ARTHRITIS & RHEUMATOLOGY CENTER OF SOUTH FLORIDA

Jigar Shah, M.D., F.A.C.R
5901 Colonial Drive, Suite 303 Margate FL 33063
Ph: 954-281-8891
Fax: 954-375-9664

First name:________________________________Last name:_________________________________

Home Address:____APT #:_____________

City:__________________________________State:_____________Zip:________________________

Home Phone:______________________Work:_____________________Cell:__________________

Email Address:____

Date of Birth:__________________________Social Security #: ______________________________

Race:_____White______Asian______Black/ African American ____Hawaiian ____Pacific Islander

Ethnicity:______Hispanic/Latino_____Not Hispanic/Latino Language Spoken:______________

Marital Status:_____Single ____Married ____Divorced ____Widowed

Sex:_____Female ____Male

Family Physician (PCP):___________________________________Phone #_____________________

Emergency Contact Information:

Name:____Phone:___________________________

Relationship to Patient: ____

HIPPA Authorization Form

I have been provided with a notice of Privacy Practice of Dr. Jigar Shah M.D, F.A.C.R, that HIPPA outlines what will be done with my Protected Health Information.

The following person (or persons) may receive disclosure of protected health information about me:

1. ______________________________________ Relationship: _________________

2. ______________________________________ Relationship: _________________

3. ______________________________________ Relationship: _________________

I understand that the information used or disclosed may be subject to redisclosure by the person or class of persons or facility receiving I, and then would no longer be protected by Federal privacy regulations. I may revoke this authorization by notifying Arthritis and Rheumatology Center of South Florida in writing my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions.

Signature:_______________________________________ Date: _________________

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RHEUMATOLOGY PATIENT HISTORY FORM

NAME: ______________________________ Birthdate:_____/_____/_____

Last First M. I.

Whom do we thank for referring you here? ______________________________

Name of your primary care physician: ______________________________

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:

Left Right Left

Left Right

Are you _____ right or _____ left handed?
(Which hand do you sign your name with?)

What diagnosis have you been given, if any?

____

____

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

____

____

____

RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

	Yourself	Relative	Relationship
Osteoarthritis	❑	❑	______
Arthritis (type unknown)	❑	❑	______
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

Any previous Fracture ❑ Yes ❑ No

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

Do you drink alcohol? ❑ No ❑ Yes

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

MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what? ______________________________

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

SYSTEMS REVIEW

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

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 heartbeat
- ❑ Sudden changes in heartbeat
- ❑ Shortness of breath
- ❑ Difficulty in breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing
- ❑ Fainting or loss of consciousness

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)

- ❑ Headaches
- ❑ Dizziness

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

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

NERVOUS SYSTEM
- ❑ 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: _____

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HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal health care information (PHI). Please read it carefully before signing.

Arthritis & Rheumatology Center of South Florida will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization, you acknowledge and agree that Arthritis & Rheumatology Center of South Florida may use or disclose medical records, treatment notes, test results or any other part of the medical chart for the purpose of medical treatment, processing or collecting financial reimbursements.

By signing this authorization, you agree Arthritis & Rheumatology Center of South Florida or its Business Associates may disclose your personal health care information to other treating physician's or insurance companies or other collection agencies if needed. **You are also consenting to communication through our office email Frontdesk@floridarheumcenter.com**

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Arthritis & Rheumatology Center of South Florida HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Arthritis & Rheumatology Center of South Florida for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization; (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA; (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Covered Entity; or (d) six years from the date this authorization was executed.

By signing this authorization, you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA. This form also allows Arthritis & Rheumatology Center of South Florida to call my phone number on record for reminder of appointments, test results or financial information.

Print Patient's Name: ____
Patient's Signature: ____
Date: __________________________
If you are signing as the patient's representative:
Print Name & Relationship: ____
Signature of Other: ____

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Authorization for Insurance/Credit Card Payment

I,_______________________________ authorize any holder of medical or other information about me to release to my Insurance Carrier(s) or to the billing agent, of Arthritis & Rheumatology Center of South Florida, any information needed for this or related claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the part who accepts assignments.

Cardholder Name (as shown on card) _______________________________

Card Number ____

Exp Date (mm/yy) ___________

I,_______________, authorize Arthritis and Rheumatology Center of South Florida to charge my card for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization will remain in effect until I (we) cancel this authorization, to cancel you must give a 60 day notice and account must be in good standing. I understand that my information will be saved to file for future transactions on my account.

Patient's Signature: ____

Date: ________________________

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Financial Policy

As a courtesy to our patients, we will gladly file the forms necessary so that you receive the full benefits of your medical coverage. We ask that you read your insurance policy to be fully aware of any limitations of the benefits provided. If you are concerned about coverage for any of our services, please contact your insurance company prior to your visit. If your insurance company denies coverage, or we otherwise do not receive payment 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurance company and/or your employer and your insurance company. Although we will make a good faith effort to assist you in obtaining your benefits, we cannot force your insurance company to pay for the services we have provided to you.

1. A fee of $25 will be added to your account for any check dishonored by your bank.
2. It is your responsibility to provide us with your current address, phone number and insurance information at each visit.
3. It is your responsibility to confirm with your insurance carrier that our doctor is “in-network” prior to seeing the doctor. If you choose to see a provider who is not on your plan, you are responsible for payment in full.
4. If you have an HMO insurance policy that requires a referral from your primary care physician, it is your responsibility to obtain the referral prior to services.
5. All copays and deductibles, and co-insurance are due at the time of service.
6. If you miss your appointment or cancel the appointment prior to a 24 hour notice no show fee of $50 will be applied to your account.
7. A $100 administrative service fee will be applied for initial forms to be filled out by the doctor. Any additional forms after initial package will result in a $50 charge. These forms may includeFMLA and Disability. A $25 administrative service fee will be applied for any letter requested from the Dr.
8. I understand that in the event my account is placed in collection status and, as a result, turned over by the practice to a debt collector, a fee in the amount of 35% of my account balance, will be added to my outstanding balance.
9. Copies of medical records, Labs, or imaging will incur a charge of $1 per page for the first 25 pages, .25 cents per page thereafter.

By signing below, I acknowledge that I understand and agree with the terms of this financial policy. Furthermore, I authorize payment of benefits to the Arthritis & Rheumatology Center of South Florida for services rendered under the terms of my insurance policy.

Print Name:_____________________________________Signature: ____
Date: ____
If you are signing as the patient’s representative
Print Name & Relationship: ____

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Narcotic Agreement

Narcotic agreement is being executed today to prevent misunderstandings about opioid analgesics I will be taking for pain management. This is to help me, and my healthcare provider comply with the law regarding controlled pharmaceuticals. The goal of my treatment is to reduce pain to a level that is tolerable and allow me to improve day-to-day functioning. I understand that there are alternative treatments available including non-narcotic analgesics, physical therapy modalities including neuromuscular reeducation, psychological intervention, invasive procedures including injections and surgery.

I understand that narcotic medication may cause side effects including but not limited to nausea, vomiting, constipation, dry mouth, fluid retention, weight gain, weight loss, hormone suppression, itching, allergic reaction and if taking improperly may lead to excessive sedation, respiratory depression, and death.

I understand that intolerance may develop, and higher dose may be required to achieve adequate pain relief I understand thatnarcotics are likely to induce physical dependence and that abrupt withdrawal is likely to cause withdrawal symptoms. I understand that physical dependence and tolerance are different from addiction, which refer to psychological dependence on medication for purposes other than pain relief.
By signing I agree that Arthritis & Rheumatology Center of South Florida will be the sole provider of narcotic medication and I will not exceed prescribed dose. I understand that using my medicine at a rate greater then prescribed will result in my being without medication for a period of time. Lost prescriptions or medications including those stolen or inaccessible will not be replaced.

I agree to refrain from the use of illegal drugs and excessive alcohol. Noncompliance with the agreement may be grounds for discharge from the medical practice. Monthly visits will be required for medications that are not refillable.

No refills will be available during evening or weekend hours.

I agree to use only one pharmacy for filling narcotic prescriptions. The name, address and telephone number will be given to the office.

Patients may be subject to random urine or blood monitoring.

I certify that I've never been involved in the sale, illegal possession, diversion nor transport of controlled substances.

I authorize the physician and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this states Board of Pharmacy, in any investigation of any possible misuse, sale or other diversion of my pain medicine. I authorize my physician to provide a copy of this agreement to my pharmacy. I agree to allow the physician to communicate with other physicians and any pharmacists regarding use of controlled substances.

My signature below signifies that I've read each article in this document and my questions and concerns regarding treatment have been answered. I agree to abide by its requirements.

Signature:____ Date: _________________________

Physician's Certification:

I have reviewed the above document with the patient whose signature appears above. I believe that this patient suffers from chronic pain and that this patient is a candidate for pain management with opioid analgesics. This patient agrees that Arthritis & Rheumatology Center of South Florida will be the sole prescriber of narcotic medications and will not exceed prescribed doses. Noncompliance with this contract may be grounds for discharge from the medical practice.

Physician Signature: ____
Date: ________________________

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General Consent for Procedures

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision to or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved.

At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended.

The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I consent to any photographing or videotaping of the procedure that may be performed, provided my identity is concealed.

I voluntarily request a physician and other health care providers, or the designees as deemed necessary to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature: ____

Date: _________________________