Summit Rheumatology

New Patient Packet

Welcome to Our Practice!

Dr. Brittany Panico, DO

W Richard Horn, NP

Peter Hennis, NP

Summit Rheumatology
New Patient Packet

Hi there! Welcome to Summit Rheumatology, the office of Dr. Brittany Panico, DO, W Richard Horn, NP, and Peter Hennis, NP. Let's get started! Please make sure to fill out every page in this packet as accurately as possible. Once completed, you can return it to the front desk with current insurance cards and a photo ID. Make sure to have payment ready for any co-pay that you may owe.

Patient Name:____

SUMMIT
RHEUMATOLOGY

Office Policy

Please read carefully and initial on each line indicating you have read and understand our office policies and procedures. Once you have read our terms, please sign and date at the bottom. Be aware that these office policies and procedures are non-negotiable; refusal will be treated as non-compliance and can lead to discharge from the office. Thank you!

Cancellation/No Show Policy

The following information outlines your financial responsibilities related to payment for professional services.

A No-Show is when a patient fails to keep a scheduled appointment or fails to provide a 48-hour notice to cancel. A no-show will generate a $50 fee for all patients regardless of insurance. A patient that fails to come to their first appointment or has 2 no-shows will be discharged from the practice. If you have been in the ER on the day of your appointment, this fee will be excused with proper documentation of ER visit.

Initial: ______________

Late Appointment Arrival

A patient who arrives more than 10 minutes late for his/her appointment will NOT be seen; an appropriate arrival time is the responsibility of the patient.

Initial: ______________

Financial Patient Responsibility

It is the policy of the practice to treat all patients in an equitable fashion related to account balances. All services provided will be billed to your insurance carrier. Patients are responsible for providing insurance cards at every visit and notifying the office of any insurance changes to prevent any medical and billing delays. The practice will not waive, fail to collect, or discount co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with payers. That being said all co-payments will be collected upon appointment arrival. Payments plans are

available for patients who have high remaining balances and for patients who are "Self-Pay" (No Insurance). All balances that remain delinquent after 90 days will be referred to a collection agency in addition to being discharged from the office.

Initial: _____________

Patient Demographics

First/LastName:_______________________

Date of Birth:

Gender:

SSN:

Address:

City/State/Zip:

Phone #:

Can we leave voicemails? YES or NO

Email:

Marital Status

Referring Physician Name:

Emergency Contact:

Emergency Contact #

Primary Insurance

Insurance Carrier:

Member ID:

Group #:

Policyholder's Name:

Relation to Patient:

Policyholder's DOB:

Policyholder's SSN:

Secondary Insurance

Insurance Carrier:

Member ID:

Group #:

Policyholder's Name:

Relation to Patient:

Policyholder's DOB:

Self-identification: Please select all that apply:

☐Hispanic/Latino

☐ Black/African American

☐ White

☐ American Indian/Alaskan Native

☐ Asian

☐ Hawaiian Native

☐ Pacific Islander

Referring Physician Phone:

____

Primary Care Name:

____

Primary Care Phone:

____

Today's Date:

____

SUMMIT RHEUMATOLOGY

Chief Complaint

Initial: ________________________________

Patient Name: ________________________________

DOB: ________________________________

Chief Complaint: ____

Briefly describe present symptoms:

____

____

What were your first symptoms?

____

____

What joints hurt first? ____

When did you notice your symptoms starting?

____

Do you have morning stiffness? YES or NO

How long does your morning stiffness last? ________________________________

On a scale from 1 being mild pain and 10 being severe pain, what was your pain rating last week? Circle rate.

1 2 3 4 5 6 7 8 9 10

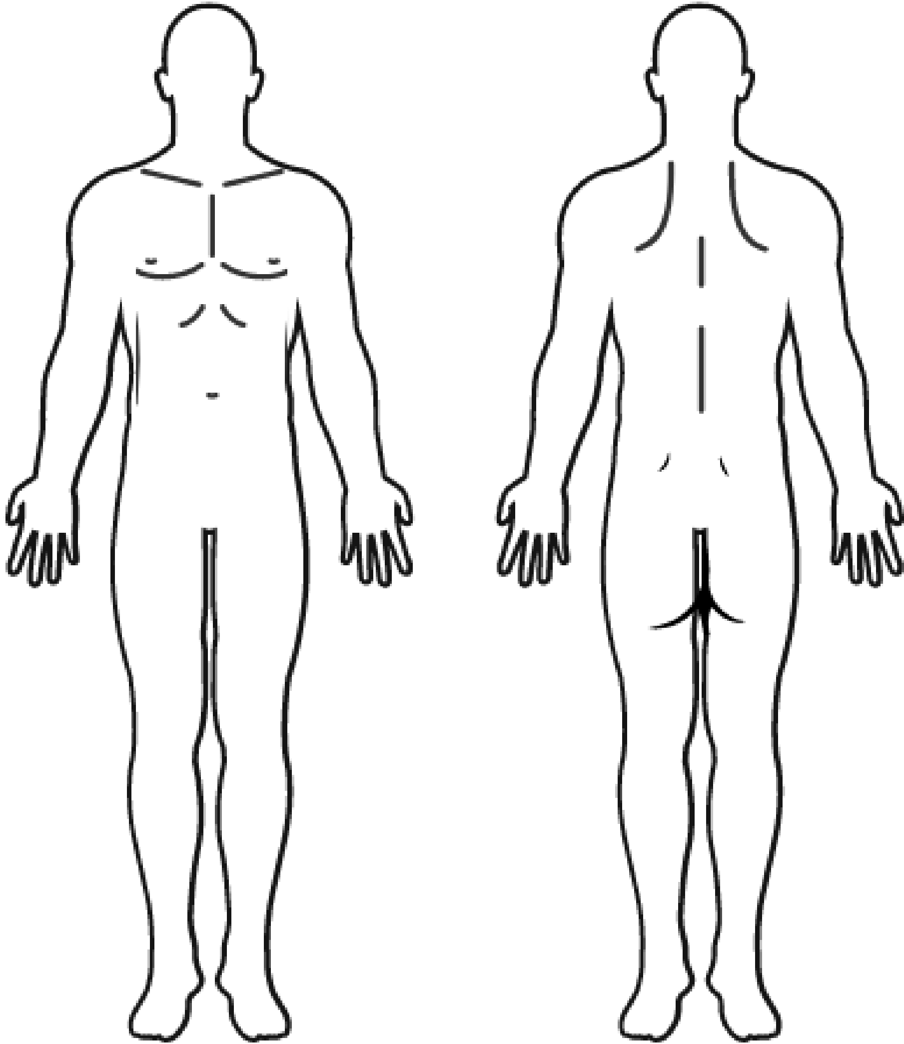
Has there been any recent changes to your daily activities? YES or NO

Explain changes:

____

____

Please use the image to circle the areas where you are experiencing pain.



At this moment, you are able to:	Without any difficulty:	With some difficulty:	With much difficulty:	Unable to do:
Dress yourself, tie shoelaces and buttons?				
Get in and out of bed?				
Lift a full cup to your mouth?				
Wash and dry your entire body?				
Bend down to pick up clothing?				
Turn regular faucets on and off?				
Get in and out of the car?				
Walk outdoors on flat ground?				

Briefly describe any family medical history that brought concern (Example: cancer, diabetes, etc.)

____

____

____

Briefly describe any medical conditions that pertain to only you, as the patient.

____

____

____

Medications & Pharmacy

Please list all allergies and reactions.

Allergy ______________________________

Reaction ______________________________

Allergy ______________________________

Reaction ______________________________

Allergy ______________________________

Reaction ______________________________

Allergy ______________________________

Reaction ______________________________

Allergy ______________________________

Reaction ______________________________

Allergy ______________________________

Reaction ______________________________

Do you currently smoke? YES or NO

How many cigarettes a day? ______________________________

Have you smoked in the past? YES or NO

Do you drink alcohol? YES or NO

How many times a month? ______________________________

Have you drunk alcohol I the past? YES or NO

Briefly describe any past surgical history, please apply dates if available:

1.	Date:
2.	Date:
3.	Date:
4.	Date:
5.	Date:
6.	Date:

List all current medications to the best of your knowledge.

Medication	Dosage	Frequency	Who Prescribes	Type of Specialists
Example: Gabapentin	300mg	Two times a day	Dr. Scott	Rheumatologist
1				
2				
3				
4				
5				
6				
7				

8				
9				
10				
11				

Preferred Pharmacy

Pharmacy Name ____

Pharmacy Address ____

____

Pharmacy Phone # ____

NOTE: Switching/transferring pharmacies will cause a delay in sending medications. It is the patient's responsibility to make us aware of any changes the day of the appointment. Failure to notify us will result in a 24-48 hour wait.

Review of Symptoms

Musculoskeletal	Cardiovascular	Eyes
Joint Pain	Chest Pain	Double Vision
Muscle Weakness	Shortness of Breath	Red Eyes
Arms	Valley Fever	Dry Eyes
Neck	TB	Poor Vision
Lower Back	Irregular Pulse	Sudden Vision Loss
Legs	Swelling	Blurry Vision
Genitourinary	**Skin**	**Ear Nose Throat Mouth**
Genital Ulcers	Skin Lesions	Jaw Pain
Urethral Discharge	Hair Loss	Nasal Congestion/Sores
Urinary Stone	Oily/Dry Skin	Sinus Problems
Miscarriages	Rash with Sun Exposure	Dry Mouth
Pregnancy	Easy Burning	Gland Enlargement
Menstrual Irregularity	Facial Rash	Head Pain/Aches
Venereal Disease	Raynaud's Phenomenon	Mouth Sores/Ulcers
Urinary Difficulty	Other Types of Rashes	Ringing in Ears
Neurological	**Gastro**	**Constitutional**
Pinched Nerves	Abdominal Pain	Night Sweats
Seizures	Loss of Appetite	Fever
Memory Loss	Constipation/Diarrhea	Weight Loss/Gain
Disorientation	Bright Red Stool	Fatigue
Coordination Difficulty	Black Tarry Stools	Shaking/Chills
Speech Difficulty	Hepatitis/Mononucleosis	**Psychiatric**
Inablity to Concentrate	Stomach Ulcer	Depression
Numbness	Jaundice	Insomnia
Recent Falls/Tripping	Vomiting/Nausea	Psychosis
Dizziness	Indigestion/Heartburn	**Endocrine**
Hematology/Lymphatic	**Respiratory**	Diabetic
Swollen Lymph Glands	Pain with Breathing	Thyroid Condition
Swollen Lymph Nodes	Chronic Cough	**Immunological**
Bruising	Wheezing	Seasonal Allergies
Bleeding Tendencies	Bloody Sputum	Immune System Problems

Patient Signature: ______________________________

Date: ______________________________

Provider Initials: __________

SUMMIT RHEUMATOLOGY

Policies

DISCLAIMER

Please be respectful of the providers time to prevent any appointment overlaps, this will delay wait times. Medication requests during the time of your appointment will be sent at the end of the day. If your current pharmacy is completely out of your medication a transfer to another pharmacy can be arranged with in a time frame of 24-48 hours. Patients with narcotic refills will be asked for a urine sample. Patients who require Family Medical Leave Act forms (FMLA) or any other disability paperwork will be charged a fee depending on complexity. These forms will not be completed during an office visit. Please keep in mind that some of our services such as ROZ, AVISE, and Vectra may be out-of-network with your insurance carrier. All patients who are receiving AVISE Lab Test will NOT pay more than $100. Patients receiving Vectra can receive financial assistance if the service bill is high, patients who have Medicare, Medicaid, Tricare, or other government health insurance can have this service at a zero out of pocket cost. All other services will be billed to your insurance carrier and applied to your out-of-network deductible if it applies. Note all services conducted are used to accurately diagnose and prescribe appropriate medications. Please sign and date confirming you have read and understand all of our office policies, terms and procedures in addition to completing and thoroughly reviewing your New Patient Packet. Thank you!

Patient Signature: ____

Date: ____

HIPPA Notice of Privacy Practices

Medical Release Form: Disclosure of PHI

Patient Name:____________________ **Date of Birth:**____________________

Provider or facility name: Summit Rheumatology

Address: 2451 E Baseline Rd Suite 425

City/State/Zip: Gilbert, AZ 85234

Phone: (480) 494-2770

Fax: (480) 494-2771

Please check one or both:

☐I hereby authorize Summit Rheumatology to RECEIVE medical records from the provider or facility below.

☐I hereby authorize Summit Rheumatology to SEND medical records to the provider or facility below.

(For more than one provider or facility, please fill out another form)

Provider Name: ____________________

Facility Name: ____________________

Address:____________________ City/State/Zip: ____________________

Phone:____________________ Fax: ____________________

__All medical records __Laboratory results __X-ray reports

_Progress/chart notes __Referrals

I hereby release the provider and the providers staff from any liability for fulfilling authorization requests of my medical information and PHI. This consent is valid for a maximum of one year or until expressly revoked by me. I may revoke this authorization at any time by providing Summit Rheumatology with a written notice.

Patient Signature: ______________________________

Date: ____________________

HIPPA Notice of Privacy Practices

Practices Continued

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

1. Our duties regarding your protected health information (PHI)

    - We are required by law to maintain the privacy of information that we create or receive about your past, present, or future health condition(s), the provisions of health care to you, and the past, present or future payment of such health care (PHI). We must provide you with this notice of our legal duties and privacy practices regarding PHI. We are legally required to follow the privacy practices that are described in this notice, as may be revised from time to time. We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to all PHI we maintain. If we revise our policy practices, we will also revise this notice, as necessary, and post a new notice in the office. You can also request a copy of this notice from our front office staff at any time.

2. Permitted Uses and Discloses of Your PHI for Treatment, Payment, or Health Care Operations. We may use and disclose your PHI for your treatment, the payment of our services and our healthcare operations.

    - Treatment: To provide, coordinate or manage your health care and related services. For example, we may use your PHI to develop a treatment plan for you and may disclose your PHI when consulting with other health care providers involved in your care. We may also provide you appointment reminders or information about treatment alternatives that may be of interest to you.

    - Payment: To bill and collect payment for the services we provide you. For example, we may use your PHI to prepare an invoice for services rendered to you and may disclose such invoice to any person responsible for the payment of such services.

    - Health Care Operations: In order to carry out our health care operations. For example, we may use your PHI to conduct business and general administrative activities and we may disclose your PHI to our accountants, attorneys, consultants, and others (business associates) as required for them to provide services to our practice.

3. Permitted Uses and Disclosures of Your PHI Without Your Authorization. We may use and disclose your PHI without your authorization in some circumstances.

- As Required by Law: When required by law, we shall use and disclose your PHI, provided our use and disclosure complies with and is limited to the requirements of such laws. For example, we shall disclose PHI in a judicial proceeding in response to a court order or to regulatory agency in response to an administrative subpoena.

- Public Health Activities and Health Oversight Activities: When required or permitted by law, we shall or may disclose PHI to a public health authority authorized to collect or receive PHI for the purpose of preventing or controlling disease, injury or disability. For example, we shall or may report information about various contagious diseases. When required or permitted by law, we shall or may disclose PHI to health oversight agency in connection with its health oversight activities authorized by law. For example, we shall or may provide information to an agency in connection with its oversight activities of the health care system.

- Serious Threats: Consistent with applicable law and standards of ethical conduct, we may disclose your PHI, if our provider in good faith believes the disclosure is necessary to avert a serious threat to health or safety. For example, we may disclose your PHI to law enforcement personnel or other persons reasonably able to prevent or lessen the threat.

- Worker's Compensation: We may disclose your PHI as authorized by and to the extent necessary to comply with worker's compensation laws. We may also provide your PHI to your employer if your employer requests your treatment for a work-related injury or illness.

4. Uses and Disclosures Requiring Your Prior Consent:

   - Upon your oral or written consent, we may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or is responsible for the payment of your care.

5. Uses and Disclosures Requiring Your Prior Authorization:

   - In any other situation not described above, including but not limited to, any disclosures to your attorney or other health care providers, we will not use or disclose any of your PHI without your prior written authorization. You may revoke any authorization granted by providing a written revocation. The revocation will only apply to the extent that we have not taken any action in reliance on the authorization given. We will provide you an authorization form upon request.

6. Your Right Regarding Your PHI:

- Limit Uses and Disclosures of Your PHI: You have the right to request that we restrict our purposes. However, we are not required to agree to your request. If we accept your request, we will put the agreed-upon limits in writing and abide by them until terminated, except in emergency situations. You may not restrict our other uses and disclosures that are required by law or are permitted without authorization.

- Communication of PHI to You: You have the right to request that you received communications containing your PHI from us at an alternate address, such as at work instead of home or by alternate means, such as only in writing and not by telephone. We must agree to your request if we can reasonably do so.

- Inspect and Copy Your PHI: Unless we are required by applicable law to provide access to your Medical Record or other records containing your PHI, you have the right to inspect or get a copy of your Medical Records or other records containing your PHI such as billing records. You must make the request in writing. If we deny your request, we will advise you in writing and explain your right to have the denial reviewed. We or our copying vendor may charge you for copies requested at a commercially reasonable rate. Instead of providing the PHI you request, you may agree to receive a summary of explanation of the PHI as long as you agree in advance to pay for the summary. If we do not have the PHI you request, but know who dies, we will inform you.

- Amendments to Your PHI: You have the right to request that we amend your PHI if you believe that it is inaccurate or incomplete. You must provide the request in writing and include your reason(s) for the request. We may deny your request if the PHI (i) is correct and complete (ii) was not created by us, (iii) may not be disclosed, or (iv) I not contained in our records, if we approve your request we will make the requested change to your PHI, request that you inform us of others that need to receive the requested change and notify other persons or entities that may have relied on the PHI.

- Complaints and Questions about Our Privacy Practices: If you think that we may have violated your privacy rights or have a complaint regarding out privacy policies or procedures, including • our compliance with these policies and procedures you may contact our office at 480-494-2770. Notice of Privacy Practices This Notice describes how health information about you (as a patient) may be used and disclosed and how you can gain access to your health information. This is required by the Privacy Regulations created as a result of Health Insurance Portability and Accountability Act of 1966. Use and Disclosure of Your Health Information in Certain Special Circumstances: The following situations may require us to use your health information: Public health authorities and health oversight agencies that are authorized by law to collect information, lawsuits and similar proceedings in response to court or administrative order, if required by a law enforcement officer, when necessary to rescue or prevent

serious threat to a person or organization able to help prevent the threat, if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities, to Federal Officials for intelligence and national security activities authorized by law, to correctional institutions or law enforcement officials if you are an inmate or under custody of a law enforcement official

7. For Worker's Compensation and similar programs. Your Right Regarding Your Health Information: You may request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instances you may ask that we contact you at home rather than work. We will accommodate reasonable request. You may request a restriction of our use or disclosures of your health information for treatment, payment or health care options. Additionally, you have the right to request that we restrict disclosure of your health information to only certain family members or friends. We are not required to agree with your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you including patient medical and billing records, but not including psychotherapy notes. You may ask to amend your health information if you believe is incorrect or incomplete. Please submit your signed and dated request in writing and submitted to our address. You may as us to give a copy of this notice at any time. I hereby acknowledge that I have been presented with a copy of the Summit Rheumatology Notice of Privacy Practices and that I will contact Summit Rheumatology with any questions.

Patient Signature: ______________________________

Date: ____________________

Authorization/Release of Medical Information

These people along with any referring, or primary care physicians listed on the patient information sheet may receive my Protected Health Information: Please Circle one of the following relationship.

1. Name:___________________ Date of Birth:________________ Phone #:_______________

   Relationship to Patient: Spouse Child Parent Other

2. Name:___________________ Date of Birth:________________ Phone #:______________

   Relationship to Patient: Spouse Child Parent Other

3. Name:___________________ Date of Birth:________________ Phone #:______________

   Relationship to Patient: Spouse Child Parent Other

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand you Notice of Privacy Practices containing a more complete description of the uses and disclosures of my healthcare information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used to disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

X ____ **Date:** ______________________

Patient Signature

____

Patient Name (Print)

SUMMIT RHEUMATOLOGY