# ARTHRITIS SPECIALISTS, LTD.

**Peter Coutlakis, M.D.**
**Lucia S. Morey, M.D.**
**Keith P.R. Burwell, D.O.**
1401 Johnston Willis Dr., Suite 1200, North Chesterfield, Va 23235
804.323.1401 • Fax: 804.323.1878

**James P. Brodeur, M.D., F.A.C.P.**
**Lindsay S. Holtz, M.D.**
8201 Atlee Road, Suite B, Mechanicsville, Va 23116
804.730.5222 • Fax: 804.730.5225

Dear _____:

You have an appointment scheduled with Dr._____

on _____ at _____. **Please arrive at_____**

**so we may complete your registration in time for the visit. It is very important that you confirm this appointment two business days before the scheduled appointment by dialing our office at 804-323-1401 option 1. Call on _____by 12:00 noon, failure to do so will result in the cancellation of this appointment. If we are unable to contact you, your appointment will be automatically cancelled and filled with another patient.**

**We have enclosed paperwork that must be completed ahead of time and brought with you to the appointment along with your insurance cards, a picture identification card or driver's license, and copay if applicable.** The appointment will last at least an hour as the doctor will obtain a medical history and a physical exam.

**If your insurance plan changes from when you originally made this appointment, please notify us to make sure we accept the new insurance plan.** Please remember that if your insurance requires a referral then it is the patient's responsibility to make sure that we receive the referral by the time of the visit or you may be asked to reschedule. Please note that if you are a Medicare patient, you must fill out the section titled "Lifetime Form" with your name as the beneficiary, with your signature and the date.

**We also ask that you have all of your doctors' offices send a copy of all lab, office visit notes, and radiology results from the past year to fax number 804-323-5016 as soon as possible. We do not need any radiology films or discs, just the written report.**

Our office is located in the Atrium wing of Johnston Willis Hospital on the first floor in Suite 1200.

**If you need to call the office the morning of your appointment due to illness, needing directions or are running late and you are calling before 8:30am, please call 804-323-1401 extension 302.**

Arthritis Specialists, Ltd.

**You may now go visit our website at: www.arthspec.com**

# Directions to Arthritis Specialists, Ltd. Johnston Willis Office

## From Goochland and points West:

Travel east on I-64
Take 288 South
Cross the James River and exit onto Midlothian Turnpike East
Travel on Midlothian Turnpike to Johnston Willis Drive
Turn left onto Johnston Willis Drive
Follow the signs to the Atrium which is to the right of the Emergency Room
Our office is located on the 1st floor of the Atrium, Suite 1200 beside the information desk

## From the West End: (Follow directions below or use 288 directions above)

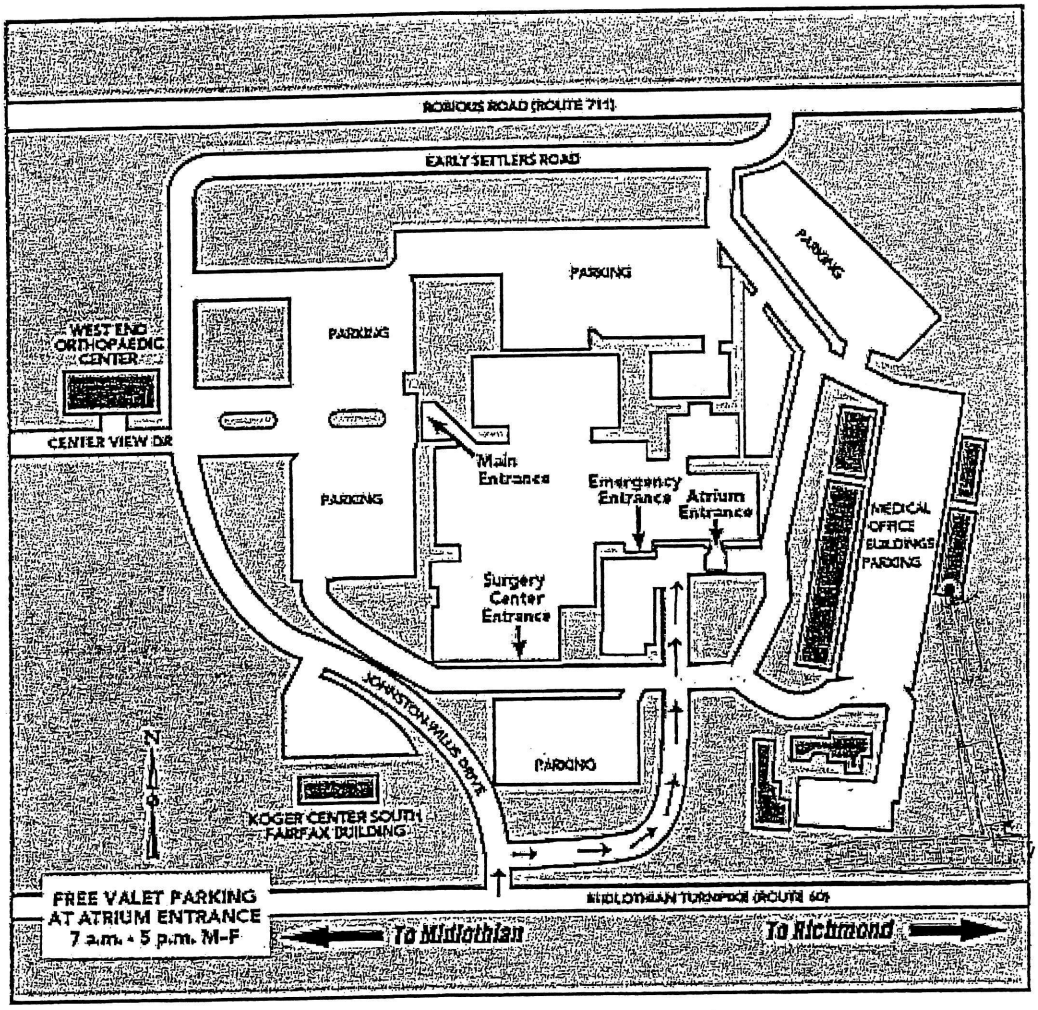
Travel South on Parham Road
Cross the Willey Bridge, Parham Road then becomes Chippenham Parkway
Take Huguenot Road exit and turn right
Travel down Huguenot Road to Midlothian Turnpike
Turn left on Midlothian Turnpike
Turn left on Johnston Willis Drive
Follow the signs to the Atrium which is to the right of the Emergency Room
Our office is located on the 1st floor of the Atrium, Suite 1200 beside the information desk

## From North side and the Fan:

Travel South on I-95 and follow signs to Powhite Parkway South
Travel across the James River and through the toll plaza
Exit onto Midlothian Turnpike West towards Midlothian
Travel about 3 miles and turn right onto Johnston Willis Drive
Follow the signs to the Atrium which is to the right of the Emergency Room
Our office is located on the 1st floor of the Atrium, Suite 1200 beside the information desk

## From the South:

Travel North on I-95
Exit on Chippenham Parkway North
Travel on Chippenham North to Midlothian Turnpike
Exit on Midlothian Turnpike West
Travel about 4 miles and turn right onto Johnston Willis Drive
Follow the signs to the Atrium which is to the right of the Emergency Room
Our office is located on the 1st floor of the Atrium, Suite 1200 beside the information desk




**Our office is located in the Atrium wing of the Johnston Willis Hospital on the first floor in Suite 1200.**

# 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* |
|---|---|---|
| | | |
| | | |
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| | | |
| | | |

**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 <u>relation</u> 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 Systems** (please mark the symptoms that you have on a regular basis)

**Constitutional Symptoms**

__Recent Weight Gain

Amount (lbs.) _____

__Recent Weight Loss

Amount (lbs.) _____

__Fatigue

__Weakness

__Night Sweats

__Fever

Hours of Sleep Per Night_____

__Chills

**Musculoskeletal**

__Morning Stiffness

How long_____

__Joint Pain

__ Joint Swelling

__Neck Pain

__Back Pain

__ Muscle Pain or Tenderness

__Muscle Nodules

__Deformities of the Joints

Other_____

**HEENT**

__Dry Mouth/Dry Eyes

__Blurred Vision

__Loss of Vision

__Mouth Ulcers

__Pain or Redness of the Eyes

__Tender Scalp

__Jaw Pain while Chewing Food

**Hematologic/Lymphatic**

__Swollen Glands

__Clots in Lungs or Legs

__Anemia

__Excess Bleeding

**Skin**

__Rash

__Psoriasis

__Tightening of the Skin

__Nodules

__Sensitivity to Sunlight

__Easy Bruising

__Nail Changes or Pits

__Loss of Hair All Over or Spots

__Facial Rash

**Pulmonary**

__Coughing

__Wheezing

__Sputum Production

__Shortness of Breath

__Chest Pain with Deep Breath

__Coughing Up Blood

**Cardiovascular**

__Raynaud's

__Fingers White, Purple, Blue in Cold

__Shortness of Breath while Lying Flat

__Heart Pounding

__Chest pain/Angina

__Heart Murmurs

__Swollen Legs or Feet

__Wake at Night to Sit Up and Catch Breath

**Gastrointestinal**

__Heartburn

__Trouble Swallowing

__Nausea

__Stomach Pain

__Diarrhea

__Constipation

__Blood in Stool

__Black/Tarry Stools

__Hepatitis

__Yellow Skin/Eyes

**Neurological System**

__Epilepsy/Seizures

__Muscle Weakness

__Headaches

__Dizziness

__Fainting

__Muscle Spasms

__Loss of Coordination

__Fainting Spells

__Numbness/Tingling Arms/Legs

**Psychiatric**

__Anxiety

__Depression

__Suicidal Thoughts

**Genitourinary**

__Burning while Urinating

__Urinating Frequently

__Kidney Stones

__Blood in Urine

__Night time Urination

__Prostate Troubles

__Miscarriages (Number:___)

__Flank Pain

Patient Signature:_____Date:_____

Physician Signature:_____Date Reviewed:_____

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

| Physicians Name | Specialty |
|---|---|
| | |
| | |
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| | |

| Pharmacy Name | Address and phone number |
|---|---|
| | |
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| | |

Patient Signature: _____ Date: _____

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**Lindsay S. Hollz, M.D.**
8201 Atlee Road, Suite B, Mechanicsville, Va 23116
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 (cash or check) 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.

# ARTHRITIS SPECIALISTS, LTD.

**Peter Coutlakis, M.D.**
**E. Forrest Jessee, Jr., M.D., F.A.C.R.**
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804.730.5222 • Fax: 804.730.5225

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.

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To Accept:

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

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

Signature: _____ Date: _____

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