ARTHRITIS SPECIALISTS, LTD.

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8201 Atlee Road, Suite B, Mechanicsville, Va 23116
804.730.5222 • Fax: 804.730.5225

Welcome to Arthritis Specialists LTD

Your appointment is with _____
on: _____@_____

PLEASE CALL OUR OFFICE TWO WORKING DAYS PRIOR TO YOUR SCHEDULED APPOINTMENT.

(CALL ON _____ BY 12:00 NOON)

IF WE DO NOT HEAR FROM YOU BY THE DATE SPECIFIED, YOUR APPOINTMENT WILL BE CANCELLED.

To help us with your consultation, it would be helpful if you would fill out the enclosed forms so that we may know more about your reasons for joining our practice, and to assist you with your care. Along with your paperwork, we ask that you bring in your insurance card, photo I.D., copay and referral (if applicable). Thank you and we look forward to meeting you.

PLEASE ARRIVE 30 MINUTES BEFORE YOUR APPOINMENT TIME

Arthritis Specialists LTD
8201 Atlee Road, Ste B
Mechanicsville, VA 23116
Phone (804) 730-5222
Fax (804) 559-8075

ENCLOSED ARE DIRECTIONS FOR YOUR USE

PLEASE FILL OUT FORMS (front and back) COMPLETELY BEFORE ARRIVING

DIRECTIONS TO ARTHRITIS SPECIALISTS, LTD. ATLEE OFFICE
8201 ATLEE ROAD, SUITE B
MECHANICSVILLE, VA 23116
804.730.5222 - FAX: 804.730.5225

DIRECTIONS FROM FREDERICKSBURG:
MERGE ONTO I-95 S TOWARD RICHMOND.
MERGE ONTO I-295 VIA EXIT NUMBER 84A
ON THE LEFT-TOWARDS ROCKY MOUNT NC.
TAKE THE VA-627 W/MEADOWBRIDGE RD EXIT - NUMBER 38-B
WHEN YOU COME TO YOUR THIRD (3) STOPLIGHT,
TAKE A RIGHT ONTO ATLEE RD, THEN MAKE YOUR FIRST LEFT
AND WE ARE THE L – SHAPED BRICK BUILDING ON THE RIGHT SIDE.

DIRECTIONS FROM RICHMOND/CHESTERFIELD
MERGE ONTO I-95 N TOWARD WASHINGTON/I-95N
MERGE ONTO I-295 S VIA EXIT 84A TOWARD I-64 E/NORFOLK/ROCKY MT NC
TAKE THE MEADOWBRIDGE RD EXIT, EXIT 38B, TOWARD VA-627W
WHEN YOU COME TO YOUR THIRD (3) STOPLIGHT,
TAKE A RIGHT ONTO ATLEE RD, THEN MAKE YOUR FIRST LEFT
AND WE ARE THE L – SHAPED BRICK BUILDING ON THE RIGHT SIDE

DIRECTIONS FROM SOUTH OF RICHMOND:
BEAR RIGHT ONTO 295 TOWARDS WILLIAMSBURG/VA BEACH
TAKE THE VA-627 W/MEADOWBRIDGE RD EXIT – NUMBER 38-B
WHEN YOU COME TO YOUR THIRD (3) STOPLIGHT,
TAKE A RIGHT ONTO ATLEE RD, THEN MAKE YOUR FIRST LEFT
AND WE ARE THE L – SHAPED BRICK BUILDING ON THE RIGHT SIDE

DIRECTIONS FROM CHARLOTTESVILLE: ENTRANCE IN THE REAR OF BUILDING
MERGE ONTO I-64 E TOWARD RICHMOND
MERGE ONTO I-295 S VIA EXIT NUMBER 177 TOWARD
WASHINGTON/NORFOLK
TAKE THE VA-627 W /MEADOWBRIDGE RD EXIT – NUMBER 38B
WHEN YOU COME TO YOUR THIRD (3) STOPLIGHT,
TAKE A RIGHT ONTO ATLEE RD, THEN MAKE YOUR FIRST LEFT
AND WE ARE THE L – SHAPED BRICK BUILDING ON THE RIGHT SIDE

DIRECTIONS FROM VA BEACH
MERGE ONTO I-64 WEST TOWARD RICHMOND
BEAR RIGHT ONTO I-295 N VIA EXIT NUMBER 200
TOWARD WASHINGTON
TAKE THE VA-627 W/ MEADOWBRIDGE RD EXIT – NUMBER 38B
WHEN YOU COME TO YOUR THIRD (3) STOPLIGHT,
TAKE A RIGHT ONTO ATLEE RD, THEN MAKE YOUR FIRST LEFT
AND WE ARE THE L – SHAPED BRICK BUILDING ON THE RIGHT SIDE

ARTHRITIS SPECIALISTS, LTD.

Patient Registration

FULL NAME					S.S. NUMBER
ADDRESS				CITY	STATE AND ZIP
BIRTH DATE	AGE	SEX	MARITAL STATUS	PRIMARY PHONE	SECONDARY PHONE
LANGUAGE		RACE		ETHNIC GROUP	

EMPLOYER	OCCUPATION
ADDRESS	BUSINESS PHONE

EMERGENCY CONTACT	PHONE
ADDRESS (IF DIFFERENT FROM ABOVE)	

FAMILY PHYSICIAN (IF ANY)	LOCATION	PHONE
REFERRING PHYSICIAN (IF ANY)	LOCATION	PHONE

Insurance Information (Name of Insurance Companies)

PRIMARY	SECONDARY	TERTIARY

PATIENT AUTHORIZATION

I hereby authorize the release of medical information to my physician(s) or my insurance company.
In order to help us provide you with the best services possible, we have adopted the following billing policy:

I understand that I am responsible for payment of my bill in full, regardless of what my insurance pays.

In the event that the responsible party defaults on payment to this office for professional services rendered within the preceding 60 days, the responsible party agrees to pay to Arthritis Specialists, Ltd. expenses incurred in effecting collection of this account, including attorney's fees equal to 33 1/3% of the balance due, as well as applicable court costs. These sums are expressly recognized to be in addition to the balance on the account at the time it is placed for collection.

Arthritis Specialists, Ltd. requires at least 24 hours notice for all appointment cancellations. If you are unable to provide 24 hours notice, you will be billed a $50.00 charge for your scheduled appointment time.

I request that the physicians and staff of Arthritis Specialists, Ltd. have any and all access to my electronic medical records for the purpose of providing me medical care.

I give my permission for physicians and staff of Arthritis Specialists, Ltd. to leave voice mails on my home phone or work phone.

By supplying my home phone number, mobile phone number, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s) to notify me of pending appointments.

Patient agrees that the physicians of Arthritis Specialists, Ltd. are specialists in Rheumatology and are not in any way practicing as *Primary Care Physicians or General Internal Medicine Physicians* for the patient. Furthermore, patient represents that he or she has a *Primary Care Physician* who serves him or her for general medical problems, both routine and emergency in nature.

Your signature below attests to your understanding and willingness to comply with the above policy. Thank you for your cooperation.
In the event one of Arthritis Specialists, Ltd.'s employees is exposed to your blood or body fluids, you consent to have your blood drawn to test for blood borne pathogens.

Signature:_____Date_____

LIFETIME FORM

Beneficiary Name:_____ Health Insurance #: _____

I request that payment under the Medicare Insurance Program be made either to me or on my behalf to Arthritis Specialists, Ltd. for any services furnished by that physician/provider.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services.

Beneficiary Signature:_____ Date_____

Arthritis Specialists, Ltd.

Name_____ **Date**_____**DOB**_____

Reason for Visit:_____

_____

Past Medical History __ *No Known Medical History*

__Anxiety	__Arthritis	__Asthma
__Back Pain	__Cancer	__Chronic Renal Insufficiency
__Clots in Legs	__Clots in Lungs	__Congestive Heart Failure
__COPD	__Crohn's Disease	__Depression
__Diabetes (Type I)	__Diabetes (Type II)	__Fibromyalgia
__Gout	__Glaucoma	__Heart Attack
__Heart Disease	__Heart Disease – Angina	__Hepatitis
__High Cholesterol	__Hypertension	__Intestinal Bleeding
__Kidney Stones	__Lupus	__Migraine Headache
__Osteoarthritis	__ Osteopenia	__Osteoporosis
__Peptic Ulcer Disease	__Prostate Trouble	__Reflux Heart Burn
__Rheumatoid Arthritis	__Seizures	__Sjogren's
__Strep Throat (Recent)	__Tension Headache	__Ulcerative Colitis
__Underactive Thyroid	__Urinary Tract Infection	
Other:(not listed above)_____ _____		

Surgical History/Operations (Please include date if possible) __ *No Known Surgical History*

_____
_____
_____
_____
_____
_____
_____

Current Medications, Dosage and Frequency __ *No Known Medication*

Medication	*Dosage*	*Frequency*

Vitamins

_____

Allergies to Medications (Please include reaction if possible) __ ***No Known Drug Allergies***

_____

_____

_____

_____

_____

_____

_____

Social History

( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed

Employment – Occupation_____

Current Smoking Status: __Never Smoked __Smoke Every day __Smoke Some Days

__ Former Smoker (Packs per day____) How long have/did you smoked? _____Age Started_____

Do you drink caffeinated beverages? ( ) No ( ) Yes Number per day? _____

Do you drink alcohol? ( ) No ( ) Yes Number per week? _____

Have you done any illicit drugs? ( ) No ( ) Yes

Family History (Please include relation if possible) __ ***No Known Family History***

__Ankylosing Spondylitis (_____)	__Arthritis (_____)	__Asthma (_____)	__Cancer (_____)
__Crohn's Disease (_____)	__Diabetes (_____)	__Epilepsy/Seizure (_____)	__Gout (_____)
__Heart Disease (_____)	__High Blood Pressure (_____)	__Kidney Disease (_____)	__Lupus or SLE (_____)
__Mental Illness (_____)	__Osteoarthritis (_____)	__Osteoporosis (_____)	__Psoriasis (_____)
__Psoriatic Arthritis (_____)	__Rheumatoid Arthritis (_____)	__Stroke (_____)	__Tuberculosis (_____)
__Ulcerative Colitis (_____)	Other:_____		

Review of Organ Systems: please mark the symptoms that you have on a regular basis.

Constitutional

- ☐ Recent weight gain, amount_____
- ☐ Recent weight loss, amount_____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Night Sweats
- ☐ Hours of sleep per night
- ☐ Chills

Head and Neck

- ☐ Dry mouth
- ☐ Dry eyes
- ☐ Blurred vision
- ☐ Loss of vision
- ☐ Mouth ulcers
- ☐ Pain or redness of the eyes
- ☐ Tender Scalp
- ☐ Jaw pain while chewing food

Pulmonary

- ☐ Cough
- ☐ Wheeze
- ☐ Sputum production
- ☐ Shortness of breath
- ☐ Chest pain with deep breathing
- ☐ Coughing up blood

Cardiovascular

- ☐ Raynaud's
- ☐ Fingers White, Purple, Blue in cold
- ☐ Short of breath when lying flat
- ☐ Heart Pounding
- ☐ Chest pain/angina
- ☐ Swollen legs or feet
- ☐ Wake at Night to Sit Up and Catch breath
- ☐ Edema

Gastrointestinal

- ☐ Heartburn
- ☐ Trouble swallowing
- ☐ Nausea
- ☐ Blood
- ☐ Mucus
- ☐ Stomach Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Black/tarry stools
- ☐ Hepatitis
- ☐ Yellow Skin/eyes

Genitourinary

- ☐ Burning while urinating
- ☐ Urinating Frequently
- ☐ Kidney stones
- ☐ Blood in urine
- ☐ Night time urination
- ☐ Prostate trouble
- ☐ Flank pain

Musculoskeletal

- ☐ Morning stiffness
- ☐ How long does the stiffness last?_____
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Neck pain
- ☐ Back pain
- ☐ Muscle pain or tenderness
- ☐ Muscle nodules
- ☐ Deformities of the joint

Hematologic/Lymphatic

- ☐ Swollen glands
- ☐ Clots in Lungs or Legs
- ☐ Anemia
- ☐ Excess Bleeding

Skin

- ☐ Rash
- ☐ Psoriasis
- ☐ Tightness of the skin
- ☐ Nodules
- ☐ Sensitivity to sunlight
- ☐ Easy bruising
- ☐ Nail changes or pits
- ☐ Loss of hair all over or spots
- ☐ Facial rash

Neurological

- ☐ Epilepsy/seizures
- ☐ Muscle weakness
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle cramps
- ☐ Loss of coordination
- ☐ Fainting Spells
- ☐ Numbness/tingling

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Suicidal thoughts

Routine Assessment of Patient Index Data

The RAPID3 includes a subset of core variables found in the Multi-dimensional HAQ (MD-HAQ). Page 1 of the MD-HAQ, shown here, includes an assessment of physical function (section 1), a patient global assessment (PGA) for pain (section 2), and a PGA for global health (section 3). RAPID3 scores are quickly tallied by adding subsets of the MD-HAQ as follows:

1. Please Check the ONE Best Answer for your Abilities At This Time:

OVER THE LAST WEEK, were you able to:	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE to do
a. Dress yourself, including tying shoelaces and doing buttons?	____0	____1	____2	____3
b. Get in and out of Bed?	____0	____1	____2	____3
c. Lift a full cup or glass to your mouth?	____0	____1	____2	____3
d. Walk outdoors on flat ground?	____0	____1	____2	____3
e. Wash and dry your entire body?	____0	____1	____2	____3
f. Bend down to pick up clothing from the floor?	____0	____1	____2	____3
g. Turn regular faucets on and off?	____0	____1	____2	____3
h. Get in and out of a car, buss, train, or airplane?	____0	____1	____2	____3
i. Walk two miles or three kilometers, if you wish?	____0	____1	____2	____3
j. Participate in recreational activities and sport as you would like, if you wish?	____0	____1	____2	____3
k. Get a good night's sleep?	____0	____1.1	____2.2	____3.3
l. Deal with feelings of anxiety or being nervous?	____0	____1.1	____2.2	____3.3
m. Deal with feelings of depression or feeling blue?	____0	____1.1	____2.2	____3.3

1. a-j FN (0-10):

1=0.3	16=5.3
2=0.7	17=5.7
3=1.0	18=6.0
4=1.3	19=6.3
5=1.7	20=6.7
6=2.0	21=7.0
7=2.3	22=7.3
8=2.7	23=7.7
9=3.0	24=8.0
10=3.3	25=8.3
11=3.7	26=8.7
12=4.0	27=9.0
13=4.3	28=9.3
14=4.7	29=9.7
15=5.0	30=10

2. PN (0-10):

3. PTGE (0-10):

RAPID3 (0-30):

2. How Much Pain Have You Had Because of Your Condition OVER THE PAST WEEK? Please Indicate Below How Sever Your Pain Has Been:

No Pain — Pain as Bad as it Could Be

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

3. Considering All the Ways in Which Illness and Health Conditions May Affect You At This Time, Please Indicate Below How You Are Doing:

Very Well — Very Poorly

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

CONVERSION TABLE

Near Remission (NR): 1=0; 2=0.7; 3=1.0

Low Severity (LS): 4=1.3; 5=1.7; 6=2.0

Moderate Severity (MS): 7=2.3; 8=2.7; 9=3.0; 10=3.3; 11=3.7; 12=4.0

High Severity (HS): 13=4.3; 14=4.7; 15=5.0; 16=5.3; 17=5.7; 18=6.0; 19=6.3; 20=6.7; 21=7.0; 22=7.3; 23=7.7; 24=8.0; 25=8.3; 26=8.7; 27=9.0; 28=9.3; 29=9.7; 30=10.0

HOW TO CALCULATE RAPID 3 SCORES

1. Ask the patient to complete questions 1, 2, and 3 while in the waiting room prior to his/her visit.
2. For question 1, add up the scores in questions A-J only (question K-M have been found to be informative, but are not scored formally). Use the formula in the box on the right to calculate the formal score (0-10). For example, a patient whose answers total 19 would score a 6.3. Enter this score as an evaluation of the patient's functional status (FN).
3. For question 2, enter the raw score (0-10) in the box on the right as an evaluation of the patient's pain tolerance (PN).
4. For question 3, enter the raw score (0-10) in the box on the right as an evaluation of the patient's global estimate (PTGE).
5. Add the total score (0-30) from questions 1, 2, and 3 and enter them as the patient's RAPID 3 cumulative score. Use the final conversion table to simplify the patient's weighed RAPID 3 score. For example, a patient who scores 11 on the cumulative RAPID 3 scale would score a weighed 3.7. A patient who scores between 0-1.0 is defined as near remission (NR); 1.3-2.0 as low severity (LS); 2.3-4.0 as moderate severity (MS); and 4.3-10.0 as high severity (HS).

Please list all of your physicians that you are authorizing us to release medical information/records to:

Physicians Name	Specialty

Pharmacy Name	Address and phone number

Patient Signature: _____ Date: _____

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804.730.5222 • Fax 804.730.5225

Dear Patient,

The appointment that you have made with our physician is a one hour consultation that has been set aside for you and you only.

At this time the physician will take an extended history from you and perform an extensive exam and evaluation.

If for some reason you cannot keep this appointment, you must call our office two business days in advance to cancel or reschedule. In not doing so, we will not be able to schedule another appointment for you until we have a $200.00 deposit to hold your appointment. After receiving your deposit, our office will call you and schedule the next available appointment.

We will refund this money back to you if you keep your appointment and gladly file any insurance that is applicable. If you do not keep your second appointment, the deposit is non-refundable.

Sincerely,

The Physicians & Staff of Arthritis Specialists, Ltd.

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Dear Patient,

We are giving you our portal log in information so that you will be able to view and print your recent office visits along with labs and x-ray reports from home.

We are requesting that all patients use our portal to obtain their labs and x-ray results. If you have abnormal labs or x-rays; you will get a call from us promptly.

We encourage you to obtain your labs or x-rays from the portal and we will discuss your results at your next office visit.

We appreciate your cooperation

Sincerely,

The Physicians of Arthritis Specialists, Ltd.

Policy and Procedures for Arthritis Specialists, Ltd.

Patient Portal Use and Consent Form

The Patient Portal is a web-based system that serves as a secure, encrypted communication link between you and Arthritis Specialists, Ltd. When you log in to the Portal with your private user name and password, you can see information that is pulled from your electronic medical record and displayed on the web page. The Patient Portal is an optional service, and we reserve the right to suspend or terminate it at any time; we will alert you to any changes as promptly as possible.

This form is intended to give you the facts and risks surrounding the use of the web portal. By signing this document, you confirm that you have read, understand, and agree to comply with our procedures and guidelines for using the Patient Portal. You also agree not to hold Arthritis Specialists, Ltd or any of their staff liable for network infractions beyond their control.

The Patient Portal has a secure tunnel connection with our office that uses encryption to keep unauthorized persons from being able to access and read your health information or your communications with us. To help insure that the tunnel remains secure, we need to have your current (private) email address and be informed if it ever changes. Keep your Portal User ID and password secure so only you can gain access to patient information. If you think someone has learned your password, immediately go to the portal site and change it. We will protect your email address as we do your medical and other personal information.

TO REQUEST ACCESS TO THE PATIENT PORTAL:

1. Read and Sign the Consent at the end of this document.
2. Once we receive this consent, we can authorize you as a user and you will receive a welcome email with your login and a temporary password. We do NOT keep record of this information.
   The email from the sender will show as "noreply@benchmarksystems.com" and the subject will read: Arthritis Specialists Patient Portal Login Access
3. The welcome email attachment will contain a link to get to our website.

   http://www.arthspec.com

- ✓ **Current functionality of Patient Portal for viewing and printing purposes**:
  (You may print by right clicking in the document area and selecting print function)
  - View Lab results
  - View Progress notes
  - View your Health Record
  - View Radiology results
  - Other functions are in development to allow easier access

- ✓ Because your login is tied directly to your Electronic Health Records in our office, you do not need to enter information such as phone numbers, addresses. If they are new or different than what you have given us before, please notify our staff when you check in at your next visit of these changes/updates.

- ✓ **Privacy:**
  - We will keep all email lists confidential and will not share this with other parties at any time.

- ✓ **Response Time:**
  - After you agree to the "Policy and Procedures" and sign this informed consent, we will attempt to send a "welcome message" to you. This will provide instructions on how to log in (it is free for you to use), and a link in the attachment will take you to our website.

To Accept:

Confidential email address, **please print clearly**: _____

Patient Name: _____ Date of Birth: _____
(Each patient must have their own form)

Signature: _____ Date: _____
