, you may be dismissed from our clinic, or asked to find a new provider. **You may be charged a $75 dollar fee for missed appointments or procedures**.

Billing/Insurance: **Insurance cards MUST** be present at the time of your FIRST appointment, and available every appointment thereafter.

You **MUST notify the clinic** if there are any changes to your insurance while you are an active patient with the clinic.

Co-payments are required due at the time of service to stay in compliance with insurance plan regulations; WE CANNOT WAIVE COPAYS.

You may receive bills in the mail from our clinic, ***please do not hesitate to call if you have any questions regarding the bill.***

Medication Refills: All prescription refill requests should be initiated through your pharmacy. Please allow three (3) business days to complete prescription requests. Refills will not be handled outside of office hours.

*Our physicians **do not** prescribe narcotics and/or any other controlled substances at Oregon Rheumatology Clinic.*

Paperwork/Forms: Any patient that needs paperwork completed by the provider must **pay the $25 dollar form fee.**

Examples: FMLA forms, Disability forms, etc.

Behavior: Physical and/or verbal abuse towards ANY staff member will not be tolerated and may result in the immediate dismissal from the clinic.

Care facilities: For patients that reside in care facilities of any type, please ensure necessary paperwork, such as physician orders, are brought to each appointment. You may be required to be seen by the physician at 90-day intervals to satisfy the regulatory compliance.

I have read, and agree with the above office policies:

Patient Name: _____ **Date:** _____

Patient Signature or Responsible Party: _____

Relationship to Patient (If Responsible Party is Not Patient): _____

PATIENT INFORMATION & RESPONSIBILITY FORM

PERSONAL INFORMATION: **TODAY'S DATE: ____/____/_____**

Patient Name: First: _____ Middle: _____ Last: _____

DOB: ____/____/_____ Sex: M / F / NB Social Security Number: _____ Marital Status: M / D / W / S / P

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address (if different): _____City: _____ State: _____ Zip: _____

Preferred Language: _____ Race:_____ Ethnicity: _____

Cell Phone: _____Home Phone: _____Work Phone: _____

Are we allowed to leave detailed messages on your voicemail? Yes ☐ No ☐ **Initials:** _____

Emergency Contact Name: _____Relationship: _____Phone #: _____

Employer Name: _____ Position: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

PATIENT PORTAL:

Patient Portal: Please provide an email address to register for Patient Portal. This is an electronic way to view lab and imaging results as well as message your provider directly. An enrollment token ID will be provided during your initial appointment.

Email Address: _____ *I wish to decline Patient Portal* ☐

PERMISSION TO VERBALLY DISCLOSE MEDICAL INFORMATION

In some cases, patients may wish to have information regarding their medical condition(s), medications, scheduled appointments, lab results, etc. discussed with individuals involved in their care such as family members, friends or caretakers. If this applies to you, please indicate below any person with whom you would like us to share protected health information regarding your care.

I give permission to Oregon Rheumatology to verbally discuss information regarding my medical care to the following person(s); **including** myself:

_____

Name **Relationship to Patient** **Phone Number**

_____

Name **Relationship to Patient** **Phone Number**

_____

Name **Relationship to Patient** **Phone Number**

Patient Signature or Responsible Party: _____

INSURANCE INFORMATION

INSURANCE INFORMATION: ***You will be asked for a copy of your insurance card(s) at each visit.***

Is the Insurance in your name? Y / N If no, who carries this insurance: _____ DOB: ___/____/____

Employer Sponsoring Insurance Plan: _____ Employer Phone Number: _____

Primary: _____ ID #: _____ Group #: _____

Claims Address: _____

Effective Date: _____ Member Services Phone Number: _____

Secondary: _____ ID #: _____ Group #: _____

Is the Insurance in your name? Y / N If no, who carries this insurance: _____ DOB: ___/____/____

Employer Sponsoring Insurance Plan: _____ Employer Phone Number: _____

Claims Address: _____

Effective Date: _____ Member Services Phone Number: _____

Pharmacy Benefit Manager: _____ RX ID: _____

RX Grp: _____RX BIN: _____ RX PCN: _____

RESPONSIBLE PARTY (IF OTHER THAN SELF, OR IF PATIENT IS A MINOR):

Name: _____ DOB: _____/_____/_____ Social Security Number: _____

Relationship: _____ Email Address: _____

Mailing Address: _____ City: _____ State: _____ Zip:_____

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION: *I certify that I had the opportunity to review and read a copy of the Oregon Rheumatology Privacy Policy. I hereby authorize Oregon Rheumatology or the provider individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.*

AUTHORIZATION TO CALL, MAIL, OR E-MAIL*: I certify that I understand the privacy risks of the mail, phone calls and emails. I hereby authorize Oregon Rheumatology representatives or my provider to mail, call, or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Oregon Rheumatology to that effect in writing.*

CONSENT TO TREATMENT: *I hereby consent to evaluation, testing and treatment by my Oregon Rheumatology provider or his/her designee.*

Patient Signature or Responsible Party: _____

ASSIGNMENT OF BENEFITS

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREAD OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE.

I hereby assign and convey directly to Oregon Rheumatology Clinic, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by Oregon Rheumatology Clinic, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Oregon Rheumatology Clinic to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to Oregon Rheumatology Clinic any and all Plan Documents, summary benefits description, insurance policy, and/or settlement information upon written or verbal request from Oregon Rheumatology Clinic or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to Oregon Rheumatology Clinic any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tortfeasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims, or chose an action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

I intend to by this assignment and designation of authorized representative to convey to Oregon Rheumatology Clinic all my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by Oregon Rheumatology Clinic, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (Oregon Rheumatology Clinic) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. Oregon Rheumatology Clinic as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense. Oregon Rheumatology Clinic may also file complaints with the Oregon Insurance Commissioner's office if necessary.

The lifetime assignment will remain in effect until revoked by me in writing. It is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it were the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient Printed Name: _____ Date of Birth: _____

Patient Signature: _____

FINANCIAL POLICY/AGREEMENT

Oregon Rheumatology is committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

We will bill your primary and secondary insurance carrier(s). As a courtesy to you, we will bill your insurance. To do this, we require that all necessary information be given to us prior to your visit. If you change coverage, it is ***your*** responsibility to inform us of that change ***before*** your scheduled visit. This will allow us to obtain necessary verification and/or authorization. *Failure to do will likely result in you being entirely responsible for charges for that visit.*

Insurance coverage varies from plan to plan. Depending on your individual insurance coverage, your plan may cover some, all, or none of the services rendered to you at Oregon Rheumatology. Regardless of your insurance coverage, you are still responsible for the bill. All insurance plans represent a contract between you and your insurance company. Therefore, it is your responsibility to see that the insurance company makes prompt payment and to handle any disputes or questions that may arise. It is our responsibility to comply with your insurance company and collect the copay amount deemed by your plan.

*****All co-payments for insurance plans are due at the time of your visit and cannot be billed.*****

Cancelled or missed appointments. To provide efficient care in a timely manner to all our patients, we require a minimum of 24 hours' notice for cancelling appointments. **Therefore**, a fee of $75 for patient visits and scheduled procedures will be charged for missed visits. *This fee must be paid before additional appointments can be scheduled.*

I have read, understood, and agree *to the Financial Policy at Oregon Rheumatology Clinic described above.*

Patient Signature or Responsible Party: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge I have had the opportunity to view and receive a copy of Oregon Rheumatology's "Notice of Privacy Practices" (available in the office or online to view).

Patient Signature or Responsible Party: _____

(OFFICE USE ONLY)

A written acknowledgement of receipt of the Notice of Privacy Practices was not attained, despite our best efforts, because:

The patient refused to sign The patient was physically unable to sign Other: _____

Initials: _____

CANCELLATION POLICY

- We require at least 48 hours' notice via phone to cancel your new patient appointment. If you cancel within this window or do not make it to your appointment, you may be charged a $75 fee or discharged from our clinic.

- We require 24 hours' notice via phone to cancel a follow-up appointment with a provider.

NOTICE OF REFERRAL RIGHTS AND ACKNOWLEDGMENT

This notice describes your referral rights when your health care provider refers you to another provider or facility for additional testing or health care services.
In accordance with Oregon law, when you are referred for care outside or within our clinic, Oregon Rheumatology is required to notify you that you may have test or service done at a facility other than the one recommended by your physician or health care provider.

Oregon law (ORS 441.098)

- A referral for a diagnostic test or health care treatment or service shall be based on the patient's clinical needs and personal health choices.
- A health practitioner shall not deny, limit, or withdraw a referral solely because the patient chooses to have the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner.
- A health practitioner or the practitioner's designee shall provide notice of patient choice at the time the patient establishes care with the practitioner and at the time the referral is communicated to the patient.
- The oral or written notice of patient choice shall clearly inform the patient:
    1) That when referred, a patient choice about where to receive services; and
    2) Where the patient can access more information about patient choice.
- The patient has a choice and when referred to a facility for a diagnostic test, pharmacy or health care treatment or services the patient may receive the diagnostic test, health care treatment, pharmacy or service at a facility other than the one recommended by the health practitioner.
- If a patient chooses to have the diagnostic test, health care treatment, pharmacy, or service at a facility different from the one recommended by a practitioner, the patient is responsible for determining the extent of coverage or the limitation on coverage for the diagnostic test, health care treatment, pharmacy or services at the facility chosen by the patient.

By signing below, I acknowledge that I have read and understand my referral rights as outlined above.

Patient Signature or Responsible Party: _____

INFORMED CONSENT FOR TELEMEDICINE SERVICES

1. NATURE OF TELEMEDICINE CONSULT & CONSENT: Telemedicine services are a newer method to discuss information regarding your case with a healthcare provider. The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with the following procedure(s) and/or service(s): new patient or follow up appointment. Telemedicine services require an audio-visual component such as a smartphone, tablet, or computer. These may occur in a Telemedicine appointment:

    I. Details of your medical history, examinations, diagnostic results may be discussed with other health professionals using interactive video, audio, and telecommunication technology.
    II. A physical examination of you may take place, if available.
    III. A non-medical technician may be present in the telemedicine studio to aid in the video transmission.
    IV. Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s)

2. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.

3. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Oregon state law apply to information disclosed during this telemedicine consultation.

4. RIGHTS: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment.

5. DISPUTES: You agree that any dispute arriving from the telemedicine consult will be resolved in Oregon, and that Oregon law shall apply to all disputes.

6. PAYMENT OF SERVICES: You agree that Oregon Rheumatology Clinic reserves the right to bill a telemedicine visit to your respective insurance company. Also, you are responsible for any patient portion of the telemedicine consult, before your telemedicine consult will be scheduled.

I agree to participate in a telemedicine consultation for the procedure(s) described above.

Patient Signature or Responsible Party: _____

New Patient Medical History- Rheumatology

Name:_____ **Date:**_____

Insurer: O Medicare PartB O Medicare Advantage O Other_____

Primary Care Physician: _____

Other Health Care Providers:_____

Race: O African American O Native Hawaiian O Caucasian/White O Indian/Native American O Alaskan O Asian O

Ethnicity: O Hispanic/Latino O Not Hispanic/Latino

Education: Grade School: 7 8 9 10 11 12 College: 1 2 3 4 Graduate School:

Occupation:_____ O Retired O Disabled

What are your symptoms today?:

_____

_____

_____

Please indicate the amount of pain you are having TODAY in each of the joint areas listed below:

	None (0)	Mild (1)	Moderate (2)	Severe (3)		None (0)	Mild (1)	Moderate (2)	Severe (3)
Left Fingers					**Right Fingers**				
Left Wrist					**Right Wrist**				
Left Elbow					**Right Elbow**				
Left Shoulder					**Right Shoulder**				
Left Hip					**Right Hip**				
Left Knee					**Right Knee**				
Left Ankle					**Right Ankle**				
Left Toes					**Right Toes**				

Have you fallen this past year? O Yes ONo

My pain is: O Constant O Occasional O Sharp O Dull O Burning

How long does your pain last? O 15 minutes O 1 hour O 4 to 6 hours O All day O All Night

Pain is worse with: _____

Pain is better with: O Heat O Ice O Exercise O Medication O Nothing Helps O other ____

Date that symptoms began: _____

_____

Diagnosis (if known): _____

Diagnostic tests: O Labs O X-rays/MRI scan O DXA scan O Other_____

Where were your tests performed?_____

REVIEW OF SYSTEMS:	**Please check if present:**	
Constitutional:	[ ] Chills	[ ] Weight Loss
	[ ] Night Sweats	[ ] Weight Gain
	[ ] Fatigue	[ ] Weakness
	[ ] Fever	
Eyes:	[ ] Redness	[ ] Blurred Vision
	[ ] Dry Eyes	
	[ ] Loss of Vision	
Ears, Nose, Mouth Throat:	[ ] Difficulty Swallowing	[ ] Dry Mouth
	[ ] Mouth or Nasal sores	[ ] Dry Mouth
Heart and Vascular System:	[ ] Chest Pain	[ ] Color changes of fingers or toes
	[ ] Irregular Heart Beat	[ ] Shortness of Breath
Respiratory:	[ ] Wheezing	[ ] History of TB or+ skin test
	[ ] Cough	**Last Chest X-ray:**
	[ ] Cough up blood	
Gastrointestinal:	[ ] Nausea / Vomiting	[ ] Hepatitis (A, B, C)
	[ ] Stomach Ulcer(s)	[ ] Gallstones
	[ ] GERO/Heartburn	[ ] Jaundice
	[ ] Diarrhea	[ ] Blood in stools
	[ ] Constipation	[ ] Crohn's disease
	[ ] Irritable Bowel Syndrome	[ ] Ulcerative Colitis
Genitourinary:	[ ] Urinary Tract Infections	[ ] Pain or Burning on Urination
	[ ] Kidney disease	[ ] Blood in Urine
Women:	**Miscarriages:**	**Pregnancies:**
	[ ] Still Menstruating	[ ] Gynecological Problems
	Age of Menopause:	
Men:	[ ] Prostate Problems	[ ] Prostate Cancer
Musculoskeletal:	[ ] Arthritis	[ ] Osteoporosis
	[ ] Broken bones after 50	[ ] Morning Stiffness
Skin	[ ] Rash	[ ] Sun Sensitivity
	[ ] Psoriasis	[ ] Skin Tightness
	[ ] Nail Changes	
Neurologic:	[ ] Headaches	[ ] Stroke
		[ ] Seizures
	[ ] Poor Balance or Falls (Gait disturbance)	[ ] Memory Loss
	[ ] Numbness	[ ] Tingling
Psychiatric:	[ ] Anxiety	[ ] Depression
Endocrinologic:	[ ] Thyroid Disease	[ ] High cholesterol/Lipids
	[ ] Diabetes	
Hematology/Oncology	[ ] Anemia	[ ] Cancer
	[ ] Clotting or Bleeding Problems	
Allergy:	[ ] Allergic Rhinitis	[ ] Hives

Please List Past Surgeries or Hospitalizations	Reason:	Year:

Social History:	
Do you currently smoke cigarettes? Yes No # Years	Have you *ever* smoked cigarettes? Yes No
Do you use other forms of tobacco? Yes No If yes, kind:	
Do you drink alcohol? Yes No	Do you use marijuana? Yes No
If yes, how many drinks per week/month/year:	Any other recreational drug use? If so, what kind:
Do you exercise regularly? Yes No How often do you work out?	Are you a current or past user of above drugs? O Current O Past - Number of years: _____
Hours of sleep per night? _____ Hours	

Family History:	**Ages**	**Health Problems:**
Mother: [ ] alive [ ] deceased		
Father: [ ] alive [ ] deceased		
Number of siblings:		
Number of Children:		
Other.		

Current Pharmacy:	**Location:**
Drug Allergies: [ ] No [ ] Yes If yes, please list:	

Current Medications:	**Dose/Frequency**	**Medical condition being treated**

Are you taking any vitamins or supplements? If so, please list below:

HEALTH ASSESSMENT QUESTIONNAIRE

Please indicate the ONE best answer for your abilities at this time:

AT THIS MOMENT, are you able to:	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE to Do
Dress yourself, including shoelaces and buttons?	( ) 0	( ) 1	( ) 2	( ) 3
Stand up from a straight chair?	( ) 0	( ) 1	( ) 2	( ) 3
Cut your own meat?	( ) 0	( ) 1	( ) 2	( ) 3
Walk outdoors on flat ground?	( ) 0	( ) 1	( ) 2	( ) 3
Wash and dry your body?	( ) 0	( ) 1	( ) 2	( ) 3
Reach and get down a 5 pound object (such as a bag of sugar) from just above your head?	( ) 0	( ) 1	( ) 2	( ) 3
Open car doors?	( ) 0	( ) 1	( ) 2	( ) 3
Run errands and shop?	( ) 0	( ) 1	( ) 2	( ) 3
Get in and out of car?	( ) 0	( ) 1	( ) 2	( ) 3

Activities: To what extent can you carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?:

O Completely O Mostly O Moderately O A Little O Not at All

How much pain have you had because of your condition OVER THE PAST WEEK? Indicated the which best describes the severity of your pain.

NO PAIN	()	()	()	()	()	()	()	()	()	()	()	()	()	()	()	()	()	()	()	()	()	SEVERE 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	10.0	

How much of a problem has fatigue or tiredness been for you IN THE PAST WEEK? Indicate that which best describes the sever- ity of your fatigue.

FATIGUE IS NO PROBLEM	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	FATIGUE IS A MAJOR PROBLEM
	0	0.5	1.0	1.5	2.0	2.5	3.0	3.5	4.0	4.5	5.0	5.5	6.0	6.5	7.0	7.5	8.0	8.5	9.0	9.5	10.0	

Considering ALL THE WAYS THAT YOUR ILLNESS AFFECTS YOU, rate how you are doing on the following scale, indicate that which best describes how you are doing.

VERY WELL	()	()	()	()	()	()	()	()	()	()	()	()	()	()	()	()	()	()	()	()	()	VERY POOR
	0.0	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	10.0	

If you are stiff in the morning, about how long does the stiffness last?

( )No stiffness ( ) 30 min or less ( ) >30 min - 1 hr ( )>1-2hrs ( ) >2 - hrs ( )>4-8hrs ( ) More than 8