ARTHRITIS CLINIC OF CENTRAL TEXAS
HASSAN ALISSA, M.D

A. Patient Information

1. Name (Last)	(First)	(Middle)	2. Date of Birth
			/ /
3. Address (street)	(Apt. No.)	City	ZIP
4. Phone (Home)	(Work)		(Cell)
( ) -	( ) -		( ) -
5. Social Security No.	6. Occupation		(Employer)
- -			
7. Driver License No.	8. Race/Ethnicity	9. Sex	10. Preferred Language
		M / F	
11. Primary Care Physician	(Phone)		(Fax)
	( ) -		( ) -
12. Referred by	(Phone)		(Fax)
	( ) -		( ) -
13. Do you have an ABN (Advance Directive)	14. Preferred Pharmacy		(Phone)
Yes / No			( ) -

B. Insurance Information

1. Primary Insurance Company	2. Phone No.	
	( ) -	
3. Address (street)	(City)	Zip
4. Policy Holder Name	5. Social Security	6. Member No.
	- -	
/ /		
10. Secondary Insurance Company	11. Phone No.	
	( ) -	
12. Address (street)	(City)	Zip
13. Policy Holder Name	14. Social Security	15. Member No.
	- -	
/ /		

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C. Responsible Person For Payment Not Covered By Insurance

1. Name (Last)	(First)	2. Relationship to patient
3. Address (Street)	(City)	Zip
( ) -	( ) -	( ) -
5. Date of Birth / 6. Sex	7. Social Security No.	
/ / M / F	- -	
8. Driver License No	9. Occupation	10. Employer

D. Emergency Contact Information

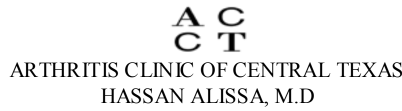
A. Name	B. Relationship to patient	
C. Phone (home)	(Work)	(Cell)
( ) -	( ) -	( ) -

E. Appointment Reminder by E-mail

1. Do you check your e-mail at least once a day?	Yes / No
2. If yes, would you like to receive an appointment reminder by e-mail a week before AND a day before your appointment	Yes / No
3. If yes, Please provide your e-mail: @	

Release of Medical Information: I hereby consent and authorize Arthritis Clinic of Central Texas to release any medical information in connection with the services rend for determination of benefits or collection of said benefits from my health insurance carrier. **Date: / /**

Patient Name	Patient Signature



ARTHRITIS CLINIC OF CENTRAL TEXAS
HASSAN ALISSA, M.D

Form of Written Acknowledgment of Receipt of Arthritis Clinic of Central Texas Notice of Patient Privacy Practices

By signing this Written Acknowledgment of Receipt of Arthritis Clinic of Central Texas Notice of patient Privacy Practices (“Acknowledgment”), I hereby expressly acknowledge my receipt of Arthritis Clinic of Central Texas Notice of Patient Privacy Practices.

Patient/Legal Representative Name: ____

Patient/Legal Representative Signature: ____

Date: _______/_______/________________

Acknowledgment **NOT** obtained because:

_____Patient/Legal Representative declined Notice of Patient Privacy Practices.
_____Patient treated in emergency room and discharged before obtaining Acknowledgment.
_____Other. Please describe briefly: ____

____

Employee Name: ____

Employee Signature: ____

Authorizations, Consents, and Agreements

Consent
Consent To Treatment: As a patient at Arthritis Clinic of Central Texas, I voluntarily agree to care and treatment provided at ACCT as a clinical patient. As a part of the course of my care and/or diagnosis and treatment of administration of medications, tests and procedures (collectively “Services”) deemed advisable by physicians (“Physicians”) or other medical professionals practicing at ACCT, employees of ACCT, S\students/externs studying at ACCT and other personnel (collectively “Care Providers”). I further understand that I may be referred for tests and procedures done at other facilities are not part of ACCT; therefore, charges for those services are separate and apart from ACCT services. **INITIAL** ________________________

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Financial

Financial Agreement: The undersigned agrees, as patient or agent of the patient, that the patient is accepting financial responsibility for services rendered and is obligated to pay the account balance in full. If there is verifiable Medical Insurance Coverage or other verifiable financial coverage, a claim will be filed as a convenience to the patient. However, it remains the responsibility of the patient/guarantor to follow up with his/her insurance company if the claim is not paid within 45 days. Pre-certification is the responsibility of the patient/guarantor and should be secure prior to services whenever possible, within policy limitations in case of emergencies. Payment for services not covered by the insurance or third party payer is the responsibility of the patient/guarantor. Our billing office will handle all self-pay portions after insurance payments. Should the account be referred to a collection agency, the undersigned may be assessed a collection fee and reasonable attorney fees and court costs. **INITIAL ____________________________**

Insurance

Assignment of Benefits: I hereby authorize all insurance companies to pay direct to Arthritis Clinic of Central Texas. I understand that this order does not relieve me of my obligation to pay the account. Also, any deductibles and co-payments are my responsibility. **INITIAL ________________**

Release of Medical Information: I hereby consent & authorize Arthritis Clinic of Central Texas and affiliates to release any medical information in connection with the services rendered for determination of benefits and/or collection of said benefits from my health insurance carrier. **INITIAL ____________**

****Medicare Beneficiaries ONLY:** I certify that the information given in applying for payment under Title XVII of Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a health insurance deductibles and coinsurance.

Medicare Supplements: I further authorize Arthritis Clinic of Central Texas to claim and receive benefit thru my Medicare supplement, ____(Name of Insurance Company/ies). This authorization includes claims for Medigap benefits and shall remain in effect until and unless revoked in writing. **INITIAL __________________**

I HAVE READ THE AUTHORIZATIONS, CONSENTS AND AGREEMENT, AND I ACCEPT THE TERMS AS DESCRIBED ABOVE. **DATE: / /**

Patient/Legal Representative Name	Patient/Legal Representative Signature

ARTHRITIS CLINIC OF CENTRAL TEXAS
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Authorization to Use or Disclose Protected Health Information

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Patient for whom authorization is made:

Name: ____Date of Birth: _________________________

Health Care Provider or Health Care Entity authorized to disclose this information:

Arthritis Clinic of Central Texas,
Hassan Alissa, M.D.
1340 Wonder World Dr. Bldg.2, Suite 2203
San Marcos, TX 78666

Person or Entity that can receive and use this information:

Name: ____
Address: ____________________________City: ____________State:________Zip Code: ________
Phone: (_____)__________________________ Fax:(______)______________________________

Specific information to be disclosed:

□ Medical Record from (date) ____/_______/________to (date) _____/_______/_______
□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.
□ Other:

Include: (Indicate by Initialing)

________Drug, Alcohol or Substance Abuse Records
________Mental Health Records (Except Psychotherapy Notes)
________HIV/AIDS-Related Information (Including HIV/AIDS Test Results)
________Genetic Information (Including Genetic Test Results)

Reason for release of information: (Choose all that Apply)

□ Treatment/Continuing Medical Care
□ Personal Use
□ Billing or Claims
□ Insurance
□ Legal Purposes
□ Disability Determination
□ School
□ Employment
□ Other (Specify):

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The individual signing this form agrees and acknowledges as follows:

Voluntary Authorization: This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

Effective Time Period: This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date:
Month: ________Day: ________Year: _________.

Right to Revoke: I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Special Information: This authorization may include disclosure of information relating to DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, except psychotherapy notes, CONFIDENTIAL HIV/AIDS-RELATED INFORMATION, and GENETIC INFORMATION only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signatures:

Patient/Legal Representative: ________________________________ Date: _____/________/__________

If Legal Representative, relationship to patient: ____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (If applicable): ________________________________Date: ______/_______/__________

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Past Medical History

Patient Name: ____**DOB:** ___/___/_______

Do you have a history of:	Yes	No	Medication List of All Meds
1. Heart Attack			
2. Coronary Artery Disease (CAD)			
3. High Blood Pressure			
4. Vascular Aneurysm			
5. Cardiac Arrhythmia			
6. Heart Murmur			
7. Congestive Heart Failure (CHF)			
8. Transient Ischemic Attack (TIA)			
9. Stroke			
10. Seizures			
11. Peripheral Neuropathy			
12. Kidney Disease			
13. Bladder Disorder			
14. Sleep Apnea			
15. Asthma			
16. COPD			
17. Stomach or Duodenal Ulcers			
18. GERD or "Heart burn"			
19. Diverticulitis			
20. Liver Problems or Hepatitis			
21. Colitis			
22. Celiac disease			
23. Blood Clot in Veins			
24. Anemia			
25. Blood Disorders			allergies to medications
26. Cancer? Type?			
27. Gout			
28. Diabetes			
29. Thyroid disorder			
30. Osteoporosis			
31. Menopause			
32. Depression			

Past Surgical History (Month / Year):	Past Surgical History (Month / Year):

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Rheum Complaint Template

You do not have to fill out this survey if symptoms are unrelated to pain, stiffness, weakness, or swelling, otherwise please circle or write in to answer the following questions.

Your complaint(s): Circle only one if possible. If you choose more than one, then they have to be of equal intensity or concern.

Pain	Swelling	Fatigue	Weakness

If it is pain, then what type?

Achy	Sharp	Throbbing	Burning

Location of the above complaint/symptom in the order of intensity: Give a number 1 to the most intense and 2 to the second in intensity and 3 for the least in intensity.

( ) Neck ( ) Mid back ( ) Lower back ( ) L / R Upper buttocks ( ) L / R Lower buttocks	( ) L / R Shoulders ( ) L / R Arms ( ) L / R Elbows ( ) L / R Forearms ( ) L / R Wrists	( ) L / R Ankles ( ) L / R Feet ( ) L / R Toes ( ) L / R Hands ( ) L / R Fingers ( ) L / R Knuckles	( ) L / R Groins ( ) L / R Sides of hips ( ) L / R Thighs ( ) L / R Knees ( ) L / R Legs

When did it start, how long ago?

Less than 6 weeks	One month	Less than 3 months	Less than 6 months	Less than a year	Less than 2 years	Less than 3 years	More than 3 years

How intense is the pain from on a scale from 0-10, 10 being the most intense?

0 1 2 3 4 5 6 7 8 9 10

Timing of the complaint?

Morning	During the Day	Evening	After activities

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If it comes in bursts, then How Long does an episode last?

Minutes	Hours	Days	Weeks	Months

What do you think triggers the symptoms or make it worse?

Cold Weather	Activities	Warm Weather	Certain Food	Certain Drug

Are you stiff in the morning?

Yes	No

How long are you stiff in the morning?

Less than 5 min	Less than 15 min	Less than ½ hour	One hour	2 hrs.	The entire morning	The entire day

1. Who referred you? Provide name and fax.	2. Who is your Primary Care Physician?
3. What prescription medications have you taken so far for the symptoms?	**4. Who prescribed it?**
5. Any change of your regular medications within the last few months of the onset of your symptoms?	**6. Any intake of over the counter medications?**
7. Any surgeries done in order to relief your symptoms? When and Where?	**8. Any joint steroids injections?**
9. What joint(s)? When and Where?	**10. Any MRI, X-rays done? When and Where?**

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11.Any Labs done? When and Where?

12.Do have any of the followings?

A. Rash	Yes / No	B. Joint swelling	Yes / No
C. Hair loss/ Alopecia	Yes / No	D. Mouth ulcers	Yes / No
E. Sensitivity to sun or light	Yes / No	F. Raynaud's	Yes / No
G. Dry eyes	Yes / No	H. Dry mouth	Yes / No
I. Pleurisy	Yes / No	J. Parotid swelling	Yes / No
K. Chronic diarrhea or abdominal symptoms	Yes / No	L. Recurrent urine or genital infections?	Yes / No
M. Lymphadenopathy (swollen glands). If Yes,		N. Psoriasis	Yes / No

Where: - Ant. Cervical - Post. Cervical - Inguinal - Supraclavicular - Axillary

13.Any history of blood clot or thrombosis?	**14.Any history of bleeding?**
Yes / No	Yes / No
15.Any history of leukopenia (Low white cell count)?	**16.Any history of thrombocytopenia (Low platelets count)?**
Yes / No	Yes / No
17.Any history of miscarriages?	• How many?
Yes / No	• Where they in a row?
	• What trimester?

18.Any history of travel in the last 2 years inside the U.S? Where?

19.Any history of travel in the last 2 years outside the U.S? Where?

20.Name of herbal supplements?

21.Any immunizations for:	**Flu**	**Pneumonia**	**Shingles**	**others**
	Yes / No	Yes / No	Yes / No	Yes / No

22.Any family history of autoimmune disease such as Rheumatoid arthritis, lupus …?

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Patient Name: ______________________________ **DOB:** ___/___/_____ **DOS:** ____/____/______

A Multi-Dimensional Health Assessment Questionnaire (R785-NP2)

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

1. 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?				
b. Get in and out of bed?				
c. Lift a full cup or glass to your mouth?				
d. Walk outdoors on flat ground?				
e. Wash and dry your entire body?				
f. Bend down to pick up clothing from the floor?				
g. Turn regular faucets on and off?				
h. Get in and out of a car, bus, train, or airplane?				
i. Walk two miles or three kilometers, if you wish?				
j. Participate in recreational activities and sports as you would like, if you wish?				
k. Get a good night's sleep?				
l. Deal with feelings of anxiety or being nervous?				
m. Deal with feelings of depression or feeling blue?				

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

NO	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	VERY
PAIN	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	PAINFUL

3. What is/are the MOST painful area(s)? Please check (√) one or two only:

○ Neck	○ Shoulders	○ Mid-back	○ Lower back	○ Elbows	○ Hands	○ Wrists
○ Hips	○ Knees	○ Thighs	○ Legs	○ Feet	○ Ankles	

How long is your morning stiffness?

○ Less than 5 mins	○ 5-10 mins	○ 15 mins	○ 30 mins	○ 45 mins
○ 1 hr.	○ 2 hrs.	○ More than 2 hrs	○ All morning	○ All day

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

VERY	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	VERY
WELL	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	POORLY

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NEW & ESTABLISHED PATIENT POLICY AND PROCEDURE

Contacting the physician or other providers in the office

1- The physician or any other provider at Arthritis Clinic of Central Texas (ACCT) is available to answer your questions at anytime. You can reach them by calling or emailing via our secured email, using Patient Fusion, your electronic portal. Our usual turn around time to answer calls or emails related to routine questions that do not involve acute pain or an urgent situation is 24-48 hrs. Please note that you are able to email the physician by using Practice Fusion by sending to the provider named: **Hassan Alissa.** You may also email Lee Ann, our NP, or any other staff member by choosing their respective names..

2- For any urgent questions related to pain, we will answer you at the end of working day, unless the pain is so severe, in that case, you may elect to walk in or call and ask to speak to the doctor ASAP. Please do not email in a situation that requires immediate attention.

Medication Refills

3- Medication refills can be done by contacting your pharmacist or by calling us. If your pharmacist confirmed no refills available, then please call us for refills.

4- For your safety refills are only provided as long as you follow up with appointments. If you rescheduled your appointment once or did not show, you refills maybe extended to the next rescheduled appointment only. If you rescheduled twice or did not show up twice, then refills will not be provided until you are present for the follow up appointment. Please know that our medications are highly toxic and any continuation without physician's supervision might involve risk to your health.

Calling for Lab Results

5- Results of labs will be available to you, by visiting your patient electronic portal (Patient Fusion) within 2 wks after the lab draw. We will only call if something needs an immediate attention, otherwise labs will be reviewed on the next office visit.

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6- New patients' lab results will also be available electronically. Please be advised that if you call after your labs results are in, in order to get a diagnosis, we will not be able to provide you with a diagnosis over the phone. We feel it is unfair to you to do so, given a diagnosis may need a re-evaluation and further questioning of your medical history, because the labs are only part of the equation and not all of it. It is unfair per example to give you a diagnosis of Rheumatoid or lupus over the phone, however it remains your right to get a copy of your labs or to ask the physician to comment on the severity of the abnormal results (too much inflammation, minimal inflammation...etc).

No Show Policy

7- No shows, who do not call within 24 hours of their appointment to reschedule create a particular challenge. They end up being seen but as a double book, 2-3 weeks later. This makes it harder to see already scheduled patients, who regularly show up to their appointments in a timely manner and creates a long wait times. In an effort to make it harder for a patient not to show up without calling in advance, we elected to charge a fee that is a meant to enforce our policy. This charge is $50 for established patient and $75 for new patients.

8- If your insurance requires a referral to see us, we will work with you to obtain it, however it ultimately remains your responsibility to make sure your referral is on file, otherwise you might end up being charged in full for the visit.

Children in Infusion Center

9- The presence of children in the infusion center carries risk on other patients and the children themselves, due to the immunosuppressive medications that might predispose the patients and children to indolent diseases. As a result, we ask you to please not bring your child with you to the infusion center. We will work with you to reschedule your infusion if needed.

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