ROS | RHEUMATOLOGY and OSTEOPOROSIS SPECIALISTS

Larry K. Broadwell, M.D.
Aaron W. Broadwell, M.D.
Mary Katherine (Katie) Walton, M.D.
Mamatha Katikaneni, M.D.
Frankie K. Pedigo, M.D.

820 Jordan Street, Suite 201
Shreveport, Louisiana 71101
Phone: (318) 221-0399
Fax: (318) 221-1940

Dear New Patient:

Welcome to our clinic! Thank you for taking time to complete your new patient paperwork. Please make sure to complete and sign all forms.

As soon as we receive your completed paperwork and a referral from your provider, we will call you to schedule your first appointment.

If your need to cancel or reschedule your New Patient appointment, please call or leave a message with our office as soon as possible using ext. 135. This will allow us to schedule another patient for that appointment.

We look forward to seeing you soon. In the meantime, if you have any questions about the enclosed forms, please feel free to call our office at (318) 221-0399.

Sincerely,

New Patient Coordinator

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Dear New Patient:

I am using a questionnaire to help me know more about you. This allows me to do a better job of assessing your musculoskeletal problems and also any other medical problems that you have that might be related. It also includes your medications, which I must know in order to prescribe medicines to you that will not interfere with what you are already taking. Please be patient, as I know it is long!

Please be here at least 30 minutes prior to your appointment to fill out our business office forms. Sometimes they too are enclosed with the questionnaire, depending upon the timing of your appointment. We pride ourselves on running on time, so please help us keep it that way!

Please contact your insurance company to verify that we are contracted providers for your plan. If you are unsure, you may contact us at any time to verify. Also, remember to bring your current insurance cards with you. Payment for your fist visit is as follows:

1. **PPO or HMO** – Any deductible that has not been paid as well as the co-pay or 10%, 20%, or 30% etc. will be subject to fulfillment depending on your insurance benefits. If you have an HMO plan that requires a referral number, you <u>must</u> make sure that we have received your referral number at least 24 hours prior to your appointment. (Please contact us prior to your appointment to make sure that the referral number has been received). Payment arrangements must be made in advance.
2. **Medicare with supplement** – Payment will depend on your supplement plan type.
3. **Medicare without supplement** – Your 20% co-insurance will be due at the time of your visit.
4. **No insurance** – Patient is required to pay $500 in advance two weeks prior to the appointment and half of the appointment cost at the end of your initial visit. Any remaining balance is due paid in full within 60 days of the appointment.

Your medical history, medications, and pertinent questions will be reviewed by one of our staff, followed by your visit with the physician. We will review your x-rays with you, decide what type of rheumatologic problem(s) you have and how you should be treated. You should plan to spend approximately 2-3 hours at a new patient appointment, although follow-ups will be considerably shorter.

If you arrive more than 10 minutes late to any appointment, you may be asked to reschedule your appointment.

For appointments that are missed or not canceled 24 hours in advance, there will be a charge. There also may be a charge for missed bone density appointments. We attempt to give courtesy calls, but if you do not receive one, you are still responsible for your appointment.

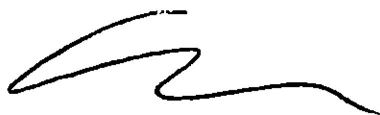
We also expect you to be compliant with any and all medications as well as a laboratory schedule if given to you.

We do not prescribe narcotics. We do not assess restrictions or disability but are happy to send records when appropriate.

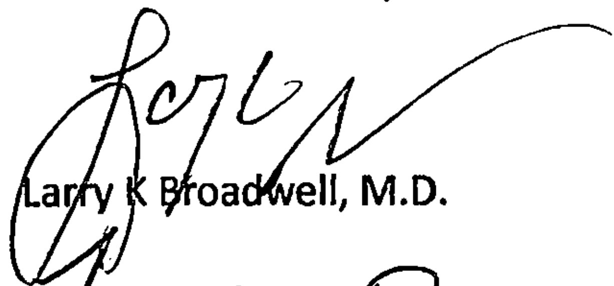
You do not need to fast for any of our laboratory tests. You can take your medications as normally scheduled the morning before your appointment.

Your condition or treatment program may not require the continued care of a rheumatologist, in which case you may be referred to your primary care physician. If you do require further rheumatologic care, then we will follow you in our clinic. I think that you will find this office to be pleasant, helpful, and comprehensive in regards to your health care.

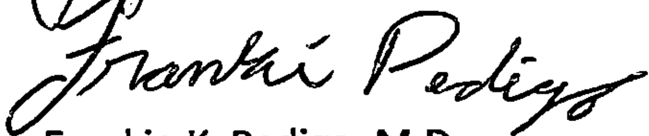
Sincerely,



Aaron W. Broadwell, M.D.



Larry K Broadwell, M.D.



Frankie K. Pedigo, M.D.

Mary Katherine Walton, M.D.

Mamatha Katikaneni, M.D.

YOUR BILLING RIGHTS – KEEP THIS NOTICE FOR FUTURE USE

This notice contains important information about your rights and our responsibilities under the Fair Credit Billing Act.

Notify Us In Case of Errors or Questions About Your Bill
If you think your bill (statement) is wrong, or if you need more information about a transaction on your bill, write us (on a separate sheet) at the address listed on your bill. Write to us as soon as possible. We must hear from you no later than sixty (60) days after we sent you the first bill on which the error or problem appeared. You can telephone us, but doing so will not preserve your rights.

In your letter, give us the following information:
*Your name and account number
*The dollar amount of the suspected error
*Describe the error and explain. If you can, why you believe there is an error. If you need more information, describe the item you are not sure about.

Your rights and our Responsibilities After We Receive Your Written Notice
We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within ninety (90) days, we must either correct the error or explain why we believe the bill was correct.
After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount you question, including finance charges, and we can apply any unpaid amount against your credit limit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question. If we find that we made a mistake on your bill, you will not have to pay any finance charges related to any questioned amount. If we did not make a mistake, you may have to pay finance charges, and you will have to make up any missed payments on the questioned amount. In either case, we will send you a statement of the amount you owe and the date that it is due.
If you fail to pay the amount that we think you owe, we may report you as delinquent. However, if our explanation does not satisfy you and you write to us within ten (10) days telling us that you still refuse to pay, we must tell anyone we report you to that you have a question about your bill.
If we do not follow these rules, we cannot collect the first $50.00 of the questioned amount, even if your bill was correct.
If you have any questions about this notice or any aspect of your statement, please let us know.

FINANCE CHARGE: The Finance Charge is computed as a periodic Rate of 1 ½% per month which is an annual Percentage Rate of 18% applied to the 90 day balance after deducting payments and credits appearing on this statement. For balances less than $50.00, there will be a minimum Finance Charge of $.50.

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You are responsible for payment of all charges and accounts due and payable in full upon receipt of your monthly statements. To avoid a Finance Charge for delayed payment, it is required that all accounts be paid as billed, when billed. If in the event that it becomes necessary to refer this account to an attorney or outside collection agency, you hereby agree to pay attorney fees of no less than 33.33% of the amount due, together with all court cost and judicial interest. If extended terms are desired on larger balances, our Credit Office personnel will be delighted to discuss the matter of a payment schedule that is best suited to you.

Please understand that you are completely responsible for payment of the account regardless of any insurance coverage that you may have. In the event of Medicare, please allow a minimum of 6 to 12 weeks for payment to be made directly to you. Charges and payments made after the statement date will appear on your next month's statement.

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All Accounts Are Due In Full Upon Receipt of Statement.

GENERAL INFORMATION

1. Please check in with one of our receptionists when you first arrive. We will take your temperature, and ask that your guests wait downstairs, unless you need physical assistance during your visit.
2. As a busy practice, we like to allow sufficient time to address all of your healthcare needs, before, during and after your first visit. Thank you for your patience during the check-in process, however if you have been waiting 15 minutes past your scheduled appointment time, please notify the receptionist.
3. We will ask you to complete a form concerning your medications, and medical and surgical problems since your last visit. This form is required to be completed by you for your insurance company at each visit.
4. Please bring a list of your current medications to each visit. We will gladly make a copy for you, and recommend that you keep this list in your purse or wallet.
5. Patients visit our office for a variety of reasons including routine office appointments, injections, bone density scans, and infusion therapy. Therefore, patients may be called back ahead of you even though you arrived first, we thank you for your patience.
6. You are our first priority, therefore we do NOT accept walk-ins.
7. If you are late for your appointment, you may be asked to reschedule.
8. Please allow 48 - 72 hours for refill requests, and let us know if you need a 30 or 90 day supply and the name of your preferred pharmacy. Please remember if you require monthly lab, we may not be able to fulfill your request, if your labs are not current. This is for your protection.
9. We do not notify you of normal lab values. If you would like a copy of your lab work, please bring a self-addressed, stamped envelope, or you may view your labs in your patient portal – https://health.eclinicalworks.com/ROS.
10. If you need us to release medical records or complete forms for you, please allow 7-10 working days.
11. Thank you for silencing your cell phone during your office visit.
12. If you ever stop your medication, or if another health care professional stops your medication, please notify us immediately.

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PATIENT INFORMATION

Patient Name | Social Security # | Age | Date of Birth | Sex M☐ F☐

Address | City | State | Zip Code

☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated | Home Phone | Spouse's Name

Please tell us who referred you to us: | Drug Allergies

RESPONSIBLE PARTY INFORMATION

Person Responsible for Medical Expenses ☐ Self ☐ Workers Comp. ☐ Cigna Health Plan | Name | Phone Number

Addresse | City | State | Zip Code

Claim #: | Litigation: ☐ Yes ☐ No | Attorney:

EMPLOYMENT INFORMATION

Employed ☐ Yes ☐ No | Employer (Father's if minor)

Address | City | State | Zip Code

Position | Business Phone Number

Spouse s Employer (or Mother's) | Address

Position | Business Phone Number

INSURANCE INFORMATION (Please list all)

Medicare Number | Medicaid No. | State

Insurance Co. Name & Address | Policy No. | Group No. | Name of Insured

Insurance Co. Name & Address | Policy No. | Group No. | Name of Insured

EMERGENCY INFORMATION

Person to contact in case of emergency other than spouse or parent: | Relationship

Address | City | State | Phone Number | Phone Number

CONSENT FOR TREATMENT - RELEASE OF INFORMATION

I consent to treatment necessary for the care of the patient mentioned above. I hereby authorize the release of all medical records to referring physicians and to my insurance companies with the following exceptions.

X ______________________________
Signature of patient or guardian

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED ATTACHED

X ______________________________
Signature

Thank you for taking time to complete this form. This information is necessary for the preparation of your clinic records.

You are responsible for all charges as billed. Any service charges for past due or collection accounts will be the responsibility of the patient. As a courtesy, we will file your insurance or medicare. However, your contract is with your insurance company. <u>You are responsible for full payment as billed</u>. If extended terms are desired on large balances, our credit office personnel will be happy to discuss a payment schedule most convenient for you.

No insurance follow-up will be made by this office. When your account has been paid in full, if your insurance company makes a payment, we will refund the patient or the insurance company within 45 days (whichever party the refund is due).

ePrescribing Consent

Patient Name: ______________________________ Date of Birth: ________________

Rheumatology & Osteoporosis Specialists has implemented electronic prescribing known as ePrescribing.

- **ePrescribing is a federally mandated initiative requiring all physicians prescribe in this manner.**
- **ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way. This process helps protect the privacy of your personal information.**
- **ePrescribing software also lets your doctor see important information - like drug interactions and your prescription history.**

The benefit to you:

- **Less confusion over handwritten prescriptions or unclear phone calls**
- **Reduced possibility of medical errors**
- **Less chance of adverse drug reactions**
- **Fewer trips to drop off at the pharmacy**
- **A safer, faster, easier way to get your prescription filled**

PREFERRED PHARMACY INFORMATION:

Name of Pharmacy: ____

Address: ________________________________ Zip Code: ______________

Phone: ____________________

Patient Consent

I agree that Rheumatology & Osteoporosis Specialists may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

This consent is valid for two years. Please notify us if your pharmacy information should change.

Patient Signature ________________________________ Date ________________

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PERSONAL INFORMATION:

Appointment Date:

Last Name:____________________________

First Name:______________Middle:_______

DOB: _______________________________

Address 1:____________________________

Address 2:____________________________

City:________________________________

State: ___________________ Zip: _______

Home Phone: ___________ Cell: ___________

Work Phone: ___________ Ext: ________

Primary Care Physician: __________________________

Referring Physician:______________________________

Gender: ☐ Male ☐ Female

Marital Status: ☐ single ☐ married ☐ widowed

SSN: ______________________________________

E-mail address: _________________________________

Pharmacy name/street: ___________________________

Name of Orthopedist (if you have one): ________________

CHIEF COMPLAINT: What is the reason for your visit today? ____

____

Please briefly describe your present symptoms: ____

____

____

When did your symptoms begin? ____

Have you been given a diagnosis? Please list: ____

Have you seen any other physicians for this problem? If so, who? __________________________________

Please list any previous treatment you have received for this problem: _______________________________

____

____

When you wake up in the morning, are your joints stiff? ☐ yes ☐ no If yes, for how many minutes/hours? __________

MEDICATIONS: Please list your current medications below (list additional on the back of this page).

Please include any over-the-counter medications, such as calcium, vitamin D, multivitamins, vitamin B12, etc.

Name	Strength	Directions (including # of pills and frequency)	How long have you taken this medication?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

MEDICAL HISTORY: Please check if you have had any other following medical problems (specify where indicated):

- ☐ Arthritis, unspecified
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Fibromyalgia
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Cancer (____________)
- ☐ Thyroid Disease
- ☐ Lung Disease (_________)
- ☐ Kidney Disease
- ☐ Colitis
- ☐ Stomach ulcers
- ☐ Anorexia
- ☐ Gastric bypass
- ☐ Anemia
- ☐ Psoriasis
- ☐ Tuberculosis
- ☐ Depression or Anxiety

Have you ever had a serious infection (i.e. requiring hospitalization or long-term treatment)? If yes, please explain: _____

____

____

Have you ever had a PPD (tuberculosis skin test)? ☐ yes ☐ no If yes, when? _____________ ☐ positive ☐ negative

List any other medical problems that are not above that you have ever been diagnosed with: ______________

____

____

____

____

VACCINATIONS:

Do you get an annual flu shot? ☐ yes ☐ no If no, why not? ____________________

Have you ever received the Pneumovax (pneumonia vaccine)? ☐ yes ☐ no If yes, when? ______________

Have you ever received the Zostavax (zoster/shingles vaccine)? ☐ yes ☐ no If yes, when? ______________

Have you received any other vaccines as an adult? If so, please list: ____________________

ALLERGIES: Please list any allergies you have to medications (or bring a list with you).

☐ Check here if you do not have any medication allergies

Medication	What happened when you took this medication?

SURGICAL HISTORY: Please list all surgeries you have had in the past (or bring a list with you).

Year of Surgery	Surgery/Procedure	Surgeon

HOSPITALIZATION: If you have ever been in the hospital, please list when and why you were admitted.

Year of Hospitalization	Reason for hospitalization

FAMILY HISTORY:

Have any of your family members been diagnosed with any of the following diseases? If so, please list how they are related to you (i.e. mother, father, sibling, aunt, etc).

□ Arthritis (type unknown) ____________
□ Osteoarthritis ____________
□ Rheumatoid Arthritis ____________
□ Lupus ____________
□ Myositis ____________
□ Psoriasis ____________
□ Gout ____________
□ Osteoporosis ____________
□ Ankylosing Spondylitis ____________
□ Colitis ____________
□ Fibromyalgia ____________

Please list any other medical diseases in your family: ____________

SOCIAL HISTORY:

Do you smoke? □ current smoker □ former smoker □ nonsmoker

If you are a current smoker: How often do you smoke? □ 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 soon after you wake do you smoke your 1st cigarette? □ within 5 min □ 6-30 min □ 31-60 min □ after 60 min

Are you interested in quitting? □ ready to quit □ thinking about quitting □ not ready to quit

Do you drink alcohol? □ yes □ no If yes: □ daily □ socially □ rarely If daily, how many beverages? ______

Occupation (current or past): ____________

Do you exercise? □ yes □ no If yes, what do you do and how often? ____________

How is your sleep at night? □ good □ fair □ poor

Do you have trouble getting to sleep? □ yes □ no If yes, why? ____________

Do you awaken during the night? □ yes □ no If yes, why? ____________

How many hours do you sleep at night? ______ Do you wake up feeling tired? □ yes □ no

Have you ever traveled outside of the continental United States? □ yes □ no If yes, where and when? ____________

If you have traveled within the continental United States within the past 2 years? If yes, where have you travelled? ______

REVIEW OF SYSTEMS: Please check if you have any of the following:

□ weight loss
□ fever
□ eye pain/redness
□ vision change
□ dry eyes
□ mouth sores
□ dry mouth
□ difficulty swallowing
□ shortness of breath
□ cough
□ chest pain
□ swelling in legs
□ nausea
□ blood in stool
□ black, tarry stool
□ easy bruising
□ prolonged bleeding
□ blood in urine
□ painful urination
□ Raynaud's Phenomenon
□ hair loss
□ rash
□ thickening of the skin
□ tingling/numbness
□ loss of strength

BONE HEALTH (both men and women please complete this section)

Have you ever had a bone density exam? □ yes □ no. If yes, when was your last exam? ____________

If you are a woman, have you gone through menopause? □ yes □ no If yes, when? ____________

Do you take calcium supplementation? □ yes □ no If yes, how much? ____________

Have you ever had your vitamin D level checked? □ yes □ no □ I don't know If yes, when was the last time? ______

How often are you out in the sun? ____________

Have you ever had a fracture/broken bone? Please list: ____________

BACK PAIN (Please complete this section if you experience ***low back, SI joint, hip or buttock*** pain)

Has your low back/SI/hip/buttock pain been present for more than 3 months? □ yes □ no

Did your back pain start slowly or all of a sudden? □ slowly □ suddenly

Did your back pain start before the age of 40? □ before age 40 □ after age 40

Does you back pain improve with exercise? □ yes □ no

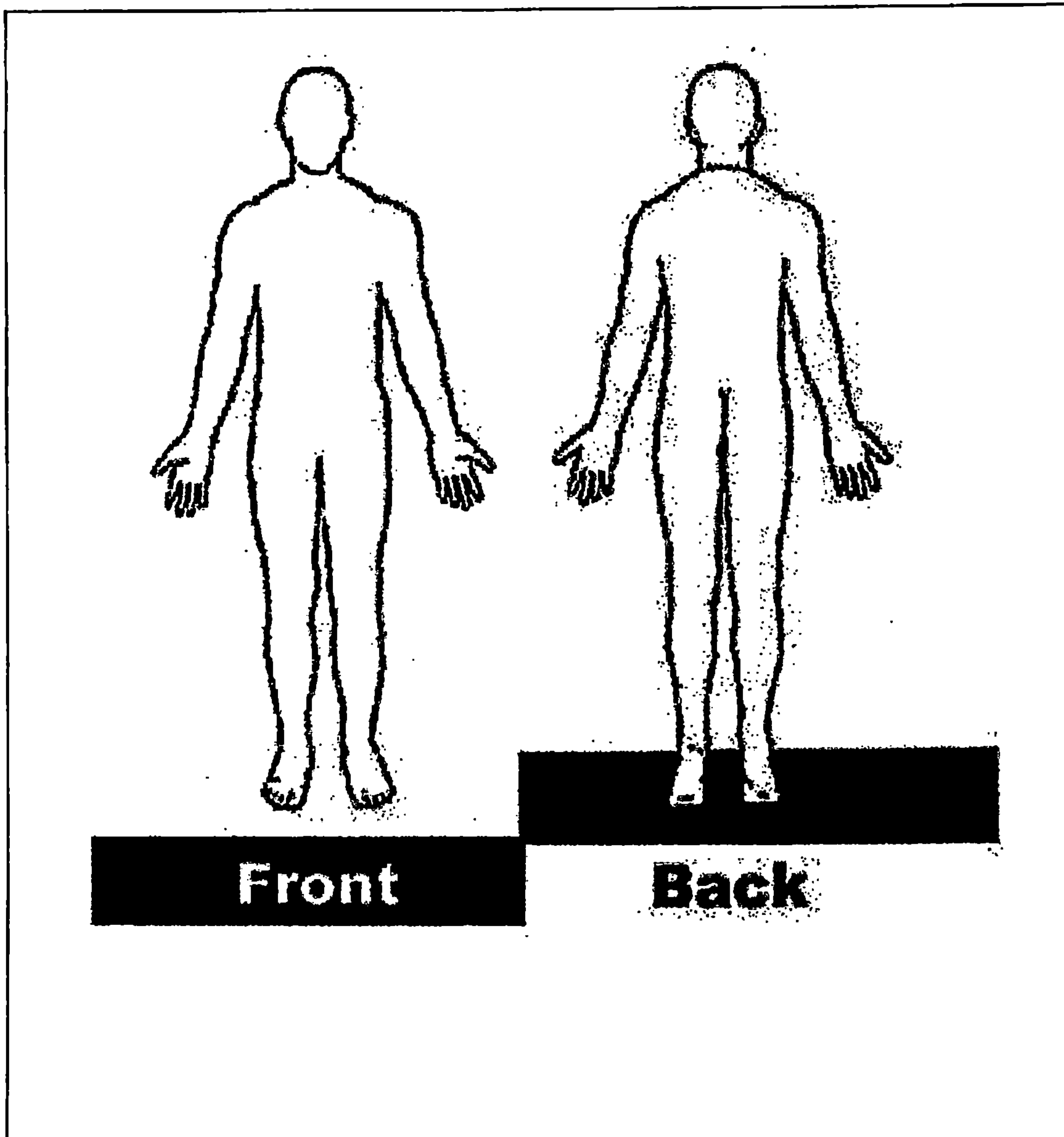
Does rest help your back pain? □ yes □ no

Do you have back pain at nighttime that improves after getting up? □ yes □ no

Does your back pain improve with the use of NSAIDs (ibuprofen, naproxen, Aleve, Motrin, Mobic, meloxicam, Celebrex, etc)? □ yes □ no

PAIN CHART (if applicable): If you are having pain, the chart below may be helpful in describing that pain. Please mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. Circle the areas that swell. To complete the picture, please draw in your face.

Aching	Numbness	Pins and Needles	Burning	Stabbing
●●●●●	=====	□□□□□□	XXXXX	//////



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RECEIPT OF **NOTICE OF PRIVACY PRACTICES AND FEE NOTIFICATION**

I, ________________________________, have received a copy of the **Rheumatology and Osteoporosis Specialists** Notice of Privacy Practices and Financial Policies.

____________________________________ ____________________

Signature of Patient Date

ROS | RHEUMATOLOGY and OSTEOPOROSIS SPECIALISTS

Family and Friends Contact Form

Persons who are involved in your care, (family, friends, etc.) may inquire about your treatment, lab results, prescriptions, etc. Please let us know which persons to whom we may share your health information. (Please note in an emergency situation, or other situations outlined in our Notice of Privacy Practice, we may share information with others who are not specifically listed on this form).

Name:______________________________ **Phone:**______________________________

□ Appointment □ Bill □ Lab Results □ Test Results □ Medical Care

Name:______________________________ **Phone:**______________________________

□ Appointment □ Bill □ Lab Results □ Test Results □ Medical Care

Name:______________________________ **Phone:**______________________________

□ Appointment □ Bill □ Lab Results □ Test Results □ Medical Care

Name:______________________________ **Phone:**______________________________

□ Appointment □ Bill □ Lab Results □ Test Results □ Medical Care

Your Home Telephone:____________________ **Your Work Telephone:**____________________

Your Cell Phone:____________________

From time to time we will leave a message for you (as stated in our Notice of Privacy Practices) on an answering machine, voice mail, or with another individual in your absence. **Is It OK for such message to include <u>details</u> (such as diagnosis and medication information) at these numbers?** ________________

______________________________ ______________________________

Signature of Patient or Legal Representative **Date**

______________________________ ______________________________

Date of Birth **ROS Physician**

______________________________ ______________________________

Print Name of Patient or Legal Representative **Relationship to Patient**

Financial Policy, Assignment Information, and Release of Information

I authorize release of any information acquired in the course of treatment necessary to complete and file medical claims to my insurance company or Medicare on my behalf. I hereby acknowledge financial responsibility for costs of services rendered for me or for the person whose account I am acting as guarantor. I authorize (assign) any insurance or Medicare benefits to be paid directly to Rheumatology & Osteoporosis Specialists, or its assignees. I am responsible for any non-covered services, supplies, co-payments or deductibles. I understand I am responsible for knowing how my insurance plan works. This acceptance and assignment will be in force for all future services by practitioners from this office.

______________________________________ ____________________

Signature of Patient or Patient's guardian/representative Date

____

Printed name of Patient or Patient's guardian/representative

Acknowledgement of Notice of Privacy Practices

I understand that as part of my health care, Rheumatology & Osteoporosis Specialist originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality.

I understand that Rheumatology & Osteoporosis Specialists maintains a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. The most recent version of this Notice is displayed in the waiting room area. I understand that Rheumatology & Osteoporosis Specialists reserves the right to change this notice and its practices as needed and will make a reasonable attempt to inform me of any changes. I understand that I can request an additional written copy of this Notice at any time. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent, and
- The right to request restrictions as to how my health information may be used or disclosed.

I have had an opportunity to receive and review the *Notice of Privacy Practices* of Rheumatology & Osteoporosis Specialists.

______________________________________ ____________________

Signature of Patient or Patient's guardian/representative Date

____

Printed name of Patient or Patient's guardian/representative

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FEE NOTIFICATION

Due to the specialized nature of our practice, and your medical condition, keeping your scheduled appointments is vital to the treatment plan established by your Physician.

Should you need to cancel your appointment, we ask that you call NO LESS than 24 hours in advance, in order for us to provide timely care to you and other patients. If you fail to show up for your appointment, or you cancel with less than 24 hours' notice, we may not be able to see another patient at your appointment time.

Therefore, if you miss an appointment or do not call 24 hours' in advance to cancel, you will be subject to a charge of $65.00. Your first missed appointment may be excused. This fee will not be charged to your insurance company, and must be paid in full within 30 days.

New patient appointments that are not cancelled with 24 hours' notice in advance will be required to pay $150.00 prior to rescheduling their new patient appointment, including if the you do not show up. Again, this fee will not be charged to your insurance company and must be paid in full.

Please remember that appointment reminder calls are a courtesy only, and failure to receive a call does not justify a missed appointment.

In addition, for any new patients with a Bone Density Scan scheduled. Please note that if insurance does not cover the scan, then a charge of $75.00 will be added to your bill for the cost of the scan in the office.

______________________________ __________________

Patient's Signature Date

By signing the above notification, you acknowledge that you are aware of possible charges that may be assessed to your account for missed appointments, as well as financial responsibility in this matter. Policy applies, regardless if not signed.

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