Rheumatic Disease Clinic

Welcome to our practice! We are genuinely pleased that you have chosen us for your medical health care.

Prior to your first visit, we need to verify your insurance to ensure that you can use your insurance benefits to the maximum allowed. If we do not have that information prior to your first visit, then you will be responsible for the charges incurred for that visit. You are responsible for your co-pay, which we will collect prior to the visit, and any deductible amounts or charges that your insurance company deems necessary.

Enclosed you will find our new patient information forms. Please fill this out and bring with you to your first appointment along with a list of any medications that you take plus data from previous doctors, which may include recent lab reports, x-rays and office notes.

Referrals, if applicable, which can be obtained from your primary care physician, are your responsibility and we ask that they be faxed or mailed to our office prior to your appointment. If we do not have the proper referral in place prior to your visit, you will be responsible for the charges incurred.

RDC provides the following services:

- Primary Care: We conduct in-office procedures, such as ECG (electrocardiography), spirometry (common pulmonary function test), laboratory testing, including rapid strep, and others. Urgent care visits can usually be accommodated on the same day.
- Our staff is dedicated to enhancing the quality of life for patients with arthritis and autoimmune disease. We strive to provide compassionate care in various areas of rheumatology:
    - Lupus Gout Osteoarthritis Sjogren's disease
    - Polymyalgia Rheumatica Fibromyalgia Scleroderma

We ask that you make every effort to keep your appointment. If you need to reschedule your appointment, please call at least 24 hours prior to your visit.

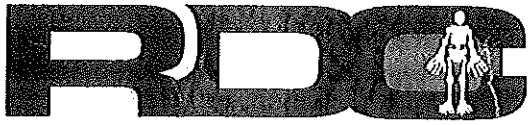
We want to thank all of our patients for choosing the Rheumatic Disease Clinic. We look forward to serving your needs now and into the future.

Sincerely,

Rheumatic Disease Clinic

Samuel B. Pegram, MD. • Everald O. Manning, M.D. • Adnan Peer, M.D.

4825 Almeda Road • Houston, TX. 77004 • Office (713)521-7865 • Fax (713)521-7856



Rheumatic Disease Clinic

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Rheumatic Disease Clinic of Houston** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO).

This notice of Privacy Practices provided by **Rheumatic Disease Clinic of Houston** describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Rheumatic Disease Clinic of Houston reserves the right to revise its Notice of Private Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Rheumatic Disease Clinic of Houston.**

With this consent, **Rheumatic Disease Clinic of Houston** may call my home or other alternative location and leave a message on voice mail or in person, in reference to any items that assist the practice in carrying out TPO. For example, appointment reminders, lab tests results, insurance items and any call pertaining to my clinical care.

With this consent, **Rheumatic Disease Clinic of Houston** may mail to my house or other alternative location any items that assist the practice in carrying out TPO, such as appointment cards or patient statements. I have the right to request that **Rheumatic Disease Clinic of Houston** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement.

By signing this form, I am consenting to allow **Rheumatic Disease Clinic of Houston** to use my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If, I do not sign this consent, or later revoke it, **Rheumatic Disease Clinic of Houston** may decline to provide treatment to me.

PATIENT'S AFFIRMATION OF RECEIPT OF PATIENT'S STATEMENT OF PRIVACY RIGHTS

I hereby acknowledge receipt of this office's Statement of Privacy Rights, provided on my behalf and in accordance with the law and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

Signature:_____ Date:_____

RHEUMATIC DISEASE CLINIC OF HOUSTON

PATIENT INFORMATION

DATE_____

Patient's Name: _____
(Last) (First) (Middle)

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ **Cell Phone:** ( ) _____

Work Phone: ( ) _____

Email Address_____home___ work___
If work, is it ok to email you? _____

Sex: _____ Marital Status: _____ Date of Birth: ___/ ___/ ___ **Social Security #:** _____-_____-_____

Patient's Employer: _____

Address: _____
(City) (State) (Zip)

Spouse's Name: _____

Spouse's Employer: _____

Address: _____
(City) (State) (Zip)

Referred By: _____**If physician please provide referring physician's phone number and address:** _____

NOTIFY IN CASE OF EMERGENCY:

Name: _____ Phone: ( ) _____ Relationship: _____

INSURANCE:

1st Insurance Company: _____

Policy Holder's Name: _____ Date of Birth: _____/ _____/ _____

ID#: _____ Group#: _____

2nd Insurance Company: _____

Policy Holder's Name: _____Date of Birth: _____/ _____/ _____

ID#: _____ Group#: _____

RHEUMATIC DISEASE CLINIC OF HOUSTON

PATIENT INFORMATION

DATE_____

ACKNOWLEDGEMENT OF RESEARCH STUDY:

Rheumatic Disease Clinic often participates in research studies. Would you be interested in being part of a study if you qualify? _____

Signature_____Date:_____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY:

This office does not accept responsibility for collecting your insurance proceeds or for the negotiating settlement of a disputed claim. If for whatever reason your insurance company does not pay your claim in full, you are responsible for payment of the entire balance including any finance charge or collection fees that may be included.

Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS:

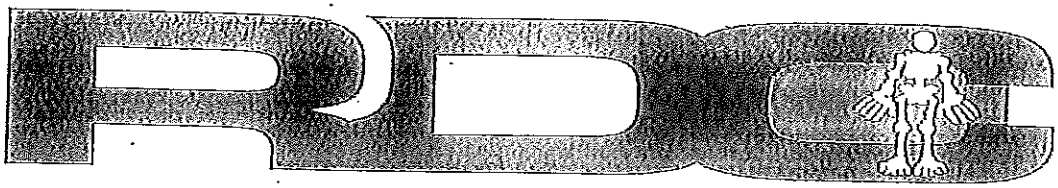
I authorize payment of Medicare and/or other insurance benefits to be made directly to Rheumatic Disease Clinic on my behalf for any and all services rendered. I also authorize Rheumatic Disease Clinic to release my protected health information for treatment and billing purposes.

Signature: _____ Date: _____

PATIENT'S AFFIRMATION OF RECEIPT OF PATIENT'S STATEMENT OF PRIVACY RIGHTS

I hereby acknowledge receipt of this office's Statement of Privacy Rights, provided on my behalf and in accordance with the law and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

Signature: _____ Date: _____



Rheumatic Disease Clinic

Authorization For Release of Medical Records to Rheumatic Disease Clinic

Patient: _____

Date of Birth: _____

Thereby Authorize and request:

_____

_____

_____

_____

To Release the complete medical records in your possession, concerning my illness and/or treatment to Rheumatic Disease Clinic at the address or fax number listed below.

Thank you,

Patient's Signature: _____

Date: _____

4825 Almeda Rd., Houston, TX 77004 ☎ (713)521-7865 office ☎ (713)521-7856 fax

Rheumatic Disease Clinic

NOTICE OF PRIVACY PRACTICES

During your treatment at Rheumatic Disease Clinic, our caregivers may gather information about your medical history and current health. This Notice of Privacy Practices explains how that information may be used and shared with others. It also explains your privacy rights regarding this information.

Rheumatic Disease Clinic is required by law to abide by the terms of this Notice, to make sure that information that identifies you is kept private, and to give you this Notice of our legal duties and practices with respect to medical information about you. We are also required to notify you in the event there is a breach of your health information.

Uses and Disclosures of your Health Information

Rheumatic Disease Clinic may use health information to carry out treatment, payment and health care operations. Treatment is the provision, coordination or management of health care. For example, we may use and disclose your information to consult with a third party or to refer you to other health care providers.

Payment includes the activities necessary to obtain reimbursement for the provision of health care. For example, we may need to give your health plan information about treatment you received at Rheumatic Disease Clinic so your health plan will pay us or reimburse you for the treatment.

Health care operations include the activities necessary for Rheumatic Disease Clinic to run its business operations. For example, we may use your information to review treatment and services and to evaluate the performance of our staff.

We may use or disclose your health information:

When required by federal, state, or local law.

To support public health activities by reporting as required or authorized by state or federal law. These reports may include the reporting of exposure to a communicable disease or risk of spreading a disease or condition.

To cooperate with law enforcement officials for certain law enforcement purposes as directed by a court order, warrant, criminal subpoena, or other lawful process.

To report abuse or neglect.

To support health oversight activities that are authorized by law, such as administrative or criminal investigations, inspections, licensure or disciplinary actions and other similar activities necessary for appropriate oversight of government benefit programs or functions.

When required by a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as required by law.

When necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, as consistent with applicable law and standards.

For judicial or administrative proceedings, in response to a valid court order, administrative order, a grand jury subpoena, or with your written consent.

For research purposes, with your written authorization or as permitted by law.

To business associates to perform functions on Rheumatic Disease Clinic's behalf, if the business associate has signed an agreement to protect the confidentiality of the information.

We may disclose your health information to a family member, other relatives, or a close friend or any other person you identify if the information relates to that person's involvement in your health care if you consent to such a disclosure. If you are unable to agree or object to the use or disclosure, we may disclose such information as necessary if we determine that it is in your best interest.

Continued on other side ⇨

Patient Rights

Inspect and obtain a copy of your health information. You have a right to inspect and obtain a copy of your health information that is used to make decisions about your care for as long as Rheumatic Disease Clinic maintains the information. You may request an electronic copy of this health information that we maintain electronically. This right does not apply to certain health information, including information compiled in reasonable anticipation of or for litigation. Requests for access to health information should be made in writing to the Rheumatic Disease Clinic Administrator. You may also ask us to provide a copy of this health information to another person. In that case, your written request must be signed by you, must clearly identify the person to whom you want us to send the copy of your health information, and must state where the copy is to be sent. If access is denied, you will be provided with a written explanation that sets forth the basis for the denial, a description of how you may review those rights and a description of how you may complain.

Request an amendment. You have the right to request that Rheumatic Disease Clinic amend your health information if it is incorrect or incomplete. Requests for amendment of information should be made in writing to Rheumatic Disease Clinic Administrator, and you must provide a reason that supports your request to have the information changed. Rheumatic Disease Clinic may deny your request for an amendment if the request is not in writing and submitted to the Administrator. In addition, we may deny your request if you ask us to amend information that: (a) was not created by Rheumatic Disease Clinic (unless the person or entity that created the information is no longer available to make the amendment); (b) is not part of the medical information kept by Rheumatic Disease Clinic; (c) is not part of the information you would be permitted to inspect and copy; or (d) is accurate and complete.

Request communications by alternative means or at alternative locations. You have the right to request confidential communications by alternative means or at alternative locations. For example, you may request that we communicate with you only by mail. We will accommodate all reasonable requests, but your request must specify how or where you wish to be contacted, and we may require you to provide information about how payment will be handled. You must request confidential communications in writing.

Request a general restriction. A general restriction is one that restricts or limits our use or disclosure of your health information. To request a general restriction, you must identify in this request: (i) what particular information you would like to limit, (ii) whether you want to limit use, disclosure, or both, and (iii) to whom you want the limits to apply. We will consider your request but are not required to agree. We have the right to terminate the restriction if: (i) you agree orally or in writing to terminate the restriction, or (ii) if we inform you of the termination, which becomes effective only for your health information created or received after we inform you of the termination.

Request a plan restriction. A plan restriction is one that meets the following three conditions: (a) it is to restrict disclosure of your health information to a health plan for purposes of payment or health care operations; (b) the health information relates solely to a health care item or service for which you, or someone on your behalf, has paid us in full; and (c) the disclosure is not otherwise required by law. If you wish to request a plan restriction, you must do so separately for each service visit, and must make your request at Rheumatic Disease Clinic **before** your visit.

Obtain a copy of this Notice. To obtain a paper copy of this notice, contact the Administrator at Rheumatic Disease Clinic.

Complaints. If you believe your privacy rights have been violated you may complain to the MinuteClinic Privacy Office. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. All complaints should be submitted in writing. You will not be penalized in any way for filing a complaint.

Rheumatic Disease Clinic Duties

Rheumatic Disease Clinic reserves the right to change its privacy practices and this Notice, and to apply the changes to any health information received or maintained by Rheumatic Disease Clinic prior to the date of the changes. If the terms of this Notice are changed, a revised version will be available upon request and will be posted in a clear and prominent location. You may access the notice by visiting our website at: www.RDCH.org

Manning

Rheumatic Disease Clinic

General Adult Medical Information Sheet

Today's Date: _____

Name: _____ Date of Birth: _____

SS#: _____ Phone No.: _____

Chief complaint: _____

DRUG ALLERGIES

☐ None _____

CURRENT MEDICATIONS

☐ None _____

FAMILY HISTORY ☐ None ☐ Unknown

	father	mother	father's family	mother's family	siblings	children
Heart Failure						
Heart Attack						
High blood pressure						
Stroke						
Colon Cancer						
Breast Cancer						
Prostate Cancer						
Diabetes						
Epilepsy/convulsions						
Bleeding disorder						
Thyroid disease						
Mental illness						

Other: _____

HOSPITALIZATIONS ☐ None

Reason	Date

SURGERIES ☐ None

Reason	Date

PAST MEDICAL HISTORY ☐ None

- ☐ Headaches _____
- ☐ Shortness of breath _____
- ☐ Heart palpitations _____
- ☐ Heart murmur _____
- ☐ Chest pain _____
- ☐ Dizziness/fainting _____
- ☐ Peripheral vascular disease _____
- ☐ Allergies/hay fever _____
- ☐ Asthma _____
- ☐ Bronchitis _____
- ☐ Pneumonia _____
- ☐ Ulcer _____
- ☐ GI disorder _____
- ☐ Gall bladder disease _____
- ☐ Prostate disease _____
- ☐ Bowel irregularity _____
- ☐ Sexual/menstrual dysfunction _____
- ☐ Venereal disease _____
- ☐ Frequent infections _____
- ☐ Hepatitis _____
- ☐ Anemia _____
- ☐ Arthritis _____
- ☐ Nervousness _____
- ☐ Depression _____
- ☐ Gout _____
- ☐ Chronic rashes _____
- ☐ Rheumatic fever _____
- ☐ Mumps _____
- ☐ Rubella _____
- ☐ Polio _____
- ☐ Diphtheria _____
- ☐ Tetanus _____
- ☐ Other _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

SYSTEM REVIEW AND SCREENING

Patient Name:_____

SYSTEM REVIEW **(please indicate if you have had in the last month)**

Gen: ☐ weight gain ☐ weight loss ☐ fatigue ☐ fever ☐ chills ☐ night sweats

Allergy: ☐ blistering of the skin ☐ congestion ☐ hives ☐ sneezing ☐ watery eyes

Eyes: ☐ eye pain ☐ red eye ☐ poor vision ☐ double vision ☐ dry eye ☐ eye discharge

Endoc: ☐ cold intolerance ☐ heat intolerance ☐ excessive sweating ☐ excessive thirst

ENT: ☐ ringing in the ears ☐ poor hearing ☐ mouth sores ☐ hoarseness ☐ difficulty swallowing

Resp: ☐ shortness of breath ☐ cough ☐ coughing blood ☐ wheezing ☐ pain with inspiration

CV: ☐ chest pain ☐ leg swelling ☐ heart racing/ skipping beats ☐ shortness of breath (SOB) lying down ☐ waking at night with SOB ☐ SOB with exertion ☐ calf / thigh pain with walking

GI: ☐ stomach pain ☐ nausea ☐ vomiting ☐ heartburn ☐ diarrhea ☐ constipation ☐ vomit blood/ "coffee grounds" ☐ yellow skin ☐ blood in stool ☐ black stools ☐ pencil thin stools

Blood: ☐ swollen glands ☐ tender glands ☐ easy bleeding ☐ easy bruising

Women: ☐ vaginal discharge ☐ vaginal rash/ulcer ☐ hot flashes ☐ irregular/frequent cycles
Breast: ☐ lump ☐ pain ☐ discharge ☐ swelling ☐ bloody discharge

Men: ☐ penile discharge ☐ penile rash/ulcer ☐ poor erections ☐ testicular lump ☐ testicular pain

Urination: ☐ difficult to pass ☐ painful ☐ with blood ☐ frequent ☐ waking at night to urinate ☐ urgency

MSK: ☐ joint pain ☐ muscle weakness ☐ joint swelling ☐ neck pain ☐ back pain ☐ muscle pain

SKIN: ☐ rash ☐ hives ☐ sun sensitivity ☐ hair loss ☐ acne ☐ changing mole ☐ itching

NeuroPsych: ☐ headache ☐ dizziness ☐ fainting ☐ lightheadedness ☐ numbness/tingling ☐ memory loss ☐ difficulty talking ☐ difficulty walking ☐ extremity or facial weakness ☐ tremor ☐ depression ☐ irritability ☐ poor sleep ☐ anxiety ☐ hallucinations

---

1. Prevention:
   a. Exercise? ☐ YES ☐ NO Activity _____
      Days/ week _____ Time/duration _____ mins
      Exertion: ☐ minimal ☐ mild ☐ heavy
   b. Have you ever had a colonoscopy? ☐ YES ☐ NO
      Estimate Date: _____ Results: _____
   d. How many sexual partners have you had in the last year? _____. In your lifetime? _____

2. Immunizations:
   a. Have you had a tetanus shot? ☐ YES ☐ NO
      Please estimate Date: _____
   b. Have you had a pneumonia shot? ☐ YES ☐ NO
      Please estimate Date: _____
   c. Have you had a shingles shot? YES NO
   d. Have you had a Meningitis shot? YES NO
   e. Have you had a HPV shot? YES NO
      (Human Papilloma Virus)

3. Depression screen (over the past month)
   a. Have you often been bothered by feeling down, depressed, or hopeless? ☐ No ☐ Yes
   b. Have you often been bothered by little interest or pleasure in doing things? ☐ No ☐ Yes

4. **Women only:**
   a. Age when periods started: _____
   b. Number of pregnancies: _____
   c. Number of miscarriages: _____
   d. Have you reached menopause? ☐ No ☐ Yes
      If yes, at what age: _____
   e. **Estimate Date** of last Pap smear: _____
      Previous abnormality? ☐ No ☐ Yes_____
      Previous biopsy? ☐ No ☐ Yes_____
   f. **Estimate Date** of last mammogram: _____
      Previous abnormality? ☐ No ☐ Yes_____
      Previous biopsy? ☐ No ☐ Yes_____

ALCOHOL STATUS

Patient Name: _____

Did you have a drink containing alcohol in the past year?

☐ Yes ☐ No

If 'Yes' : How often did you have a drink containing alcohol in the past year?

☐ Never ☐ Monthly or less ☐ 2 to 4 times a month

☐ 2 to 3 times a week ☐ 4 or more times a week

If 'Yes' : How many drinks did you have on a typical day when you were drinking in the past year?

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

If 'Yes' : How often did you have 6 or more drinks on one occasion in the past year?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

SMOKING STATUS

Please indicate status and reply accordingly

☐ Nonsmoker ☐ Former smoker ☐ Current Smoker

Former smokers

How long has it been since you last smoked?

☐ < 1 month ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months

☐ 1-5 years ☐ 5-10 years ☐ > 10 years

Current smokers

How often do you smoke cigarettes?

☐ every day ☐ some days, but not every day

How many cigarettes a day do you smoke?

☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more

How long after you wake up do you smoke your first cigarette?

☐ within 5 minutes ☐ 6-30 minutes ☐ 31-60 minutes ☐ after 60 minutes

Are you interested in quitting?

☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit