RHEUMATOLOGY PATIENT HISTORY FORM

Date: _____

Name: _____ Birthday : _____

Age: _____ Sex : _____ Marital Status : _____

Referring Doctor : _____ Dr Phone # : _____

Primary Care Physician: _____ Dr Phone # : _____

Describe briefly your present symptoms: _____

_____

_____

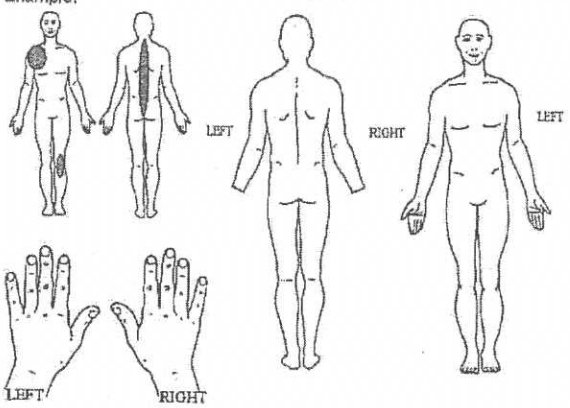
_____

_____

When did your symptoms start? _____

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.

What diagnosis have you been given, if any? _____

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

_____

Previous treatment for this problem (include physical therapy, surgery, and injections): _____

_____

_____

_____

_____

_____

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

	Yourself	Relative	→	Name/relationship
Arthritis (type unknown)	❑	❑	→	_____
Osteoarthritis	❑	❑	→	_____
Rheumatoid arthritis	❑	❑	→	_____
Gout	❑	❑	→	_____
Lupus or "SLE"	❑	❑	→	_____
Ankylosing spondylitis	❑	❑	→	_____
Childhood arthritis	❑	❑	→	_____
Sjogren's syndrome	❑	❑	→	_____
Osteoporosis	❑	❑	→	_____
Psoriasis/psoriatic arthritis	❑	❑	→	_____

PAST MEDICAL HISTORY

Do you now or have you ever had: (check if "yes")

❑ Diabetes
❑ High blood pressure
❑ High cholesterol
❑ Hypothyroidism
❑ Goiter
❑ Cancer (type) _____
❑ Leukemia
❑ Psoriasis
❑ Angina
❑ Heart problems
❑ Heart murmur
❑ Pneumonia
❑ Pulmonary embolism
❑ Asthma
❑ Emphysema
❑ Stroke
❑ Epilepsy (seizures)
❑ Cataracts
❑ Kidney disease
❑ Kidney stones
❑ Crohn's disease
❑ Colitis
❑ Anemia
❑ Jaundice
❑ Hepatitis
❑ Stomach or peptic ulcer
❑ Rheumatic fever
❑ Tuberculosis
❑ HIV/AIDS

Other significant illnesses (please list): _____

_____

Previous Operations

	Type	*Year*	*Reason*
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____

Any previous fractures? ❑ No ❑ Yes Describe _____

Any other serious injuries? ❑ No ❑ Yes Describe _____

Do you smoke? ❑ Yes ❑ No ❑ In the past - How long ago? _____

Do you drink alcohol? ❑ No ❑ Yes : Usual drink: _____ How much: _____

Has anyone ever told you to cut down on your drinking? ❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ No ❑ Yes If yes, please list: _____

Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No

MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what? _____

_____

Please list any medications that you are now taking. Include non-prescription medications, such as aspirin, vitamins, glucosamine, laxatives, calcium, etc.

Name of drug	Dose (include strength and number of pills per day)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

PERSONAL HISTORY

What is your highest educational level? ❑ High school ❑ Some college courses ❑ College graduate ❑ Advanced degree

What is your current or past occupation? _____

Are you currently working? : ❑ Yes ❑ No If yes, hours/week _____ If not, are you ❑ retired ❑ disabled ❑ sick leave?

Do you receive disability or SSI? ❑ Yes ❑ No If yes, for what disability? _____

What date did this disability begin? _____

With whom do you currently live? _____

How much exercise do you get each week? _____ What kind of exercise? _____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at death	Cause
Father				
Mother				

Number of siblings: _____ Number living _____

Number of children _____ Number living _____ List ages of each _____

Health of children: _____

_____

SYSTEMS REVIEW

Date of last eye exam _____ Date of last chest x-ray _____

Date of last bone density test _____

Result of last TB (PPD) test: ❑ Never done ❑ Negative ❑ Positive Date test performed: _____

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Morning stiffness
  Lasting how long ___ Minutes
  ___ Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

List joints affected in the last 6 months

_____
_____
_____
_____

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye

MOUTH
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑Loss of taste
- ❑ Dryness
- ❑ Recent increase in tooth cavities

NOSE
- ❑ Nosebleeds
- ❑ Loss of smell

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw while chewing

NECK
- ❑ Swollen glands
- ❑ Tender glands

HEART AND LUNGS
- ❑ Pain in chest
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ Shortness of breath
- ❑ Difficulty in breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain relieved by food
- ❑ Vomiting of blood/"coffee grounds"
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

KIDNEY/URINE/BLADDER
- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, "smoky" urine
- ❑ Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Frequent urination
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties
- ❑ Prostate trouble

BLOOD
- ❑ Anemia
- ❑ Bleeding tendency

SKIN
- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive
- ❑ Skin tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold (Raynaud's)

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling in hands/feet
- ❑ Memory loss
- ❑ Muscle weakness

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

For women only:

Age when periods began: _____
Number of pregnancies: _____
Number of miscarriages: _____
Have you reached menopause?
❑ No ❑ Yes If yes, at what age: ____
Date of last Pap smear: _____
Date of last mammogram: _____

If you are still having periods:
Are they regular? ❑ Yes ❑ No
How many days apart? _____

Multi-Dimensional Health Assessment Questionnaire (R808-NP2)

This questionnaire includes information not available from blood tests, X-rays, or any source other than you. Please try to answer each question, even if you do not think it is related to you at this time. Try to complete as much as you can yourself, but if you need help, please ask. <u>There are no right or wrong answers.</u> Please answer exactly as you think or feel. Thank you.

Please check (√) the ONE best answer for your abilities at this time:

OVER THE LAST WEEK, were you able to:	Without **ANY** Difficulty	With **SOME** Difficulty	With **MUCH** Difficulty	**UNABLE** To Do
a. Dress yourself, including tying shoelaces and doing buttons?	0	1	2	3
b. Get in and out of bed?	0	1	2	3
c. Lift a full cup or glass to your mouth?	0	1	2	3
d. Walk outdoors on flat ground?	0	1	2	3
e. Wash and dry your entire body?	0	1	2	3
f. Bend down to pick up clothing from the floor?	0	1	2	3
g. Turn regular faucets on and off?	0	1	2	3
h. Get in and out of a car, bus, train, or airplane?	0	1	2	3
i. Walk two miles or three kilometers, if you wish?	0	1	2	3
j. Participate in recreational activities and sports as you would like, if you wish?	0	1	2	3
k. Get a good night's sleep?	0	1.1	2.2	3.3
l. Deal with feelings of anxiety or being nervous?	0	1.1	2.2	3.3
m. Deal with feelings of depression or feeling blue?	0	1.1	2.2	3.3

How much pain have you had because of your condition OVER THE PAST WEEK? Please indicate below how severe your pain has been:

NO PAIN ○ PAIN AS BAD AS IT COULD BE
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

Please place a check (√) in the appropriate spot to indicate the amount of pain you are having today in each of the joint areas listed below:

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
a. LEFT FINGERS	☐ 0	☐ 1	☐ 2	☐ 3	i. RIGHT FINGERS	☐ 0	☐ 1	☐ 2	☐ 3
b. LEFT WRIST	☐ 0	☐ 1	☐ 2	☐ 3	j. RIGHT WRIST	☐ 0	☐ 1	☐ 2	☐ 3
c. LEFT ELBOW	☐ 0	☐ 1	☐ 2	☐ 3	k. RIGHT ELBOW	☐ 0	☐ 1	☐ 2	☐ 3
d. LEFT SHOULDER	☐ 0	☐ 1	☐ 2	☐ 3	l. RIGHT SHOULDER	☐ 0	☐ 1	☐ 2	☐ 3
e. LEFT HIP	☐ 0	☐ 1	☐ 2	☐ 3	m. RIGHT HIP	☐ 0	☐ 1	☐ 2	☐ 3
f. LEFT KNEE	☐ 0	☐ 1	☐ 2	☐ 3	n. RIGHT KNEE	☐ 0	☐ 1	☐ 2	☐ 3
g. LEFT ANKLE	☐ 0	☐ 1	☐ 2	☐ 3	o. RIGHT ANKLE	☐ 0	☐ 1	☐ 2	☐ 3
h. LEFT TOES	☐ 0	☐ 1	☐ 2	☐ 3	p. RIGHT TOES	☐ 0	☐ 1	☐ 2	☐ 3
q. NECK	☐ 0	☐ 1	☐ 2	☐ 3	r. BACK	☐ 0	☐ 1	☐ 2	☐ 3

Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

VERY WELL ○ VERY POORLY
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

How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK?

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

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1.a-j FN (0-10): ☐

1=0.3 16=5.3
2=0.7 17=5.7
3=1.0 18=6.0
4=1.3 19=6.3
5=1.7 20=6.7
6=2.0 21=7.0
7=2.3 22=7.3
8=2.7 23=7.7
9=3.0 24=8.0
10=3.3 25=8.3
11=3.7 26=8.7
12=4.0 27=9.0
13=4.3 28=9.3
14=4.7 29=9.7
15=5.0 30=10

2.PN (0-10): ☐

4.PTGL (0-10): ☐

RAPID 3 (0-30) ☐

Cat:
HS = >12
MS = 6.1-12
LS = 3.1-6
R = ≤3

Authorization to Disclose Protected Health Information

(Copy of records takes 7 to 14 business days to process)

PLEASE PRINT CLEARLY- You must provide full mailing address or this form will be returned to you

Patient Name: _____ SSN: _____ Medical Record # _____
Address: _____ City: _____ State: _____ Zip: _____
Phone (home): _____(work)_____ DOB: _____

1. I authorize the use or disclosure of the above named individual's Protected Health Information as described below.
2. Omni Helathcare is authorized to _____ make the disclosure to _____ receive the disclosure from the following individual or organization.

   Omni Healthcare

3. The type and amount of information to be used and disclosed is as follows: (includes dates where appropriate)

   ☐ Progress Notes ☐ Medication List ☐ Immunization Record

   ☐ Labortatory Results from (date) _____ to (date) _____

   ☐ X-Ray and Diagnostic Reports from (date) _____ to (date) _____

   ☐ Entire Record ☐ Other _____

4. REASON FOR REQUEST: (PLEASE CHECK ONE)

   ☐ Medical Care ☐ Insurance ☐ Personal ☐ Attorney ☐ Clinical Research ☐ Marketing

5. Medical records are to include any and all of Federal and State protected information to include diagnosis, treatment and/or examination related to mental health related care, drug and/or abuse, HIV testing/AIDS, and sexually transmitted-diseases.
6. I hereby release OMNI and its employees from any and all liability that may arise from the release of information as I have directed.
7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.
8. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re disclosure and the information may not be protected by the federal confidentiality rules. If I have questions about disclose of my health information, I can contact the Medical Records Department and obtain a copy of the Privacy Notice.

   Printed Name of Patient :_____ Date: _____

   Signature of Patient: _____

   Witness Name: _____ Date: _____

Designation of Health Care Surrogate

Name: _____

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name _____
Street Address _____
City _____ State _____
Phone _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name _____
Street Address _____
City _____ State _____
Phone _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility. Additional instructions (optional):

_____
_____
_____
_____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name _____

Signature _____ Date _____

Witness _____
Street Address _____
City _____ State _____
Phone _____
Date _____

Witness _____
Street Address _____
City _____ State _____
Phone _____
Date _____

Consent for communication and/or disclosure

I request the following alternatives or limitations relating to communications directed to me by my healthcare provider or employee of Omni Healthcare.

Do we have your permission to:

Call you at home? _____Yes _____ No

If yes may we leave the following information on your answering machine/voice mail?

Appointment information _____Yes _____ No
Billing information _____Yes _____ No
Medical information _____Yes _____ No
Labs/Prescriptions _____Yes _____ No

Call you at work? _____Yes _____ No

If yes may we leave the following information on your answering machine/voice mail?

Appointment information _____Yes _____ No
Billing information _____Yes _____ No
Medical information _____Yes _____ No
Labs/Prescriptions _____Yes _____ No

Call you on your cell? _____Yes _____ No

If yes may we leave the following information on your answering machine/voice mail?

Appointment information _____Yes _____ No
Billing information _____Yes _____ No
Medical information _____Yes _____ No
Labs/Prescriptions _____Yes _____ No

I give my permission to share the following information with the person(s) listed below:

Primary Care Physician: _____
(Name) (City/State)

Other Person:

_____
(Name) (Relationship)
Appointment Information: Yes/No Medical: Yes/No Billing: Yes/No

_____
(Name) (Relationship)
Appointment Information: Yes/No Medical: Yes/No Billing: Yes/No

_____
(Name) (Relationship)
Appointment Information: Yes/No Medical: Yes/No Billing: Yes/No

_____ _____
Patient Name Date

_____
Patient Signature/Guardian/Legal Representative

_____ _____
Witness Name Date

_____
Witness Signature

Living Will

Declaration made this _____ day of _____, 2____, I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and

_____(initial) I have a terminal condition,
or _____(initial) I have an end-stage condition,
or _____(initial) I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I do ___, I do not ___ desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name _____
Street Address _____
City _____ State _____ Phone _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional): _____
_____
_____
_____
_____

Signature _____ Date _____

Witness _____
Street Address _____
City _____ State _____
Phone _____
Date _____

Witness _____
Street Address _____
City _____ State _____
Phone _____
Date _____

Notice of Privacy Practices Acknowledgment Form

The Health Insurance Portability and Accountability Act (HIPPA) provides a safeguards to protect your privacy. Implementation of HIPPA requirements officially began April 14, 2003. Many of the policies have been *our* practice for years. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services- www.hhs.gov.

OMNI Healthcare has adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handles appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for handling of charts, patient records, PHI (Protective Health Information) and other documents or information.
2. It is the policy of this office to remind patients of their appointments/ We do this by telephone, e-mail, U.S. Mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable and informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPPA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws,
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

The undersigned certifies that he/she read the forgoing, received a copy of the Notice of Privacy Practice and is the patient, patients guardian, or legal representative.

_____ _____

Patient Name Date

_____

Patient Signature/Guardian/Legal Representative

_____ _____

Witness Name Date

_____

Office Policy

- **Late Arrivals:** After 15 minutes the patient will be considered late, and the appointment will be rescheduled. _____ Initials

- **Broken appointment:** Patients must call office with at least 24 hours advance notice of the appointment to cancel or reschedule. If not there will be a $25.00 charge added to your account. Patients with 3 or more broken appointments without good reason could result in dismissal. _____ Initials

- **Confirming appointments:** It is our policy to confirm all appointments. It is the patient's responsibility to remember their own appointment. If the patient does not call or show for their appointment this is considered a broken appointment. _____Initials

- **Personal information changes**: It is the patient's responsibility to notify our office of changes such as insurance, address, phone number and health history. Our office will update patient's history once a year. _____Initials

Thank you for your cooperation.

_____
Patient Name

_____ _____
Patient Signature/Guardian/Legal Representative Date

_____
Witness Name

_____ _____
Witness Signature Date

Patient Information Sheet

PATIENT INFORMATION			
Patient Last Name:	First:		Middle:
Social Security #			
Street Address:			
City:	State:		Zip:
Home #:	Work#:		Cell #:
Sex: ___Male ___Female	Date of Birth:		Age:
Are you Military? If so: ___Active Duty or ___Retired			
Employer:	Occupation:		
Employer Street Address:			
Employer City:	State:		Zip:
Employer Phone #:	Marital Status: ___Single ___Married ___Divorced ___Widowed ___Separated		
Email Address:			
Employment Status: ___Full Time ___Part Time ___Not Employed ___Self Employed ___Retired ___Military			
Are You A Student: ___Yes ___No	Student Status: ___Full Time ___Part Time		

REFERRING & PRIMARY PHYSICIAN INFORMATION		
Referring Physician Name:		
Street Address:		
City:	State:	Zip:
Phone Number:	Specialty:	
Primary Care Physician Name:		
Street Address:		
City:	State:	Zip:

GUARANTOR INFORMATION (Who is responsible for you financially)		
Name:	Relationship to Patient:	
Street Address:		
City:	State:	Zip:
Home Phone#:	Work#:	Cell #:
Sex: ___Male ___Female	Date of Birth:	
Social Security #:		
Please list other family members that Guarantor is responsible for that are Omni patients:		
Employer Name:		
E-Mail Address:		

EMERGENCY CONTACT INFORMATION		
Name:	Relationship to Patient:	
Street Address:		
City:	State:	Zip:
Home Phone#:	Work#:	Cell #:

INSURANCE INFORMATION		
Is Your Visit Related To: ___Auto Accident ___Workers Compensation		
PRIMARY Insurance Company Name:		
Policy #:		
Group Name:	Group #:	
Claims Street Address:		
City:	State:	Zip:
Effective Date of Insurance:		
Insurance Phone #:		
Policy Holder Name:	Relationship to Patient:	
Policy Holder Employer:		
Policy Holder Social Security #:	Sex: ___Male ___Female	
SECONDARY Insurance Company Name:		
Policy #:		
Group Name:	Group #:	
Claims Street Address:		
City:	State:	Zip:
Effective Date of Insurance:		
Insurance Phone #:		
Policy Holder Name:	Relationship to Patient:	
Policy Holder Employer:		
Policy Holder Social Security #:	Sex: ___Male ___Female	

RACE, ETHNICITY & LANGUAGE INFORMATION
(The government asks OMNI Healthcare and all healthcare providers to collect the information below.)
Race: ___White ___Black/African American ___Hispanic ___Asian ___American Indian/Alaska Native ___Native Hawaiian ___Other_____
Ethnicity: ___Hispanic/Latino ___Not Hispanic/Latino ___Other_____
Primary Language Spoken: _English ___Spanish ___Creole ___Other:_____

PHARMACY INFORMATION		
Pharmacy Name:		
Street Address:		
City:	State:	Zip:
Pharmacy Phone#:	Pharmacy Fax#:	

Patient Financial Policy

Thank you for choosing OMNI Healthcare as your healthcare provider. We are committed to building a successful physician- patient relationship with you and your family. Please understand that payment for services is a part of that relationship. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

Patient Information:
A fully completed, current patient registration will be on file in the patient chart during the time in which the patient is considered an active patient. Patient registration will be updated by the patient yearly or as changes in the demographic information occurs and will include where the patient can be reached by phone. A signature by the responsible party is required.

Insurance Claims:
Primary Insurance: OMNI Healthcare will file claims with the patient's insurance upon the patient's submission of proof of insurance; (insurance card indicating coverage, identification number, and group number). In the event the patient has insurance coverage but cannot provide documentation, payment is due at the time of service. Upon receipt of the insurance card, OMNI Healthcare will submit the health insurance claim form indicating patient payment at the time of service.

Secondary Insurance: Claims will be filed with secondary insurance if adequate information is received at the time of service. However, if payment is not received in our office within 45 days after filing, the responsibility will be transferred to the patient and due upon receipt.

Patient Financial Responsibility:
If no insurance is to be filed by OMNI Healthcare, or if OMNI Healthcare is not a participating provider, **full payment is due** at the time services are rendered. We are willing to work with you to develop a payment schedule to meet your needs and ours. Co-payments, deductibles, co-insurance, and non-covered services are due at time of service. Payment arrangements will be made with a signed Payment Agreement and the approval of the office manager.

Minors/ Dependents:
Children under the age of 18 will require the signature of a responsible adult party on the registration form.

Worker's Compensation:
Worker's compensation will be filed if the patient notifies OMNI Healthcare upon scheduling an appointment and supplies billing information upon arrival. Details of the accident will be required and a worker's compensation form will be completed.
Motor Vehicle Accidents:
Payment of visits for auto accidents will be due at time of service. OMNI Healthcare will provide a health insurance claim form and details of examination upon patient signature for release of records.

Method of Payment:

- Acceptable methods of payments are cash, check, Visa, MasterCard, Discover, and American Express.
- Credit Cards mentioned above will be accepted by phone or fax.

Accounts Past Due:

- Payment from statement is due upon receipt.
- Delinquent accounts may result in small claims court, a collection agency, credit bureau reporting and/or possible discharge from the practice.
- After 90 days an account will be turned over to collections. The person financially responsible for the account will be responsible for all collection costs including reasonable attorney fees of not less that 30% and court costs.
- A patient may remit in full for all outstanding charges owed on account and include amounts previously placed with the collection service. Under these circumstances, a physician may reserve the right to re-establish the patient to active status in the practice.

Missed Appointments:

- OMNI Healthcare requires 24 hour notice of appointment cancellation. Consecutive appointments missed and not previously canceled will be documented and excessive abuse could result in a possible discharge from the practice.
- Interpreter fees incurred as a result of a missed appointment or an appointment not canceled within 24 hours of the appointment time will be billed to the patient.

Account Consultation:

Physicians do not discuss financial issues. Our billing staff member is trained to discuss your account and make payment arrangements. They will be happy to help you, but if you need further assistance, our Billing Director may be consulted as well.

Medical Records:

If you require us to transfer your records to another physician, other than your primary care physician, there will be a fee. This fee must be paid prior to the transfer of the records. There is no cost to provide to your primary care physician.

I have received a copy of the OMNI Healthcare financial policy.

_____

Patient Name

_____ _____

Patient Signature/Guardian/Legal Representative Date

_____

Witness Name

_____ _____

Witness Signature Date

OMNI HEALTHCARE

"Effective Immediately"

We will require 48-72 hours for all prescription refills.

This will include:

- Patient phone in requests
- Pharmacy refill faxes
- Patient walk in requests
- Internet requests

All pain medications must be picked up as they can no longer be called into the pharmacy.

_____
Patient Name

_____ _____
Patient Signature/Guardian/Legal Representative Date

_____
Witness Name

_____ _____
Witness Signature Date

Understanding Your Healthcare Records/Information

This notice is to inform you how information about you may be used and disclosed and how you can get access to it. Please review this carefully.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnosis, and plans for future care and treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication among the many professionals who contribute to your care.
- Legal document which you or a third-party payer can verify that services billed were actually provided.

Understanding what is in your medical records and how it is used helps to;

- Ensure it's accuracy.
- Better understand who, what, when, where, and why others may access your health information.
- Make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your records are the physical property of your healthcare provider that complied it, the information contained belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45CFR 164.522.
- Obtain a paper copy of the notice practices upon request.
- Request a copy of your health records as provided for in 45CFR 164.522.

I have read and understand the above:

_____ _____

Patient Name Date

_____

Patient Signature/Guardian/Legal Representative

_____ _____

Witness Name Date

_____

Witness Signature