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 you 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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GENERAL INFORMATION

1. Please check in with one of our receptionists when you first arrive after checking in on the Kiosk.
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 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 monitoring labs, 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 sign up for the patient portal at https://health.eclinicalworks.com/ROS to view them.
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.

PERSONAL INFORMATION:

Last Name:_____

First Name:_____Middle:_____ Primary Care Physician: _____

DOB: _____ Referring Physician:_____

Address 1:_____ Gender: □ Male □ Female □ Other_____

Address 2:_____ Marital Status: □ single □ married □ widowed

City:_____ SSN: _____

State: _____ Zip: _____ E-mail address: _____

Home Phone: _____ Cell: _____ Pharmacy name/street: _____

Work Phone: _____ Ext: _____ 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 (or bring a list with you).

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):

□ Psoriasis	□ High Blood Pressure	□ Lung Disease (_____)	□ Gastric Bypass
□ Osteoarthritis	□ Heart Disease	□ Kidney Disease	□ Anemia
□ Rheumatoid Arthritis	□ Diabetes	□ Crohn's Disease	□ Fibromyalgia
□ Lupus	□ Cancer (_____)	□ Ulcerative Colitis	□ Hepatitis B or C
□ Osteoporosis	□ Thyroid Disease	□ Stomach Ulcers	□ 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 tuberculosis 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 a pneumonia vaccine (Pneumovax or Prevnar)? □ yes □ no If yes, when?

_____

Have you ever received Shingrix (shingles vaccine)? □ yes □ no

Have you received any other vaccines **as an adult**? COVID? Hepatitis B? 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).

□ Psoriasis _____
□ Osteoarthritis _____
□ Rheumatoid Arthritis _____
□ Lupus _____
□ Crohn's Disease _____
□ Gout _____
□ Osteoporosis _____
□ Ankylosing Spondylitis _____
□ Ulcerative Colitis _____

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

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

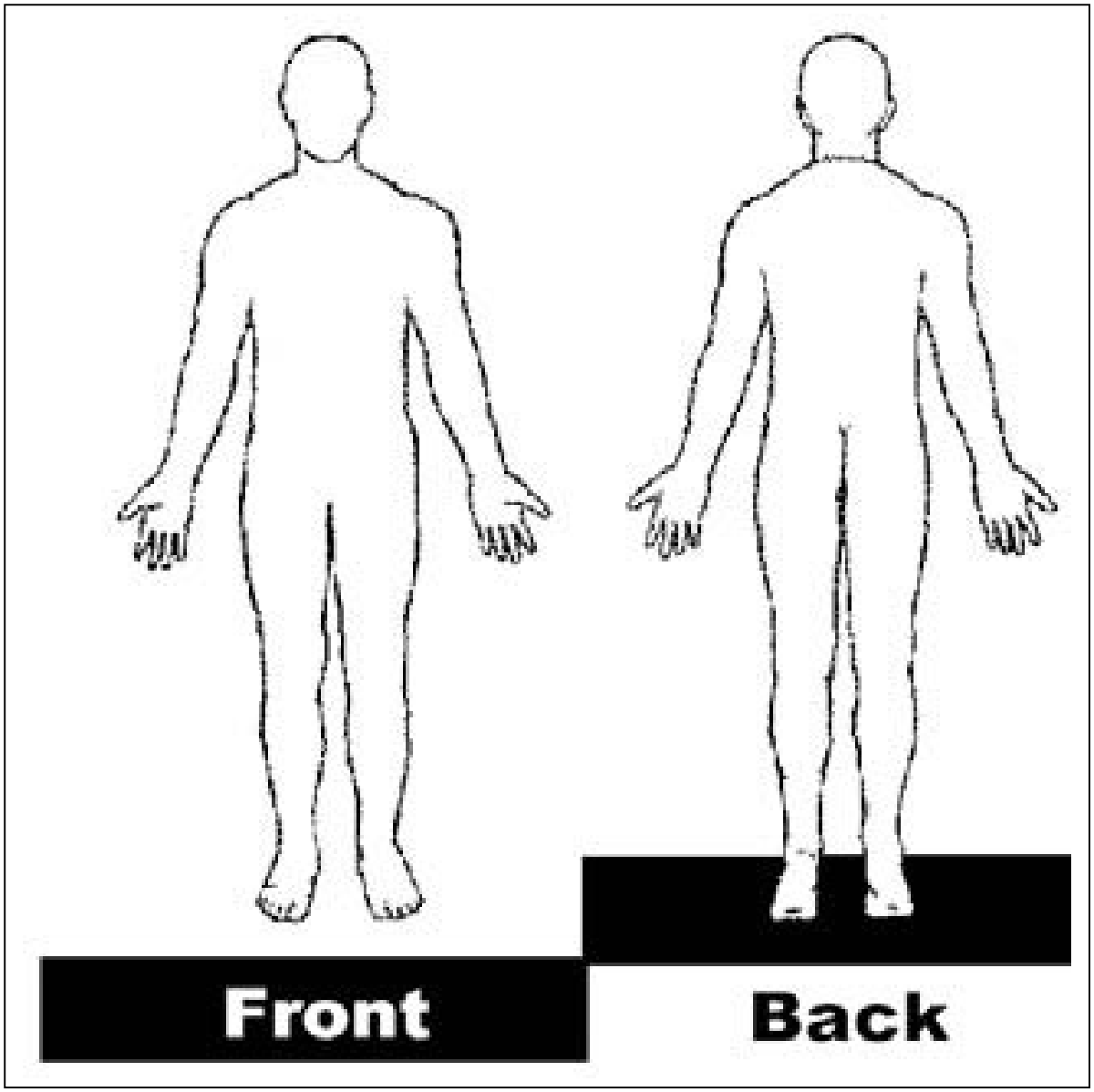
□ weight loss
□ fever
□ eye pain/redness
□ vision change
□ dry eyes
□ mouth sores
□ dry mouth
□ difficulty swallowing
□ shortness of breath
□ cough
□ chest pain
□ swelling in legs
□ nausea
□ blood in stool
□ black, tarry stool
□ easy bruising
□ prolonged bleeding
□ blood in urine
□ painful urination
□ 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: _____

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	/ / / / / /



BACK PAIN/STIFFNESS (**Please complete if you experience low back, SI joint, hip or buttock pain or stiffness**)

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

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

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

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

Does rest help your back pain/stiffness? □ yes □ no

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

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

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: _____
Phone:_____ Zip Code: _____

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.**

Please notify us if your pharmacy information should change.

Patient Signature _____ Date _____

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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 48 hours in advance, in order for us to provide timely care for you and other patients. If you fail to show up for your appointment, or you cancel with less than 48 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 48 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 within 48 hours' notice in advance will incur a $150.00 fee due to the extensive nature of records reviews and preparation time for your appointment. 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 or cancelled appointments, as well as financial responsibility in this matter. Of note, these fees do not apply if you have Medicaid.

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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 Specialists 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

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.

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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 emergency situations, or other situations outlined in our Notice of Privacy Practice, we may share information with others who are not specifically listed on this form).

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What is the best phone number to contact you? _____

The number you provided: (Home, Work, Cell)_____

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 this number? _____**

_____	_____
Signature of Patient or Legal Representative	**Date**
_____	_____
Date of Birth	**ROS Physician**
_____	_____
Print Name of Patient or Legal Representative	**Relationship to Patient**