920 Town Center Drive
Suite I-30 - Oxford Court
Langhorne, PA 19047
215-752-8680

7908 Bustleton Avenue
Bustleton & Borbeck
Philadelphia, PA 19152
215-725-7400

We welcome you as a new patient to our office!

To make your appointment as efficient and stress-free as possible, we have enclosed directions to the office, a checklist of items for your appointment, and your patient information packet.
Please be aware that your first appointment may take 1 – 1 ½ hours, so it is very important that all information requested is available at the time of the appointment.

CHECKLIST OF ITEMS TO BRING WITH YOU TO THIS APPOINTMENT:

- □ Enclosed patient information packet. Please take the time to complete this before arriving, it is necessary for this appointment.
- □ Medical Records. This may include blood work, x-rays, MRI's, dexa scans etc. (patients usually obtain copies from the referring physician or primary doctor)
- □ Medical Insurance & Prescription Coverage Card
- □ Your specialist copay, and if applicable, your insurance deductible.(Cash, or Credit Card)
- □ Photo Identification, State/Federal Issued (Drivers/Non-Drivers License, Passport, etc.)
- □ Referral from your primary care physician (when required by your insurance plan)
  Our NPI number is: 1700823838

You are welcome to arrive 15 minutes ahead of your appointment to complete patient intake/registration.

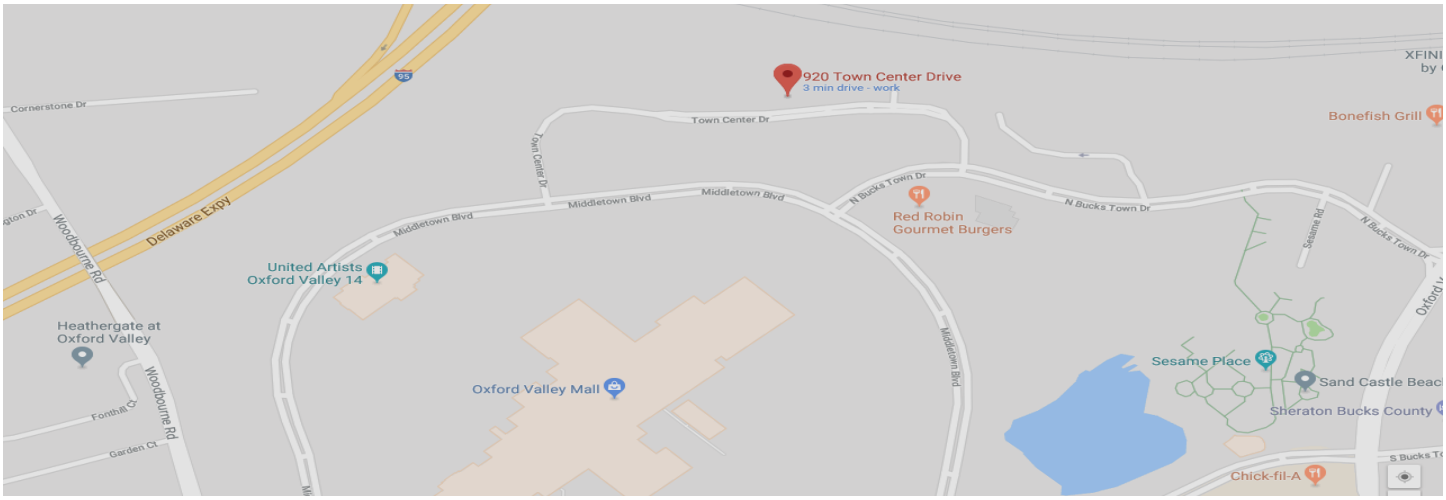
We look forward to meeting with you and participating in your care.
If you have any questions, please feel free to call the office.

Thank You.

PLEASE NOTE
OUR STAFF WILL CALL YOU IN THE DAYS BEFORE THIS APPT TO REMIND & CONFIRM.
KINDLY GIVE 24 HOURS NOTICE TO CANCEL/RESCHEDULE AN APPOINTMENT, IT IS APPRECIATED.

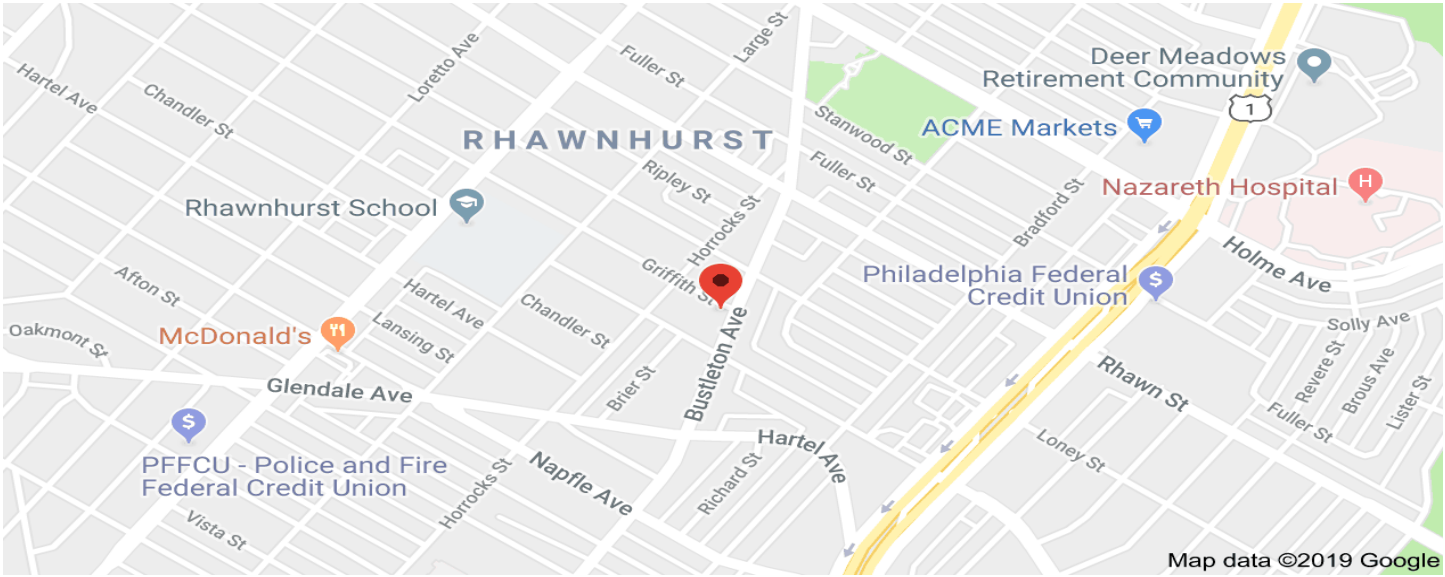
Directions to our Langhorne office

Take I-95 and I-295 ---> Take exit 5A
Merge onto US-1 N toward Morrisville
Take the exit toward Oxford Valley.
Turn RIGHT onto Oxford Valley Rd (signs for Levittown)
Turn RIGHT onto N Bucks Town Dr, Turn RIGHT onto Town Center Dr
The offices will be on your right. Please note: We are in the last Oxford Court Bldg on the right. You are approaching from the back of the bldg, the correct parking will view the front of our bldg.
(**NOTE** - GPS will send you to our back door, please drive to the next lot for patient access to our office)



Directions to our Philadelphia Office

Take I-95 to Exit 30 (Cottman Avenue)
Continue straight onto Cottman Avenue
At Frankford Ave, SLIGHT RIGHT to continue onto Ryan Avenue
Continue onto Borbeck Avenue. Turn RIGHT onto Bustleton Avenue
The office is located on your right side before Rhawn Street.
Parking is available behind the bldg or on the surrounding streets.



PATIENT REGISTRATION
PLEASE PRINT ALL INFORMATION CLEARLY

Appointment Date: _____/_____/_____

Patient Full Name: _____Birthdate _____ / _____ / _____

Gender: Male Female _____ **Birthplace:** ▢ USA ▢ Other: _____
Language: ▢ English ▢ Spanish ▢Other: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

√ **Check box next to number given if okay to leave detailed medical and/or billing messages:**

▢ Phone # (_____) _____ - _____ Work # (_____) _____ - _____

▢ Cell # (_____) _____ - _____ Email: _____

Referred to Arthritis Group by: (circle one and list name of referring person in the space provided)

Self Family Member Friend Physician / Health Professional

Referral By: _____ Phone: _____

Correspondence regarding your care at the Arthritis Group will be sent to the following:

Family Physician: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Are there any other Doctors you would like the Arthritis Group to send reports about your care to?
If so, please list the name and specialty of the doctor we should send reports to:

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Emergency Contact:

Name: _____ Relationship: _____

Phone 1: _____ Phone 2: _____

May we disclose medical/billing information and/or testing results to this person?: ▢ **Yes** ▢ **No**

Current Pharmacy & Pharmacy Coverage Information

RX Plan Name: _____ **PHONE #** _____

MEMBER ID # _____ **EFFECTIVE:** _____

RX BIN#: _____ **PERSON#** _____ **RX GROUP:** _____

LOCAL/RETAIL PHARMACY

Pharmacy Name: _____ Phone:_____

Address: _____

MAIL ORDER PHARMACY

Pharmacy Name: _____ Phone: _____

Address: _____

SPECIALTY PHARMACY

Pharmacy Name: _____ Phone: _____

Address: _____

Patient Name: _____ **DOB:** _____ / _____ / _____

Appointment Date: _____ / _____ / _____

PLEASE LIST THE PATIENT'S MEDICAL INSURANCE INFORMATION HERE

Present your insurance card(s) to the receptionist for scanning

◇ Primary Insurance: _____ **Specialist Copay $**_____

ID #: _____ **Group #:** _____

Subscriber Name: _____Birthdate: _____/_____/_____
Relationship
to patient::_____ Phone: _____
employer
Employer: _____address:_____

◇ Secondary Insurance**:** _____ **Specialist Copay $**_____

ID #: _____ **Group #:** _____

Subscriber Name: _____Birthdate: _____/_____/_____
Relationship
to patient::_____ Phone: _____
employer
Employer: _____address:_____

****If Medicare is secondary please explain why:** _____

_____

Patient Name: _____ **DOB:** _____ / _____ / _____

APPOINTMENT DATE: _____/_____/_____

MEDICARE AUTHORIZATION

I authorize the release of any information necessary to process claims on my behalf to Medicare, and payment of said claims directly to ARTHRITIS GROUP

X_____ _____

Signature of Patient or Patient's Representative **Date**

MEDICAL INFORMATION RELEASE AUTHORIZATION

I authorize the release of any information necessary to process claims on my behalf, and payment of said claims directly to ARTHRITIS GROUP

X_____ _____

Signature of Patient or Patient's Representative **Date**

ACKNOWLEDGEMENT FOR RECEIPT OF NOTICE OF HIPAA/PPACA PRIVACY PRACTICES

I hereby acknowledge that I have reviewed ARTHRITIS GROUP Notice of Privacy Practices. Any questions, restrictions, or other information regarding these practices will be specified in writing by me, the patient.

X_____ _____

Signature of Patient or Patient's Representative **Date**

ACKNOWLEDGEMENT FOR RECEIPT OF PAYMENT POLICY (attached)

I have read and understand the payment policy and agree to abide by its guidelines, all questions have been answered to my satisfaction, and I am aware that I may be billed for any/all services not covered by insurance.

X_____ _____

Signature of Patient or Patient's Representative **Date**

PHARMACY RECORDS

I give permission to the Arthritis Group, and physicians/clinical staff, to access, obtain, and review information available from my pharmacy file to create and maintain thorough and complete medical records.

X_____ _____

Signature of Patient or Patient's Representative **Date**

*********If completed by patient representative, please complete below for this form to be valid*********

► _____ ◄

Print Name Authority Signature of Patient Representative Date

Patient Name: _____ **DOB:** _____ / _____ / _____

ELECTRONIC MEDICAL RECORD SHARING AUTHORIZATION

We now have added the ability to share information with your other physicians using SureScripts networks across many EMR programs. This type of sharing already occurs across hospital based networks using the same EMR system, allowing physicians in those networks access to all of your medical records.
This is the first step toward sharing patient information across many EMR systems. It is called *intraoperability* and is the future of healthcare. This allows a patients medical records to be shared regardless of the EMR system a provider elects to use. This will allow us and your other physicians to share medical records, avoid redundant testing, and have an overall more complete picture of your healthcare. We all believe that this feature will benefit our patients by increasing the efficiency & quality of the care you receive.

Of course, your participation in this feature is voluntary and you will need to provide us with signed permission to share your information, you may also exclude medical records you do NOT want shared by attaching a list of those records.

If you agree to participate please print & sign below. If you have any questions please speak to your physician and he/she would be happy to answer any questions you may have.

I give permission to activate record sharing for my electronic health records:

Print Name: _____**DOB:** ____/_____/_____

Sign: _____ **Date:** _____

PRESENT ILLNESS/COMPLAINT

(please obtain & enclose a copy of your relevant medical records/test results)
Briefly explain the signs/symptoms that you've been experiencing in the past few weeks/months. Also, list any treatments, therapies, injections, etc., already tried *do not list medications, they will be listed later*:

_____

_____

_____

List any other medical professionals you have seen for this matter:

_____

_____

PAST ARTHRITIS-RELATED AND RHEUMATOLOGIC HISTORY

Have you been diagnosed by a physician with any of the following conditions?	
Osteoarthritis	▢ No ▢ Yes, when:
Rheumatoid Arthritis	▢ No ▢ Yes, when:
Lupus or SLE	▢ No ▢ Yes, when:
Osteoporosis or Hip Fracture	▢ No ▢ Yes, when:
Gout	▢ No ▢ Yes, when:
Ankylosing Spondylitis	▢ No ▢ Yes, when:

Patient's Past Medical History

Please circle any of the following YOU have ever had:

Anemia / low blood counts	High Cholesterol	Psoriasis / skin conditions
Asthma	HIV/AIDS	Rheumatic Fever
Cancer, type: _____	Kidney Disease	Seizures
Cataracts	Liver problems	Stroke
COPD / Emphysema	Lung Disease	Stomach Ulcer(s)
Diabetes	Lymphoma/Leukemia	TB skin test positive
Heart Disease	Migraine Headaches	Thyroid problems
Hepatitis B	Nervous Breakdown	Tuberculosis
Hepatitis C	Pneumonia	Ulcerative Colitis / Crohn
High Blood Pressure	Psychiatric illness	

Other illnesses: _____

List any previous fractures / broken bones / or serious injuries

1. _____ year: _____ outcome: _____
2. _____ year: _____ outcome: _____

Vaccinations: check those you have had & provide date

□ Flu shot, date: _____ □ Pneumonia vaccine, date: _____ □ Shingles vaccine, date: _____

□ Covid Vaccine: manufacturer: _____ Date dose #1: _____ Date dose #2: _____

Surgical History

Please list all Surgeries/operations, month/year, and reason for operation (or attach list)

Surgeries / Operations	Month / Year	Reason

Patient Name: _____ **DOB:** _____ / _____ / _____

Appointment Date: _____/_____/_____

Medications

DO YOU HAVE ANY MEDICATION ALLERGIES? ___ No ___ Yes, list:_____

_____

ANY OTHER ALLERGIES? ___ No ___ Yes, list:_____

PLEASE LIST ONLY YOUR CURRENT MEDICATIONS, including supplements, vitamins, and over the counter medications **(or attach list)**

Medication Name & mg	How often?	Who prescribes this?	Why do you take this medication?
Example: Celebrex 200mg	1/day	Dr. smith	Joint pain

Have you participated in any clinical trials for new medications?

_____

Patient Name: _____ **DOB:** _____ / _____ / _____

Appointment Date: _____/_____/_____

–

Family History

FAMILY MEDICAL HISTORY

	Age If Living	Medical Conditions	Age at Death	Cause of Death
Parents - please provide age & health info or if deceased provide age at death and health info				
Father				
Mother				
Siblings - circle to indicate brother/sister & provide age/health info or age at death & health info				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Children - circle to indicate son/daughter & provide age/health info or age at death & health info				
Son/Daughter				
Son/Daughter				
Son/Daughter				
Son/Daughter				

Patient Name: _____ **DOB:** _____ / _____ / _____

Appointment Date: _____/_____/_____

Do you have any <u>blood relatives</u> with the following conditions?
Please circle & list relationship

CONDITION	RELATIVE	CONDITION	RELATIVE
Alcoholism		Lung disease	
Ankylosing Spondylitis		Lupus	
Cancer, *TYPE:*		Osteoarthritis (OA)	
Childhood Arthritis		Osteoporosis/Hip Fracture	
Colitis / Crohn's disease		Osteoporosis/other fracture	
Diabetes		Psoriasis	
Glaucoma		Psoriatic Arthritis	
Gout		Rheumatic Fever	
High Blood Pressure		Rheumatoid arthritis (RA)	
HIV/AIDS		Stomach Ulcer	
Kidney Disease		Stroke	
Liver problems		Tuberculosis	
Other significant illnesses of any <u>blood relative</u>, please list:			

Patient Name: _____ **DOB:** _____ / _____ / _____

Appointment Date: _____/_____/_____

PATIENT SOCIAL HISTORY

DO YOU DRINK CAFFEINATED BEVERAGES?

☐ NO ☐ YES,TYPE: COFFEE/SODA/ TEA/ENERGY DRINKS/OTHER: _____ CUPS/OZ DAILY?_____

DO YOU SMOKE/USE TOBACCO PRODUCTS?

☐NEVER ☐QUIT, WHEN?_____ ☐ YES, HOW MUCH PER DAY?_____

DO YOU DRINK ALCOHOL?

☐NEVER ☐YES, HOW OFTEN (CIRCLE) DAILY WEEKLY SOCIALLY OCCASIONALLY RARELY

HAS ANYONE EVER TOLD YOU TO CUT DOWN ON YOUR DRINKING? _____

DO YOU USE DRUGS THAT ARE NOT PRESCRIBED TO YOU? ☐NO ☐YES, LIST:_____

DO YOU USE DRUGS FOR REASONS WHICH ARE NOT MEDICAL? ☐NO ☐YES, LIST:_____

DO YOU EXERCISE REGULARLY? ☐NO ☐YES, TYPE/AMOUNT PER WEEK_____

HOW MANY HOURS OF SLEEP DO YOU GET EVERY NIGHT? _____ **FEEL RESTED WHEN YOU WAKE?** ___NO __YES

WHICH HAND DO YOU USE TO WRITE / DO MOST ACTIVITIES? _____

CIRCLE ANY OF THE FOLLOWING DEVICES THAT YOU USE REGULARLY: CANE WALKER WHEELCHAIR STAIR-LIFT

MARITAL STATUS: ☐ NEVER MARRIED ☐ SINGLE ☐ MARRIED, MAIDEN NAME:_____

☐ DIVORCED ☐ DOMESTIC PARTNER ☐ WIDOWED

PLEASE LIST THE **NUMBER OF PERSONS IN YOUR HOUSEHOLD** _____

EDUCATION: PLEASE CIRCLE HIGHEST LEVEL COMPLETED (FOR PHYSICIAN TO PATIENT INSTRUCTIONAL PURPOSES)

GRADE: 5 6 7 8 9 10 11 12 COLLEGE: 1 2 3 4 TRADE SCHOOL MBA PHD

EMPLOYMENT STATUS: ☐EMPLOYED FULL-TIME ☐EMPLOYED PART-TIME ☐UNEMPLOYED

☐STUDENT ☐RETIRED, YEAR:_____ ☐DISABLED, DATE:_____ ☐ MEDICAL LEAVE, DATE:_____

CURRENT/MOST RECENT OCCUPATION: _____

CURRENT EMPLOYER & ADDRESS _____ _____

ARE YOU APPLYING FOR DISABILITY? _____ NO _____ YES
DO YOU HAVE A MEDICALLY RELATED LAWSUIT PENDING? _____ NO _____YES

PATIENT NAME: _____ **DOB:** _____ / _____ / _____

APPOINTMENT DATE: _____/_____/_____

Systems Review - Please indicate which of the following symptoms has **significantly affected you in the past 6 months**

General	**Respiratory**	**Skin**
Weight Gain or Weight Loss	Shortness of Breath	Rashes
Fatigue	Cough	Hives
Fever	Coughing up blood	Sun Sensitivity
Eyes	Wheezing	Tightening of skin
Pain in eyes	**Gastrointestinal**	Hands change color when cold
Redness	Nausea	**Neurologic**
Loss of Vision	Vomiting	Headaches
Blurry Vision	Blood in Stool	Dizziness
Dryness	Increasing constipation	Muscle Spasms
Ear/Nose/Throat	Persistent Diarrhea	Numbness / Tingling
Ringing in ears	Heartburn	Memory Loss
Loss of hearing	**Kidneys and Bladder**	**Psychiatric**
Severe nosebleeds	Painful Urination	Anxiety
Ulcers in mouth	Blood in Urine	Depression
Dry Mouth	Cloudy / Foamy Urine	Sleep Difficulties
Frequent Sore Throat	Decreased Kidney Function	**Endocrine**
Difficulty Swallowing	**Genital**	Blood Sugar problem
Cardiovascular	Discharge from penis / vagina	Thyroid problem
Chest Pain	Ulcers	
Irregular Heartbeat	Sexually transmitted disease	

Patient Name: _____ **DOB:** _____ / _____ / _____

Appointment Date: _____/_____/_____

Summary of Important office policies and procedures

Office Hours: Physician/NP/RN Hours are by appointment only, and vary as necessary by provider.

Telephone Hours: PHILADELPHIA OFFICE - Monday through Friday

BUCKS COUNTY OFFICE - Monday through Friday : 9am – 12pm and 1:00pm - 4pm

Scheduling appointments: Please make sure your follow-up appointment is scheduled before leaving the office. You may also schedule appointments by calling the office during telephone hours.

Missed/Canceled appointments: If you need to cancel your appointment, please do so at least 24 hours prior to your appointment.As a courtesy, we attempt to contact every patient to remind them of their appointment. However, it is the responsibility of the patient to arrive for their appointment on time. If you arrive more than 10 minutes late, we reserve the right to ask you to reschedule. If you are running late we recommend that you call our office to verify your appointment will be honored. In the absence of an emergency, patients who fail to cancel an appointment with 24 hrs notice may be charged a fee for no-show.

Children not permitted: our office is not equipped for children, for safety reasons children will not be permitted in exam rooms, therefore, we ask that you make alternate childcare arrangements for your visit. Children may not be left unattended or with our staff members. Please bring another adult if a child must accompany you to your appointment.

Review of test results: If your physician has ordered medical testing (blood work, MRI, x-ray, etc.), the testing will be reviewed at your follow up appointment. This allows the time required for proper discussion and development of a treatment plan between the physician and patient.

Refilling medications: Please obtain all of your medication refills at the time of your office visit. This ensures accurate and timely refills and prevents unnecessary telephone calls. Keep in mind that we only refill the medications we prescribe. If you need a refill between appointments please ask your pharmacist to initiate a refill request. Allow at least 48 hours for processing of refill requests. A refill request may trigger a call for you to schedule an office visit for management of your condition and monitoring of your medications. If prior authorization is required by your insurer we are typically notified by your pharmacist, but you may contact the office to notify us also.

Communicating with the office and/or doctors: A telephone call or message can never replace an office evaluation of a problem. Brief questions to clarify confusion can be answered over the phone or by the patient portal. New symptoms or complex questions will require an appointment. If you leave a voice/portal message for the office, allow 24 hours for the office to return your call before calling the office again. Messages are retrieved throughout day and reviewed, by the doctors/staff. Our staff is qualified to answer most questions as instructed by the doctors. If necessary, your doctor will return phone calls/patient portal messages after scheduled office hours.

All patients must have a Primary Care Physician: Our practice is limited to the specialty of rheumatology. Therefore you should have a PCP for non-rheumatology related medical care. In-patient hospital consultation services are provided on a limited basis only at certain hospitals, by the physician on call.

Patient privacy: Your privacy is very important to us and to ensure your privacy you may be asked to provide a picture ID to verify your identity upon arrival at the office. Please refer to the HIPAA privacy policy posted in the waiting area.

Forms/Request for Medical Records: Completion of any form that requires your doctors input can be very time consuming for both you and your provider. You may be asked to schedule an appointment with your provider to review the requested information. Charges will apply for records requests and/or form completion. Requests for medical records or information will not be accepted via fax. Please allow 10 days for forms to be completed, and up to 20 days for records requests.

Your medical records are available to you via the Patient Portal, 24 hours a day, 7 days a week. To sign up for access visit our website at www.arthritsgrouppa.com, and click the link for “patient portal” in the upper right of the webpage.

Insurance/Billing: Our office does not Bill to or Participate with Workers Compensation or Personal Injury. We accept most area insurance coverage, call the office for a current list. You are responsible to obtain a referral, if required, for each visit. You are responsible for your co-pays and deductibles. By federal law and physician contract, deductibles and co-pays may not be waived. We do not accept Medicaid. If you have Medicaid, please contact the telephone number on the back of your insurance card to find a participating Medicaid provider. Please see our payment policy for more information.

Disability Policy

Our physicians/health care staff cannot become involved in any disability-related activity, including such things as filling out forms for your employer or disability insurer, making a determination about your ability to do a job, communicating with an attorney, filling out any governmental form such as Family Medical Leave Act (FMLA), or parking handicap passes, etc, until you have seen your physician at least three times, or an established patient who has received care within the past 3 months.

Payment Policy

Thank you for choosing us to participate in your care. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, and ask us any questions you may have. A copy will be provided to you upon request.

1. **Insurance:** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance policy, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles: All *specialist* co-payments and deductibles must be paid at the time of service**. This arrangement is part of your contract with your insurance company. Failure on our part to collect ***specialist*** co-payments and deductibles from patients can be considered a violation of our contract with your insurer. Please help us in upholding our contract by paying your ***specialist*** co-payment at each visit.
3. **Non-covered services:** Please be aware that some – and perhaps all – of the services you receive may be non-covered by your particular insurer. You will be responsible for payment of these services.
4. **Proof of insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If your insurer sends a check directly to you for services performed by this office, you agree to immediately forward payment to our office in full with a copy of the statement (EOB) from your insurance carrier.
6. **Coverage changes:** If your insurance changes, please **notify us *before* your next visit** so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance may automatically be billed to you.
7. **Nonpayment:** If your account is over 90 days past due, your account may be submitted to our collections agency. Budgets & Partial payments can be accepted if negotiated with this office.
8. **Missed appointments:** Our policy is to charge $25.00 - $50.00 for missed appointments or appointments not canceled within a reasonable amount of time (24 hours notice). These charges will be your responsibility and will be billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the very best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for taking the time to read and understand our payment policy. Please let us know if you have any questions or concerns.