



Please fill out the enclosed information forms and bring them with you to your appointment. Please have any pertinent medical records, lab results or x-rays forwarded to our office. In order to provide the highest quality medical care, we ask that all new patients fill out a *Patient Personal History Form* before their visit and undergo a complete, arthritis specific, evaluation at the time of their first visit.

Please review *Our Financial Policy* that is included with this packet. We participate with many insurance plans and we will bill them as a courtesy to you. However, if we do not participate with yours, or you do not have insurance, you will be required to pay for the office visit portion at the time of service. The charge for the comprehensive arthritis evaluation is \$493.00. An additional charge will be made for any laboratory or x-ray studies that may be needed.

Our office is located at 200 Spruce Street, Suite 100. The closest cross streets are Quebec and 6th Avenue.

A wheelchair can be made available to you by phoning ahead with your expected time of arrival. If you have any questions please feel free to call and discuss them. We are looking forward to seeing you.

Denver Arthritis Clinic Staff

Enclosures:

New Patient Policies
Financial Policy
New Patient Information
Patient Personal History

NEW PATIENT POLICIES

Welcome to Denver Arthritis Clinic!

To give the best care for our patients, we would appreciate your cooperation with the following policies:

- We have enclosed “new patient” paperwork for you to fill out completely and to bring with you to your appointment.
- The Denver Arthritis Clinic utilizes an automated messaging system called TeleVox[®]. TeleVox[®]'s automated messaging system delivers a personalized message to you including your name, date, time, and location of your appointment.
 - Please know that you must CONFIRM by pressing “1” on your telephone keypad to let us know you received the message and have confirmed your appointment.
 - It is the policy of the DAC to charge the following fees if you have an appointment and do not call to cancel it. 1st no show \$25.00, 2nd no show \$50.00, and 3rd no show \$75.00
- If you are over 15 minutes late for your appointment you might be asked to reschedule.
- Please be sure to bring your insurance cards and be prepared to pay your co-pay at the time of service. If you do not pay your co-pay at the time of service, a \$5.00 rebill charge will be added.
- Please make sure you have a referral from your primary care physician before your scheduled appointment (if your insurance requires one). Failure to have a referral on file in our office prior to your appointment will require payment in full at the time of service, or for the appointment to be rescheduled.
- Please bring any recent lab work with you.
- Please bring a list of your current medications (including doses) with you.
- Often, new patient consultations include having x-rays. If you would feel more comfortable wearing shorts and a t-shirt instead of a gown, please bring those to change in to.

Please call our office at 303-394-2828 if you have any questions. We look forward to seeing you!

NEW PATIENT INFORMATION

Please PRINT and COMPLETE ALL INFORMATION

PATIENT INFORMATION

Today's Date: _____

Is your visit related to a legal case? Yes No
 Are you planning to apply for disability? Yes No

Patient Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Ph#: _____ Work Ph#: _____
 Cell Ph#: _____
 Employer Name: _____
 Employer Address: _____
 City: _____ State: _____ Zip: _____

How would you like to be addressed? _____
 SS#: _____ Marital Status: S M D W O
 Date of Birth: _____ Sex: M F
 Email: _____
 Spouse's Name: _____
 SS#: _____ Date of Birth: _____
 How did you hear about the DAC? _____

PERSON WHO SIGNS CONSENT AND IS RESPONSIBLE FOR BILL

SELF

Insured (Responsible) Party Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Ph#: _____ Work Ph#: _____

Relationship to Patient: _____
 Date of Birth: _____ SS#: _____
 Cell Ph#: _____

PHYSICIAN INFORMATION

Referring MD: _____ Phone #: _____ Address: _____

INSURANCE (Please complete thoroughly. We will need a copy of your insurance card.)

Primary Insurance <input type="checkbox"/> Commercial <input type="checkbox"/> HMO <input type="checkbox"/> PPO
Address:
City, State, Zip:
Phone:
ID Number:
Policy/Group Number:
Effective Date:
CO-PAY:
Policy Holder Information (if different than patient) <input type="checkbox"/> SELF
Name:
ID Number:
Employer:
Policy/Group Number:
SS#:
Date of Birth:

Secondary Insurance <input type="checkbox"/> Commercial <input type="checkbox"/> HMO <input type="checkbox"/> PPO
Address:
City, State, Zip:
Phone:
ID Number:
Policy/Group Number:
Effective Date:
CO-PAY:
Policy Holder Information (if different than patient) <input type="checkbox"/> SELF
Name:
ID Number:
Employer:
Policy/Group Number:
SS#:
Date of Birth:

NOTIFY IN EMERGENCY: (PERSON NOT LIVING WITH YOU)

Name: _____
 Address: _____

Home Ph#: _____ Work Ph#: _____
 Relationship: _____

PLEASE SIGN BY BOTH X's

I authorize payment of medical benefits to physician or supplier for these services and all future claims.

I authorize payment of medical benefits to physician or supplier for these services and all future claims.

X: _____
 Signed (Insured or Authorized Representative)

X: _____
 Signed (Insured or Authorized Representative)



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read our Notice of Privacy Practices brochure carefully and completely before signing the Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Persons: Carol Rendon or Barbara Schmaltz
Telephone: 303-302-7350 or 303-302-7400
Email: crendon@denverarthritisclinic.com
Address: 200 Spruce Street, Suite 100, Denver, CO 80230

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to either the Contact Persons listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____ (print name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. This request supersedes any prior request for confidential channel communications I may have made.

Form with fields for HOME, WORK, CELL, OTHER phone numbers and checkboxes for message preferences (Do/Do Not) and contact information (Mail, Email, Fax, Other).

I, _____ (print name) have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

You are entitled to a copy of this consent after you sign it. Include completed Consent in the patient's chart.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ (print name) have received a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

OUR FINANCIAL POLICY

We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our *Policy* that we require you to read and sign prior to any treatment.

REGARDING INSURANCE

We will gladly bill your insurance company directly if you have provided us with all the necessary information to do so. Your contract for health insurance is between you and your insurance company. We are not a party to that contract. The services that you receive and the bill is an agreement between you and the Denver Arthritis Clinic. **It is ultimately your responsibility to see that your bill is paid in full.** Agreements with insurance companies vary greatly and it is your responsibility to know what is their portion and what is yours. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner. If your insurance company does not begin paying Denver Arthritis Clinic within 5 weeks, it will be your responsibility to contact them. You will be notified by mail of the balance due on your account, and you may request a statement of account if necessary. It will reflect what your insurance company, upon verification, told us is your portion to pay. We expect this payment within 15 days. If payment is not received within this 15-day period, a finance charge of 1.5% will be assessed per month. In the event a check is returned for any reason, a \$20.00 charge will be made to your account.

Many insurance companies require a referral to a specialist prior to any appointment. **It is your responsibility to ensure that this referral is obtained prior to all scheduled appointments.** To obtain a referral you will need to contact your physician and request one. Failure to have a referral on file in our office prior to your appointment will require payment in full at the time of service, or for the appointment to be rescheduled.

Regarding Insurance Plans where we are a participating provider: All co-pays and deductibles are due prior to treatment. If you do not pay your co-pay at the time of service, a \$5.00 rebill charge will be added. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph. If you receive payment made out to both The Denver Arthritis Clinic and you, please endorse the check and forward to us. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances.

PAYMENT FOR SERVICES

Payment is due in full at the time of service for those without insurance coverage. All payment arrangements must be made in advance with Sandra in the billing office at 303-394-2828 x266. If we bill your insurance and reimbursement is 100% denied, we will bill you our Self Pay rates plus an 18% per annum service charge. If you are unsure of self pay rates, it is your responsibility to ask. On occasion, certain procedures may not be reimbursed by your insurance company. If it is expected that insurance will not cover, payment is due at the time of service.

Interest is charged on accounts due beyond the grace period. We allow a grace period of 2 months after receiving a final determination from your insurance company or date of service if you are a cash pay patient. After that time, we will add a 1.5% per month to the total due beyond the grace period.

We have designated a \$25 fee per form payable in cash or check due when the form is picked up. Forms may include: Disability, School and Work Physicals, Public Service Requests, and other miscellaneous forms.

NO SHOW & LATE CANCELLATION

If you are unable to attend, **YOU MUST NOTIFY THE CLINIC AT LEAST 8 HOURS IN ADVANCE AND RESCHEDULE TO MAKE UP THE MISSED APPOINTMENT.** It is the policy of the DAC to charge the patient the following fees if they have an appointment and do not call to cancel it. 1st no show \$25.00 ■ 2nd no show \$50.00 ■ 3rd no show \$75.00

This fee is not payable by any insurance company, and remains the responsibility of the patient. This is due in full prior to your next appointment. You will be considered for termination from the practice once you have accumulated 3 no-show appointments. It is certainly our hope that it does not reach that point.

I have read the *Financial Policy*. I understand and agree to this *Financial Policy*.

Print Name: _____

Signed: _____

Dated: _____

PATIENT PERSONAL HISTORY

Date of Appointment: _____
No

Is your visit related to a legal case? Yes No

Name: _____

Birthplace: _____

Age: _____ Sex: F M Marital Status (optional): _____

Religion (optional): _____

Primary Care Doctor:	Address:	Phone:
Referring Doctor:	Address:	Phone:
Other Doctor:	Address:	Phone:
Other Doctor:	Address:	Phone:

FAMILY HISTORY

	SEX	AGE	HEALTH	AGE AT DEATH	CAUSE OF DEATH
Mother:					
Father:					
Brothers/Sisters:					
Sons/Daughters:					

FAMILY MEMBER'S HISTORY	Similar problems to yours?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, who?
	Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, who?
	Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, who?
	Osteoarthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, who?
	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, who?
	Lupus (SLE)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, who?
	Ankylosing Spondylitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, who?
	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, who?
	Bleeding Tendency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, who?
	Blood Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, who?
	Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, who?
	Chronic Back Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, who?
	Other problems diagnosed in family members?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, who?

PERSONAL HISTORY

Are you working now? <input type="checkbox"/> YES <input type="checkbox"/> NO	Present occupation: If not working, why?	Past occupation:
Sports, hobbies, interests:		
Have you ever smoked cigarettes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How many per day? For how many years?
Do you still smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, how long ago did you quit?
Do you regularly drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How much alcohol do you routinely drink?
Has alcohol ever been a problem for you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use recreational drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How much? How Often? What kind?
Where have you lived (geographically)?		



YOUR PAST MEDICAL HISTORY									
<i>Record the diseases, surgeries and injuries. Have you experienced any of the following—if yes, please give your age when first diagnosed.</i>				Check (✓) if Yes	Date	Age	Check (✓) if Yes	Date	Age
Ulcers-Gastric/Duodenal									
Diabetes									
Cancer-what type?									
High Blood Pressure									
High Cholesterol									
Heart Disease									
Lung Disease									
Blood Clots									
Transfusions									
Osteoporosis									
Tuberculosis									
HIV/AIDS									
Hepatitis C									
Intestinal Disease									
Liver Disease									
Kidney Disease									
Nervous System Disorder									

MEDICATIONS

<i>Are you presently taking any medications? (PLEASE LIST ANY THAT APPLY)</i>					
Name	For What Condition	Dose	Name	For What Condition	Dose
Prescription Medications			Vitamins and Supplements		

Are you allergic to eggs or vaccines? Yes No

Are you allergic to any medication? Yes No If yes, medication: _____ Reaction: _____

Describe any other allergies you have: _____

Are you having any fevers, shaking chills or night sweats? Yes No

How is your appetite? Good Fair Poor

Have you gained weight? Yes No Have you lost weight? Yes No If yes, were you trying to lose weight? Yes No

How many pounds have you lost or gained? _____ Over how many months? _____

Are you on a special diet Yes No If yes, what kind? _____

Do you exercise? Yes No What kind of exercise? _____ Times per week: _____

Do you walk regularly? Yes No How many miles or minutes? _____ Times per week: _____



Denver Arthritis Clinic

BRIEFLY DESCRIBE YOUR CURRENT SYMPTOMS	WHEN DID YOU FIRST NOTICE THESE SYMPTOMS?

RHEUMATIC DISEASE EVALUATION

Have you ever been diagnosed as having arthritis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when?	By whom?
What kind of arthritis?		Was the physician a rheumatologist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had joint injections?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when and in which joints?	
Do you have morning stiffness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Approximately how many minutes per day?	
Do you become unusually fatigued in the afternoon or evening?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you hands get blue or white with cold?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had excessive or unusual hair loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have significantly dry eyes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Dry mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please CIRCLE joints which have been involved:

Jaw	Neck	Back	Shoulders	Elbows	Wrists
Fingers	Hips	Knees	Ankles	Heels	Feet

List names of physicians, podiatrists, or chiropractors you have seen for arthritis and the approximate dates of those evaluations:

PLEASE STATE ANY THAT APPLY TO YOU:

Condition	Check (✓) if Yes	Condition	Check (✓) if Yes	Condition	Check (✓) if Yes
Fevers		Chronic Cough		History of Kidney Disease	
Chills		Chest Pain		Burning on Urination	
Sensitive to Cold		Shortness of Breath		Bloody Urine	
Sensitive to Heat		Pleurisy		Abdominal / Stomach Pains	
Rashes		Pericarditis		Recent Change in Bowel Habits	
Psoriasis		Nervousness		Diarrhea	
Red Eyes		Depression		Constipation	
Painful Eyes		Numbness		Black Stools	
Mouth Sores		Epilepsy or Seizures		Bloody Stools	
Difficulty Swallowing				Colitis	

Have you had a bone density test (DXA scan)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	When?	Where?
Ethnic Background:			
Have you fallen in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Were you hurt?	
Do you exercise regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How and how often?	
Do you eat/drink dairy products?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How much?	
Do you take calcium / vitamin D?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How much?	
Have you broken any bones as an adult?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Which bones/how/when?	
Do any relatives have osteoporosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who?	



Denver Arthritis Clinic

FOR FEMALE PATIENTS ONLY

Recent change in menstrual flow?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last period:
Date of last pap smear:		Date of last mammogram:
Number of miscarriages:		Birth control method:
When did you go through menopause?		Have you ever taken estrogen? <input type="checkbox"/> Yes <input type="checkbox"/> No

HAVE YOU TAKEN ANY OF THE FOLLOWING DRUGS?

Name of Medication	Dates Taken	Was it Effective?	Side Effects	Name of Medication	Dates Taken	Was it Effective?	Side Effects
ANTI-INFLAMMATORY MEDICINES				SLEEPING MEDICINES			
Motrin (Ibuprofen)				Ambien (Zolpidem)			
Aleve (Naproxen)				Lunesta			
Voltaren, Cataflam (diclofenac)				Lyrica			
Lodine (Etodolac)				Neurontin			
Clinoril (Sulindac)				Lunesta			
Bextra (Valdecoxib)				Zyloprim (Allopurinol)			
Indocin (Indomethacin)				Benemid (Probenecid)			
Daypro (Oxaprozin)				Elavil (Amitriptylene)			
Celebrex (Celecoxib)				Pamelor (Nortriptylene)			
Feldene (Piroxicam)				Desyrel (Trazodene)			
Vioxx (Rofecoxib)				Restoril (Temazepam)			
Relafen (Nabumetone)				Rozerem (Ramelteon)			
Tolectin (Tolmetin)							
Prednisone, Medrol (Steroid pills)							
Gold (pills or injections)							
ARTHRITIS MEDICINES				OSTEOPOROSIS MEDICINES			
Azulfidine (Sulfasalazine)				Fosamax (Alendronate)			
Plaquenil (Hydroxychlorquine)				Actonel (Risedronate)			
Methotrexate (Rheumatrex)				Boniva Oral IV			
Arava (Leflunomide)				Reclast (Aclasta)			
Imuran (Azathioprine)				Evista (Raloxifene)			
Cellcept / Myfortic				Premarin, Estrace, Ogen (Estrogen)			
Enbrel (Etanercept)				Miacalcin (Calcitonin Nasal Spray)			
Remicade (Infliximab)				Forteo (Parathyroid Hormone)			
Humira (Adalimumab)							
Kineret (Anakinra)							
Orencia (Abatacept)							
Rituxan (Rituximab)							
PAIN MEDICINES							
Narcotic Pain Relievers (Codeine, Vicodin, Darvocet, Percocet)							
Muscle Relaxants (Flexeril, Soma, Skelaxin, Zanaflex)							

Dates Reviewed

Physician's Signature
