Articularis
HEALTHCARE GROUP

Augusta
ARTHRITIS CENTER, INC

PRIOR TO YOUR APPOINTMENT, PLEASE:

1. **COMPLETE THIS PAPERWORK**. It must be brought in to your appointment. **Please email or fax it back to us to ensure appointment is not cancelled.**

2. **FIND OUT YOUR PREFERRED LABORATORY**. If you do not know which one to use, please call your insurance company to find out. Quest draws labs in our office, so we need to know if you or your insurance company prefers a different lab. (If you have Medicare, they will cover any lab, we just need to know which one you prefer.)

BRING WITH YOU TO YOUR APPOINTMENT:

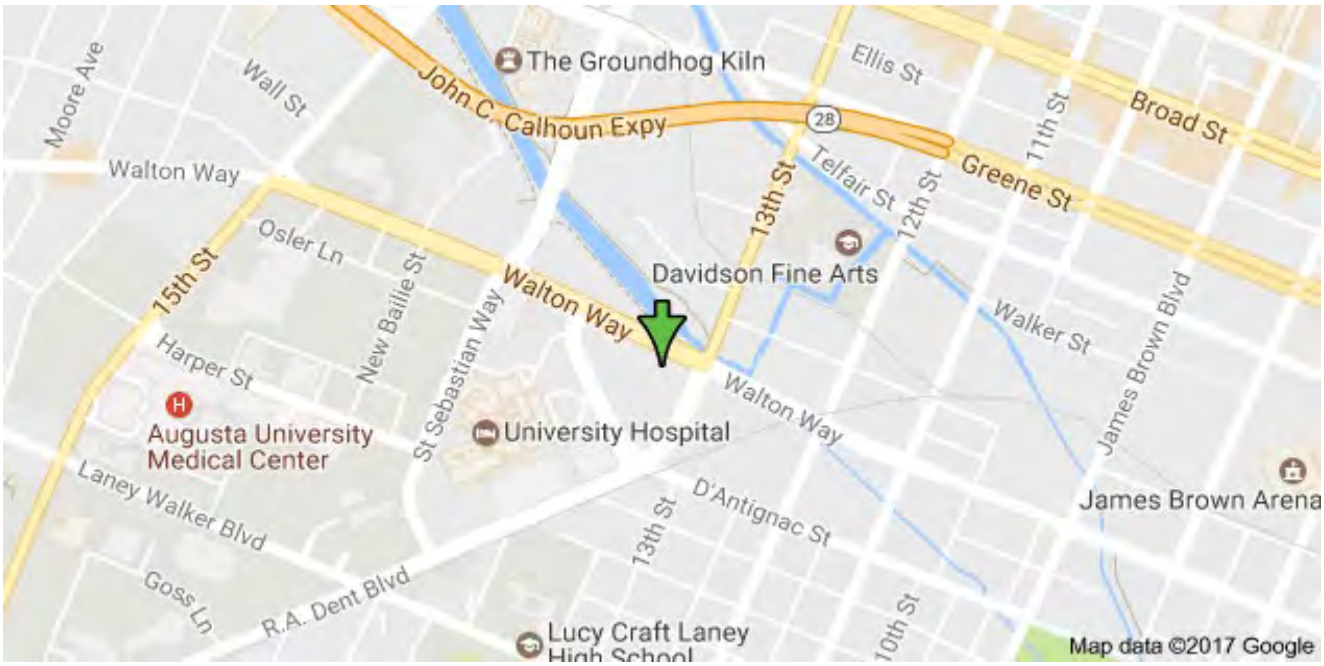
1. This completed paperwork-if not emailed or faxed back-if no paperwork upon arrival appointment will be cancelled.
2. Photo ID-if not brought to the appointment, the appointment will be cancelled.
3. Insurance Card(s)-if not brought to the appointment, the appointment will be cancelled.
4. Prescription Card (if separate from your insurance card)

PLEASE ARRIVE ON TIME AND BE PREPARED TO BE IN THE OFFICE FOR SEVERAL HOURS.

IF YOU DO NOT ARRIVE AT THE REQUESTED TIME WITH THE REQUIRED ITEMS, YOUR APPOINTMENT MAY BE CANCELLED AND YOUR $50.00 DEPOSIT FORFEITED.

IN ORDER TO RESCHEDULE, YOU WILL HAVE TO PAY A NEW DEPOSIT FOR A NEW APPOINTMENT.

Directions to Augusta Arthritis Center



Our office is located on the first floor of Professional Building 3 in the Piedmont (previously University) Hospital Professional Center, at the intersection of Walton Way and 13th Street. Free parking is available in the adjacent parking lot.

811 13TH STREET, SUITE 14
AUGUSTA, GA 30901
PHONE: 706-828-0043
FAX: 706-828-0450

RICHARD S. FIELD, M.D. RENÉE PETERKIN-MCCALMAN, M.D. IAN M. WARD, M.D.

Please arrive for your appointment with Dr. _____ on _____ at _____.

(Your appointment time will be 30 minutes after the arrival time listed above. Please be sure to arrive no later than the given arrival time to allow for our registration process.)

Welcome to our practice!

Our staff would like to take this opportunity to welcome you to our practice. We are delighted that you have chosen us for your medical needs. At Augusta Arthritis Center, we take great pride in the relationships that we have established with our patients and the ability to give a personalized approach to difficult problems.

As a patient of Augusta Arthritis Center, Inc., we appreciate you following the guidelines of the practice which helps us maintain our goals

Please arrive at your scheduled appointment time with the completed paperwork to allow for the registration process.
There is a $50 no-show and cancellation fee for all new patient appointments not kept or not cancelled 48 hours prior to your appointment date. A credit/debit card number is required at the time of scheduling to secure all new patient appointments.

Your card will be charged a deposit of $50 on _____.

The $50.00 Deposit will be refunded AFTER your insurance processes your claim and there is no remaining balance. It will Not be refunded at the time of your visit. Please call Rebekah/Karen to request the refund.

- Cash payments, deductibles and co-payments must be paid at the time of service. Payments for medical services not covered by insurance plans are the patient's responsibility.
- Self-Pay patients are required to bring $300 to their initial visit.
- Our Prescription Refill Policy is as follows: Please request refills at your visit. If you call in for refills, they will be called in between the hours of 10am-6pm. Please have the pharmacy name and number on hand when you call. Controlled substances will not be called in or filled after hours. A 24-hour advanced notice is required for all written prescriptions. All patient phone calls or requests will be addressed by a nurse within 24 hours.
- Our Lab Results Policy is as follows: Please do not call asking to discuss lab results. Your doctor/staff will call only if labs are at critical values. Otherwise, any labs will be discussed at the next appointment. Additionally, if registered, your lab results will be available to view on the patient portal once they have been processed.

Please bring completed forms, your photo ID and insurance cards, including prescription drug cards to your visit.

AUGUSTA ARTHRITIS CENTER, INC.
PATIENT INFORMATION

PLEASE PRINT LEGIBLY

Last Name	First Name	Middle Initial
Street Address		Apt/Lot #
City	State	Zip
SSN#	DOB	Circle One: Mr. Mrs. Ms. Dr.
Cell Phone #	Home Phone #	PRIMARY PHONE: CELL HOME
Email	Employment	Full-time Part-time Retired Disabled
Sex M F	Marital Status: S M D W	Race / Employer
Referring Physician		Phone #
Primary Care Physician		Phone #
Spouse		Cell #
Emergency Contact	Relationship	Phone #
Primary Insurance Name		
Policy Holder Name	DOB	Relationship to Patient
Policy #	Group#	
Secondary Insurance Name		
Policy Holder Name	DOB	Relationship to Patient
Policy #	Group#	

Consent for Treatment, Payment, and Acknowledgement of Receipt of Notice of Privacy Practices: I request that payment under the medical insurance program be made payable to Augusta Arthritis Center, Inc. for services rendered. I understand that I am financially responsible for all charges incurred at Augusta Arthritis Center, Inc. I authorize disclosure of my personal health information to carry out treatment, payment, or health care procedures. I have received the privacy policy and Notice of Information Practices that provides a more complete description of information uses and disclosures. I agree to pay any and all charges that exceed or not paid/covered by my insurance. In the event my account is turned over to a collection agency, I will be billed the additional collection fees.

Patient Signature:_____ Date:_____

Augusta Arthritis Center, Inc

HEALTH QUESTIONNAIRE

Patient Name:_____ Date of Birth:_____

Reason for visit:_____

Preferred Laboratory: _____

Preferred Pharmacy:_____ Address:_____

City/State: _____ Zip: _____

Current medications:

Name of medication	Strength	How often	Prescribing Doctor
1 _____	/_____mg	_____	Dr._____
2 _____	/_____mg	_____	Dr._____
3 _____	/_____mg	_____	Dr._____
4 _____	/_____mg	_____	Dr._____
5 _____	/_____mg	_____	Dr._____
6_____	/_____mg	_____	Dr._____
7 _____	/_____mg	_____	Dr._____
8_____	/_____mg	_____	Dr._____
9 _____	/_____mg	_____	Dr._____
10_____	/_____mg	_____	Dr._____
11 _____	/_____mg	_____	Dr._____
12_____	/_____mg	_____	Dr._____
13 _____	/_____mg	_____	Dr._____
14_____	/_____mg	_____	Dr._____

Medications you have **tried in the past** for your arthritis condition.

Name of medication	Dates you took them	Why you stopped taking them
1 _____	/_____-_____	_____
2 _____	/_____-_____	_____
3 _____	/_____-_____	_____
4 _____	/_____-_____	_____
5 _____	/_____-_____	_____
6 _____	/_____-_____	_____
7 _____	/_____-_____	_____
8 _____	/_____-_____	_____

Augusta Arthritis Center, Inc

Patient Name:_____Date of Birth;_____

Allergies including reaction:_____

Prior surgeries:_____

Women Age 65-85yrs-Last DEXA Bone Scan (done every 2 years):_____

Past medical history: Please list any other diseases or illnesses you have now or have had previously.

1 _____ 4 _____

2 _____ 5 _____

3 _____ 6 _____

Have you ever smoked cigarettes or used tobacco in other forms? **YES** **NO** (circle one)
If yes, when you were smoking your heaviest, how many packs per day did you smoke on _____pack(s). average: What year did you start smoking? _____. If you subsequently quit, what year did you quit? _____.
Do you drink alcohol? **YES** **NO** (circle one)
If yes, do you drink BEER, **WINE** or **LIQUOR?** _____ On average, how many drinks per week? _____.

What other physicians care for you; now or in the past?

1_____ 4 _____

2_____ 5 _____

3_____ 6_____

Is there a history of arthritis or rheumatic disease in your family? **YES** **NO** (circle one)

If yes, please indicate Father, Mother, or Grandparent.

Rheumatoid Arthritis: _____Gout: _____

Lupus: _____Psoriasis: _____

Other: _____

Is your arthritis problem a result of an accident or trauma? **YES** **NO** (circle one)

Please note:

*We **DO NOT** provide care for problems related to accidents for which there is ongoing litigation for Workman's Compensations. Notify the office if you are unclear about your case

***Disability or FMLA forms will NOT be completed until you have received SIX MONTHS of established care from our practice.**

Augusta Arthritis Center, Inc

811 13th Street, Suite 14
Augusta, GA 30901-2771
Phone: 706-828-0043
Fax: 706-828-0450

Richard S. Field, M.D. Renée Peterkin-McCalman, M.D. Ian M. Ward, M.D.

Medical Information Release Form (HIPAA Release Form)

I understand that Augusta Arthritis Center, Inc. maintains my personal records, medical history, symptoms, examinations, and test results as a part of my healthcare. This information is not to be given to any other person without my permission. Therefore, this is a written consent to authorize release of my medical information.

RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records, laboratory values, prescribed medications, treatment plan, examination rendered, and claims information. This information may be released to:

Spouse:_____

Child(ren):_____

Other:_____

Check if okay to leave detailed health information on voicemai( )Y/N( )

Information is **NOT** to be released to anyone_____

Name (Please Print):_____ Date of birth: _____

PatientSignature:_____ Date:_____

Witness Signature:_____ Date:_____

Augusta Arthritis Center, Inc.
Patient Scheduling Policy

We are committed to providing our patients with the best possible medical care and minimizing administrative costs. This scheduling policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for professional services.

New Patients

- Our physicians are very thorough with each and every patient. Please be prepared for the possibility that you will be in our office for several hours. We will need to review all of your medical history at your first visit.
- Due to an increased number of no-shows and cancellation of New Patient appointments, we are now charging a $50 fee for all appointments that have not been cancelled 48 hours prior to the scheduled appointment date. A payment of $50 will be required to schedule and secure all New Patient appointments. This payment will be taken over the phone when scheduling the appointment and will be applied to your account for your copayment, deductible and/or coinsurance. If you are owed a refund, it can be issued upon the payment of your first claim.
- If you are unable to keep your appointment, kindly call our office at least 48 hours prior to your appointment time. We will work with you to reschedule you to a more convenient time. The $50 fee will be applied and charged to all appointments cancelled and NOT rescheduled 48 hours prior to the appointment date. If you fail to cancel your appointment with 48-hour notice, your $50 deposit will be forfeited.
- Cash Payments and co-payments must be paid at the time of service.
- Self-pay patients are required to bring a remaining payment in the amount of $250 to their initial visit, which will be collected prior to being seen by the physician.

Follow-up Appointments

- Established patients with a balance greater than $100 must clear the outstanding balance with the billing department before scheduling any future appointments. Payment plans can be arranged if necessary.
- A $25 no-show/late cancellation fee will be applied to all follow-up visits that are not cancelled with a 48-hour notice. The fee must be paid prior to rescheduling.
- Any patient who no-shows or cancels 2 appointments without giving a 48-hour notice cannot be rescheduled without a $50 deposit by credit card.
- If a patient cancels or no-shows 3 times in a calendar year, they will be discharged from the practice.
- It is the patient's responsibility to keep up with their appointment times. Reminder calls are a courtesy.
- It is the patient's responsibility to obtain any referral required by their insurance for their office visit. If a patient shows up for their office visit without an updated referral, they can pay a $25 fee for our office to obtain the referral or reschedule after they receive the referral.
- All treatments given in the infusion center must be cancelled with a 48-hour notice. A $50 late cancellation fee will apply to all infusion/injectable treatment appointments not cancelled with the appropriate notification.

***If you are 15 minutes late to your appointment, you will be rescheduled. ***

Our practice firmly believes that a good physician-patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to the medical practice. We are here to help you.

Patient Name (PLEASE PRINT):_____

Patient Signature: _____ Date:_____

Augusta Arthritis Center, Inc.
Patient Financial Policy

We are committed to providing our patients with the best possible medical care and minimizing administrative costs. This financial policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for professional services.

- As the owner of your insurance policy, you are solely responsible for the policies regarding your plan.
- Our practice participates with numerous insurance companies. For patients who are beneficiaries of one of these insurance companies, our billing office will submit a claim for services rendered. All necessary insurance information, including any forms, must be completed by the patient prior to leaving the office.
- If a patient has insurance in which we do not participate, our office is happy to file the claim upon request; however, payment in full is expected at the time of service. If we are out of network with your secondary insurance (such as SC Medicaid), you will be responsible for any balances assigned as patient responsibility by your primary insurance.
- There is a mandatory deposit of $125 for all existing non-insured patients and $300 for new non-insured patients. This deposit will be applied to all charges incurred during your visit. If you are unable to make a deposit, your visit may be rescheduled.
- It is the patient's responsibility to pay any deductible, copayment, or any portion of the charges as specified by the plan at the time of visit. Payments for medical services not covered by an individual's insurance plan are the patient's responsibility and payment in full is due at the time of visit.
- Payment for professional services can be made with cash, check, or credit/debit card.
- Financial assistance is available for qualified patients. If a patient feels that he or she may qualify for assistance, the practice receptionist should be notified for referral to the appropriate individual. Patients who do not have insurance are expected to pay for professional services at the time of service unless prior arrangements have been made with us.
- It is the patient's responsibility to ensure that any required referrals or pre-certifications for treatment are provided to the practice prior to the visit. Visits may be rescheduled, or the patient may be financially responsible due to lack of the referral or authorization from their insurance company
- It is the patient's responsibility to provide us with current insurance information and bring his/her insurance card to each visit.
- Any patient who no-shows or cancels 2 appointments without giving a 48-hour notice cannot be rescheduled without a $50 deposit by credit card. Make sure we have proper documentation in the notes screen.
- Our staff is happy to help with insurance questions relating to how a claim was filed or regarding any additional information the payer might need to process the claim. Specific coverage issues, however, can only be addressed by the insurance company member services department. *(Telephone number is printed on your insurance card.)*
- If your insurance company requests additional information from you, it is important to reply with their requests in a timely manner considering that the balance of your claim and bill is ultimately the patient's responsibility whether your insurance company pays your claim or not. If the insurance company does not pay your claim in 45 days, the balance is billed to and becomes the responsibility of the patient.
- It is the patient's responsibility to notify us with any changes to insurance coverage and to make sure Augusta Arthritis Center has the proper insurance information. If we do not have the correct insurance information, the patient is responsible for the total bill.
- All labs drawn in our office will be processed by Quest. If you wish to have your labs processed by a different laboratory, please inform the physician during your visit.

Our practice firmly believes that a good physician-patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to the medical practice. We are here to help you.

Patient Name (PLEASE PRINT):_____

Patient Signature:_____ Date:_____

Augusta Arthritis Center, Inc. Patient Refill Policy

We are committed to providing our patients with the best possible medical care and minimizing administrative costs. This prescription refill policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for professional services.

Refill requests will only be accepted if the following appropriate criteria have been met:

- Physicians will not accept refill requests after hours or on the weekends.
- Refill requests will be submitted to your pharmacy. Please allow 24 hours for this process. You may contact your pharmacy after 24 hours to check on your refill. If there are problems with your refill, you may call our offices only after you have spoken with your pharmacy.
- All narcotic refill requests will take 48 hours to process. You may pick up your prescription at our office no sooner than 48 hours after it was called in.
- Your prescription can only be discussed with a physician, nurse, or medical assistant.
- Our office is closed on Fridays. No prescription requests will be taken Friday, Saturday or Sunday.
- The requested medication has been ordered previously by an Augusta Arthritis Center, Inc. physician.
- The patient has been seen by the physician in the last **6 months** or it is documented that the physician has ordered a **1 year follow up**.
- The patient has kept the last scheduled appointment or has been rescheduled for a date within the next 4 weeks.
- A patient requesting DMARDS must have had the **required** blood work within the last **6 – 8 weeks**. The nurse may arrange for the patient to get blood work completed, if necessary.
- All prescriptions will be written for periods no longer than your next scheduled appointment.
- If a patient misses their appointment and calls in for a prescription, the nurse may only authorize enough medication to meet the patient's dosing requirement until the next scheduled appointment. If possible, patients may be worked in within 1 week.
- No further refills can be authorized unless the next scheduled appointment is kept.

Our practice firmly believes that a good physician-patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to the medical practice. We are here to help you.

Only the following person(s) may be permitted to pick up prescriptions on my behalf:

1._____ 2._____

Patient Name (PLEASE PRINT):_____

Patient Signature:_____ Date:_____

Articularis HEALTHCARE GROUP

Articularis Healthcare Group, Inc. Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Contact the Privacy Officer 843-572-4840 with any questions.
Effective: November 13, 2019

We are committed to protect the privacy of your personal health information (PHI). This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. You will be notified of any breach of unsecured PHI. We will follow the terms outlined in this Notice. We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- Providing a copy of the new Notice in our office or by mail, upon request.
- Posting the revised Notice on our website, www.articularishealthcare.com.

Uses and Disclosures of Your PHI
The law permits or requires us to use or disclose your PHI for various reasons, which we explain in this Notice. We have included some examples, but we have not listed every permissible use or disclosure. When using or disclosing PHI or requesting your PHI from another source, we will make reasonable efforts to limit our use, disclosure, or request about your PHI to the minimum we need to accomplish our intended purpose.

Uses and Disclosures for Treatment, Payment or Health Care Operations

- **Treatment.** We may use or disclose your PHI and share it with other professionals who are treating you, including doctors, nurses, technicians, medical students, or hospital personnel involved in your care. For example, we might disclose information about your overall health condition with physicians who are treating you for a specific injury or condition.
- **Payment.** We may use and disclose your PHI to bill and get payment from health plans or others. For example, we share your PHI with your health insurance plan so it will pay for the services you receive.
- **Health Care Operations.** We may use and disclose your PHI to run our practice and improve your care. For example, we may use your PHI to manage the services you receive or to monitor the quality of our health care services.

Other Uses and Disclosures of Your PHI
We may share your information in other ways, usually for public health or research purposes or to contribute to the public good. For example, these other uses and disclosures may involve:

- **Our Business Associates.** We may use and disclose your PHI to our business associates that perform services on our behalf, such as auditing, legal, or transcription. The law requires our business associates and their subcontractors to protect your PHI in the same way we do. We also contractually require these parties to use and disclose your PHI only as permitted and to appropriately safeguard your PHI.
- **Health Information Exchanges.** We participate in health information exchanges (**HIEs**), which support electronic information sharing among members for treatment, payment, and health care operations purposes. Individuals may opt-out of HIEs. We will use reasonable efforts to limit the sharing of PHI in these electronic sharing activities for individuals who have opted out. If you would like to opt out, please contact our Privacy Officer.
- **Legal Compliance.** For example, we will share your PHI if the Department of Health and Human Services requires it when investigating our compliance with privacy laws.
- **Public Health and Safety Activities.** For example, we may share your PHI to report injuries, births, and deaths; prevent disease; report adverse reactions to medications or medical device product defects; report suspected child neglect or abuse or domestic violence; or avert a serious threat to public health or safety.
- **Responding to Legal Actions.** For example, we may share your PHI to respond to a court or administrative order or subpoena; discovery request; or another lawful process.
- **Research.** For example, we may share your PHI for some types of health research that do not require your authorization, such as if an institutional review board (**IRB**) has waived the written authorization requirement [because the disclosure only involves minimal privacy risks].
- **Medical Examiners or Funeral Directors.** For example, we may share PHI with coroners, medical examiners, or funeral directors when an individual dies.
- **Organ or Tissue Donation.** For example, we may share your PHI to arrange an authorized organ or tissue donation from you or a transplant for you.

- **Workers' Compensation.** We may use and disclose your PHI for workers' compensation claims; health oversight activities by federal or state agencies; law enforcement purposes or with a law enforcement official; or specialized government functions, such as military and veterans' activities, national security and intelligence, presidential protective services or medical suitability.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, please contact us and we will make reasonable efforts to follow your instructions. You have both the right and choice to tell us whether to:

- Share information such as your PHI, general condition or location, with friends or family members, or other persons involved in your care.
- Share information in a disaster relief situation, such as to a relief organization to assist with locating or notifying your family, close friends or others involved in your care.

We may share your information if we believe it is in your best interest, according to our best judgement, and:

- If you are unable to tell us your preference, for example, if you are unconscious.
- When needed to lessen a serious and imminent threat to health or safety.

Your Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing.

Inspect and obtain a copy of your protected health information. You may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested, we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost-based fee for a copy of the records.

Request Additional Restrictions. You have the right to ask us to limit what we use or share about your PHI. You can contact us and request us not to use or share certain PHI for treatment, payment, or operations or with certain persons involved in your care. For these requests:

- we are not required to agree;
- we may say "no" if it would affect your care; but
- we will not agree to disclose information to a health plan for purposes of payment or health care operations if the requested restriction concerns a health care item or service for which you or another person, other than the health plan, paid in full out-of-pocket, unless otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations. We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

Make Amendments. You may ask us to correct or amend PHI that we maintain about you that you think is incorrect or inaccurate. For these requests:

- You must submit requests in writing, specify the inaccurate or incorrect PHI and provide a reason that supports your request.
- We will generally decide to grant or deny your request within 60 days. If we cannot act within 60 days, we will give you a reason for the delay in writing and include when you can expect us to complete our decision.
- We may deny your request for an amendment if you ask us to amend PHI that is not part of our record, that we did not create, that is not part of a designated record set, or that is accurate and complete.

Request an Accounting of Disclosures. This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12-month period, you may be charged a reasonable fee.

Additional Privacy Rights

You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency we will give you this Notice as soon as possible. You have a right to receive notification of any breach of your protected health information.

Complaints

You have the right to complain if you feel we have violated your rights. We will not retaliate against you for filing a complaint. You may either file a complaint:

- directly with us by contacting the Privacy Officer. **All complaints must be submitted in writing.**
- with the Office for Civil Rights at the US Department of Health and Human Services (HHS). Send a letter to U.S. HHS at 200 Independence Ave., S.W., Washington, D.C. 20201; call 1-800-368-1019; or visit www.hhs.gov/ocr/privacy/hipaa/complaints/.

Augusta Arthritis Center, Inc

Acknowledgment of Receipt
"NOTICE OF PRIVACY PRACTICES"

I acknowledge that I have received a copy of the ***"Notice of Privacy Practices"*** for protected health information on the date set forth below.

_____ **Date of Receipt**

_____
Patient Date of Birth

_____ **Print Patient Name**

_____
Print Name of Authorized Personal Representative

_____ **Patient Signature**

_____
Signature of Authorized Personal Representative

_____
Please Indicate Relationship to Patient

FOR USE BY PRACTICE PERSONNEL ONLY
*(Complete only if patient acknowledgement is **not** obtained)*

An Acknowledgement of Receipt of Notice of Privacy Practices was not received because:

- ◯ Patient refused to sign Acknowledgment
- ◯ Unable to gain signed Acknowledgment due to communication / language or another barrier
- ◯ Patient was unable to sign Acknowledgment due to emergency treatment situation
- ◯ Other (*please indicate reason):* _____

_____ **Staff Signature**