Cape Fear Arthritis Care

1003 Olde Waterford Way, Suite 1B / Leland, NC 28451 / 910-679-3212 / www.cfac.co

Welcome, and thank you for choosing Cape Fear Arthritis Care. We are happy to have you as our patient! Please read and **complete these forms BEFORE you arrive for your appointment**, and bring everything with you, including **your insurance card(s) and a photo ID**. This document contains important information about our office policies and procedures. **If you have any questions about this information, please feel free to call us at 910-679-3212 x 701. Our Patient Advocate is happy to help you!**

Paperwork Reduction: This is a "green" practice- we use an Electronic Health Records (EHR) system compliant with all federal standards, and we strive to keep paperwork to a minimum (we don't even send out patient statements!). We have reduced the number of forms you have to fill out to the absolute minimum necessary. We do ask that you be as thorough as possible to give our providers the information needed to assess and treat your condition(s) properly.

Prescriptions/ Refills: Prescriptions are handled electronically through our EHR system. If you are out of refills, please contact your pharmacy and they will notify us. If YOUR INSURANCE requires a prior authorization for medications we prescribe, we will attempt to obtain authorization on your behalf. **PLEASE NOTE:** There will be a delay while we wait for YOUR INSURANCE to process the authorization.

Lab Results: If your provider orders labs or other testing for you, we will schedule a return visit so he/she may discuss those results with you. Lab results are also available via our Patient Portal- you will be given instructions to access it via email after your first visit. The portal does NOT replace the need for a face-to-face discussion of the results with your provider.

Health Insurance: We have already contacted your insurance plan/Medicare/Medicaid to verify your current eligibility for coverage, as well as any copay/deductible/coinsurance that applies to your benefit plan. Those amounts are due at the time of service. We will file a claim with your primary and secondary insurance (if any); you will receive an Explanation of Benefits notice from your insurance plan showing how they processed your claim. That document will serve as your notice if there is any additional balance due, beyond what we collected from you at the time of service. PLEASE NOTE: We do not choose your benefits and are not responsible for how your plan processes your claims or calculates your benefits, so please refer any questions about those issues to your insurance company or employer plan administrator.

Cancelling/Rescheduling Appointments: Keeping your appointments as scheduled is an important part of complying with your plan of care and helping us serve all patients in a timely manner. We understand that occasionally circumstances arise that you can't anticipate. If you are unable to keep a scheduled appointment, we require a MINIMUM of 24 hours prior notice so we can contact a patient on our waiting list to take your place. Fees for missed appointments are as follows: $100 for initial visit, $50 for follow up visit, and $100 for infusion and physical therapy visits. While we try to call patients to give reminders, it is the patient's responsibility to keep track of scheduled appointments. Just because you don't get a reminder call from us doesn't mean you don't have a scheduled appointment.

Financial Policy

Please read this policy thoroughly. If you have questions, please call us prior to your first visit.

Cape Fear Arthritis Care is a family-owned practice. **We are not a part of, nor do we receive any financial support from, any healthcare corporation or hospital.** Patients come first at our practice! We believe independent physician practices provide the best care and patient experience, and we want to continue to provide a friendly and caring atmosphere to serve our patients. **But the economic realities of being "on our own" mean that our financial policies may be different from what you are accustomed to at corporate or hospital-owned practices.**

We have implemented the following financial policy in order to deliver a more convenient and consistent payment experience to our patients. This makes paying your healthcare bills a convenient experience, just like paying for a hotel visit or a subscription streaming service. **You will NOT receive a paper statement in the mail.** Your insurance carrier will send you an Explanation of Benefits to explain how they processed your claims – all questions about your insurance benefits/payments should be directed to them (we don't choose or administer your benefits).

Rest assured- our process is **completely secure** and compliant with all federal laws regarding credit card transactions.

Here's how it works:

1. We securely save your credit or debit card before or during your visit.
2. We communicate with your health plan to determine your payment amount for the services.
3. We will collect all copays (or deductibles/coinsurance, if your plan has no copays) at the time of service.
4. If, after your claim is processed by insurance, there is any further amount due from you, we will email you with the amount to be charged to your card on file.
5. We process the payment for you automatically and email you the receipt.

If you have any questions or concerns about this financial policy, our Billing Specialist or COO will be happy to discuss those with you PRIOR to treatment.

I have read this financial policy and agree to abide by its terms as long as I am a patient at Cape Fear Arthritis Care. I authorize Cape Fear Arthritis Care to charge my credit/debit/or HSA card on file for any balance that is owed after insurance and point of service (patient) payments for a particular date of service have been applied to my account. This authorization is valid without any additional consent on my part.

Printed name of patient____

Patient Signature____Date________________

Patient Registration Form **PLEASE PRINT CLEARLY**

Patient's Name____
First MI Last

Date of Birth________/_____________/__________

Street Address:____

City_______________________________ State__________ Zip___________________

Home Phone:_________________________ Cell Phone:_______________________________

Work Phone:_________________________ Email:______________________________________

Preferred Phone Number: ____ Home ____ Cell ____Work

If patient is under 21:

Are the parents ____Married ____ Divorced ____Unmarried

Who is the custodial parent?_____________________________________

Responsible party:_______________________________ Phone #____________________________

In case of emergency, whom should we call?_____________________________________

Relationship:______________________________ Phone number:____________________________

Primary Care Physician's name:____________________________________Phone______________

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

- I authorize insurance payment of medical benefits to Cape Fear Arthritis Care for services rendered. I understand that I am financially responsible for any services no covered by insurance carrier(s).
- I authorize Cape Fear Arthritis Care to treat me and use my personal health information necessary to complete and process my insurance claims.

X____Date_____/_____/_____
Patient/responsible party signature

Patient Rights and Responsibilities

We believe it is important for patients to know what they should expect from us AND what is expected from them, so we have prepared this short list of patient rights and responsibilities.

Patients have the right to:

- --Quality medical care in a safe environment
- --Be treated with respect and dignity
- --Understand their treatment plan

Patients have the RESPONSIBILITY to:

- --Keep their scheduled appointments or give **at least 24 hours notice** if unable to do so
- --Follow their prescribed course of treatment or discuss it with the practitioner if unable/unwilling to do so
- --Pay amounts not covered by insurance promptly.

We understand that occasionally you may not be able to keep a scheduled appointment- all we ask is that you give us enough notice so we can contact another patient on our waiting list so he/she can be seen at that time. Our current waiting time for appointments is 6 weeks- that is a long time to wait if you're in pain!- and we believe it is simple courtesy to let someone else have your appointment time if you can't be here.

We at Cape Fear Arthritis Care want your experience here to be a pleasant one. If you have any questions/concerns about our office policies, please feel free to ask to speak with our Practice Administrator or Chief Operating Officer. We are happy to help you!

HIPAA DISCLOSURE AUTHORIZATION

I, ________________________, authorize Cape Fear Arthritis Care to speak with and disclose information about my medical care and conditions to the following persons:

Name ________________________ Relationship__________________

Name ________________________ Relationship__________________

Name ________________________ Relationship__________________

Name ________________________ Relationship__________________

I further authorize Cape Fear Arthritis Care to contact me and leave messages on:
__ Home Phone______________________
__ Cell Phone________________________
__Email____________________________
__Other____________________________

This authorization will remain in place until rescinded by me.

____ DOB___/____/_____ Date_________________
(Patient Signature)

Defining Pain

Everybody experiences pain differently. How one experiences pain is at least as important as what is causing pain. For this reason, we need some standards in how to define pain. Below is a pain scale. Please read it carefully, then use the numbers to answer the following questions.

0- No Pain.

Mild Pain- Nagging, annoying, but doesn't really interfere with daily living activities.	Moderate Pain- Interferes significantly with daily living activities	Severe Pain-Disabling; unable to perform daily living activities.
1 – Pain is very mild, barely noticeable. Most of the time you don't think about it.	4 – Moderate pain. If you are deeply involved in an activity, it can be ignored for a period of time, but it is still distracting.	7- Severe pain that dominates your senses and significantly limits your ability to perform normal daily activities or maintain social relationships. Interferes with sleep.
2 – Minor Pain. Annoying and may have occasional stronger twinges.	5 – Moderately strong pain. It can't be ignored for more than a few minutes, but with effort you still can manage to work or participate in some social activities.	8 – Intense pain. Physical activity is severely limited. Conversing requires great effort.
3 – Pain is noticeable and distracting, however, you can get used to it and adapt.	6 – Moderately strong pain that interferes with normal daily activities. Difficulty concentrating.	9 – Excruciating pain. Unable to converse. Crying out and/or moaning uncontrollably.
		10 – Unspeakable pain. Bedridden and possibly delirious. Very few people will ever experience this level of pain.

What number corresponds to your pain right now?__________
What is the highest number of pain you experience?__________
When do you have that level of pain and what makes it worse?____
____
____
What is the lowest number of pain you experience?__________
What gives you pain relief?____
What is the average level of discomfort you have had for the past 2 weeks?____________
Is your pain worse in the morning when you first get up?________ What number?_______
Is your pain worse with activity during the day?___________ What number?_________

Ability to Function

For each of the following, please mark the response that best describes your ability.

	Without ANY difficulty	With SOME difficulty	With MUCH difficulty	UNABLE to do
Dress yourself, including tying shoelaces and doing buttons	___________	___________	___________	___________
Get in and out of bed	___________	___________	___________	___________
Lift cup or glass to your mouth	___________	___________	___________	___________
Walk outdoors on flat ground	___________	___________	___________	___________
Wash and dry entire body	___________	___________	___________	___________
Pick up something off the floor	___________	___________	___________	___________
Turn a doorknob or faucet	___________	___________	___________	___________
Get in & out of the car	___________	___________	___________	___________

System Review Sheet

Circle any symptoms you have had in the past 12 months and add comments

General Recent weight change Fatigue Weakness Fever Night Sweats **HEENT** Dry eyes Dry mouth Visual change or loss Oral Ulcers Eye pain, irritation, redness Increase in dental cavities Nosebleeds Hoarseness Difficulty swallowing Pain in jaw while chewing **Neck** Swollen glands Tender glands	**Heart and Lungs** Chest discomfort Pain with breathing or coughing Irregular or rapid heartbeat Shortness of breath Cough- Productive Y/N Wheezing **Abdomen** Abdominal pain or discomfort Bloating Nausea Vomiting Persistent diarrhea Constipation Heartburn **Genitourinary** Sexually transmitted disease Pain on urination Blood in urine Rash, dryness, ulcers **Blood** Anemia Bleeding tendency	**Skin** Easy bruising Rash from sun exposure Skin tightening Nodules or bumps Hair loss Other rash Psoriasis Nail changes **Extremities** Swelling Color changes such as blue or white with cold exposure **Nervous system** Headaches Dizziness Numbness/tingling in hands/feet --Intermittent --Permanent Memory loss Muscle weakness

Pertinent medical history:

Allergies:____

Personal past medical history: Please list all diseases or conditions that you are now or have been treated for in the past:____

____

____

Past surgical history: Please list previous surgeries and year performed:____

____

____

Serious injuries or hospitalizations:____

____

Health maintenance: Last chest x-ray____________, TB test______________, Colonoscopy___________Eye exam__________
Bone Mineral Density test_________________ Have you been treated for low bone mass/osteoporosis?_________________

Family history: Please list all conditions family members have been diagnosed with, including parents, cousins, grandparents, siblings, aunts, uncles____

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Prescription Medication	Purpose or Reason Taken	Dose	Time(s) Of Day	Form (Liquid, capsule, tablet)	Special Instructions
Over the Counter/ Vitamins/Supplements	**Purpose or Reason Take**	**Dose**	**Time(s) Of Day**	**Form (Liquid, capsule, tablet)**	**Special Instructions**

Primary Care Doctor____Phone #_______________________________

Preferred Pharmacy____ Phone #_______________________________

Drug Allergies____

Your Phone #___________________________________ Today's Date:____

Cape Fear Arthritis Care

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization : In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

____

Print Patient's Name   Date

I,____, acknowledge that I (Signature of Patient or Parent or Legal Guardian)

Have either received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's

NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I,______________________________, consent to the use and disclosure of
(Signature of Patient or Parent or Legal Guardian)

My personal health information by your office for Treatment, Billing / Payment and Health care

Operations as outlined in the NOTICE OF PRIVACY PRACTICES.