DIRECTIONS to Albuquerque Center for Rheumatology

1617 University Blvd. NE.

From I-40 Going East

Exit 4th Street

Follow Frontage Rd. to University Blvd.

Turn Right on University – Clinic will be on the Right up the hill

From I-40 Going West

Exit University Blvd.

Turn Left on University Blvd under I-40

Clinic will be on the Right up the hill

From I-25 Going South

Exit 277 (Comanche, Candelaria, Menaul)

Turn Left at Menaul and then Right on University Blvd.

Clinic will be on the Right up the hill

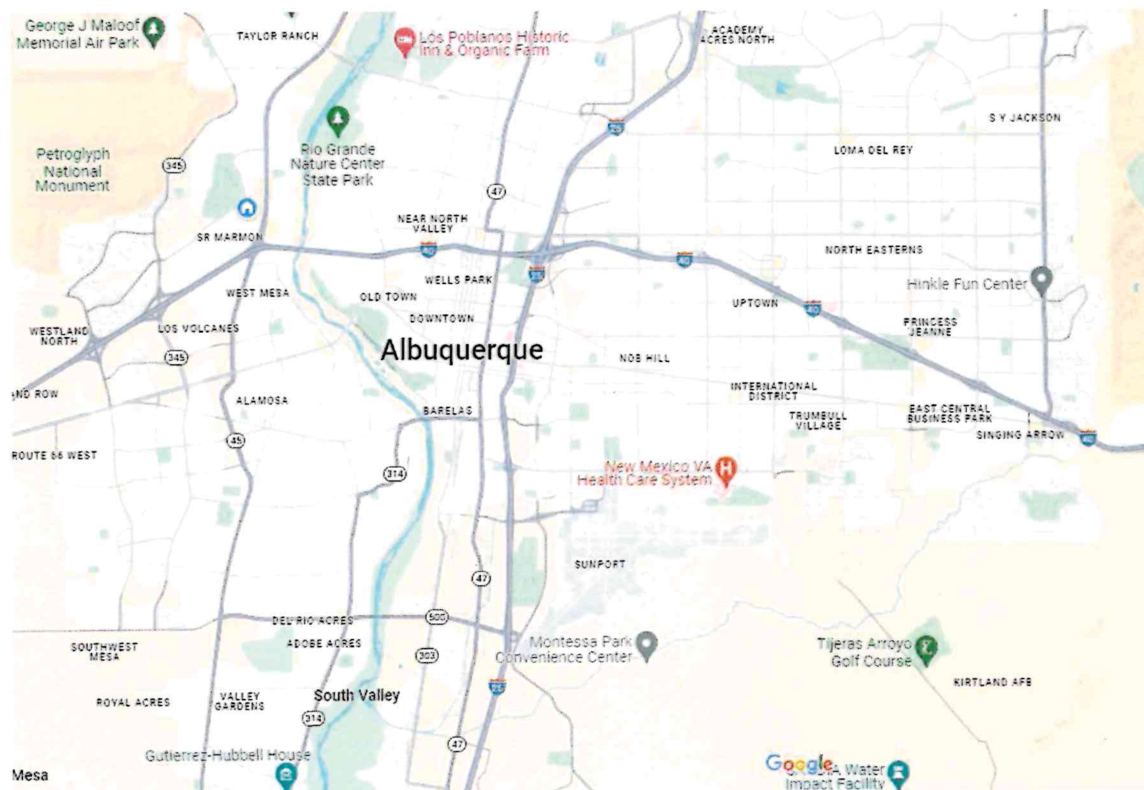
From I-25 Going North

Exit Lomas

Turn Right on Lomas go East to University Blvd.

Turn Left on University Blvd.

Pass the stoplight at Indian School and Clinic will be on the Left



ALBUQUERQUE
CENTER for
RHEUMATOLOGY

Notice of Privacy Practices

Notice Effective: April 2003
Revised: 2009, 9/2013 and 12/2023
The Privacy Officer, 1617 University Blvd NE, Albuquerque, NM 87102, 505-341-4148

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may, our Business Associates and their subcontractors, use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations – or for any other purposes that are permitted by law. It also describes your rights and our legal obligations with respect to your PHI. If you have any questions about this Notice, please contact our Privacy Officer listed above.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Treatment: We use medical information about you to provide, coordinate and manage your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to authorized persons or family who can help you when you are sick or injured, or after you die.

Payment: We use and disclose medical information about you to obtain payment for the services we provide. For example, we may submit information to your health plan for you if required for payment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you or for coordination of care.

Healthcare Operations: We may use and disclose medical information about you to operate this medical practice. These activities may include, but are not limited to quality assessment of the care we provide, employee review, obtaining health plan authorizations or referrals, information necessary for medical reviews, legal services and audits - including fraud and abuse detection, compliance programs, business planning and management, other health care providers, health care clearinghouses or health plans that have a relationship with you, quality improvement processes and their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, training of medical/healthcare students, licensing, or health care fraud and

abuse detection and compliance efforts. We may use a sign-in sheet at the registration desk. We may call you by name in the waiting room when it is time for your appointment, we may use your PHI to contact you to remind you of your appointment, inform you about treatment alternatives or other health-related benefits. If we use or disclose your PHI for fundraising activities, we will provide you with the choice to opt out of those activities. You may also choose to opt back in.

We may also share your medical information with our "business associates," such as billing and technology. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information.

Breach Notification: In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification.

We may use and disclose your PHI in other situations without your authorization. These situations include as required by law, public health issues as required by law, communicable diseases, health oversight for audits, investigations and inspection, legal proceedings, abuse and neglect, law enforcement, coroners, organ/tissue donation, research, criminal activity, military activity and national security, workers' compensation and other required uses and disclosures.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

YOUR HEALTH INFORMATION RIGHTS

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. Send a letter stating the information you would like to obtain to the following: The Privacy Officer, 1617 University Blvd NE, Albuquerque, NM 87102.

Right to Request Special Privacy Protections You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request and will notify you of our decision.

Right to Request Confidential Communication You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

Right to Inspect and Copy You have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was

obtained under a promise of confidentiality. If you request a copy of your information, you may be charged a reasonable fee for the costs of copying, mailing or other supplies or services associated with your request.

Right to Amend or Supplement PHI You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend it in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information, if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

Right to an Accounting of Disclosures You have the right to receive a list of disclosures pursuant to your written authorization, of your PHI that have been made on or after April 14, 2003 (September 1, 2011, in the case of disclosures of your PHI from electronic health records) over a period of up to six years prior to the date of your request. Certain disclosures are not required to be included in such accounting of disclosures, including but not limited to disclosures made for treatment, payment, or health care operations. If you request more than one accounting within a 12-month period, we will charge a reasonable, cost-based fee for each subsequent accounting.

Right to a Paper or Electronic Copy of this Notice You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously agreed to receive this Notice electronically.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such an amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the way this office handles a complaint, you may submit a formal complaint to the United States Secretary of Health and Human Services. You will not be penalized or in any other way retaliated against for filing a complaint with this office of the Office for Civil Rights.

Please sign the accompanying "Acknowledgment" form. Note that by signing the Acknowledgment form you are only acknowledging that you have received or have been given the opportunity to receive a copy of our Notice of Privacy Practices.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of your protected health information or (PHI) not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide ACR permission to use or disclose health information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for any reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and are required to retain records of the care that we provide to you.

ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE

We request that you sign that you have received the Notice of Privacy Practices. If you choose, or are not able to sign, a staff member will sign on your behalf and add their name and the date. This acknowledgement will be filed and kept with your records.

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I, ______________________________, have received the Notice of Privacy Practices for Albuquerque Center for Rheumatology, LLC, (ACR).

X____ **Date**____________________________

In lieu of a patient signature, a staff member of ACR states that the patient has been given a current copy of the Notice of Privacy Practices.

X____ **Date**______________________________

PATIENT INFORMATION SHEET

(PLEASE PRINT)

Demographics

Name ______________________________

Address ______________________________

City ____________ State ____________ Zip ____________

Phone ____________ Alternate Phone ____________

Date of birth ____________ Male ______ Female ______

Social Security Number ____-____-____ Email Address ____________

Employer ____________ Phone ____________

Married ______ Single ______ Widowed ______ Divorced ______

Spouse Name ____________ Spouse DOB ____________ Spouse Social Security # ____________

Insurance Information

Primary Insurance Company ______________________________

Member Identification Number ____________ Group Number ____________

Insured Name ____________ Date of Birth ____________

Relationship: Self__ Spouse__ Child __Other__

Secondary Insurance Company ______________________________

Member ____________ Group ____________

Insured's name: ____________ Date of Birth: ____________

Relationship: Self ___Spouse__ Child ___Other____

Appointments

If you are a **NEW** patient, **please arrive 30 minutes prior** to your scheduled appointment.
If you are an **established patient, please arrive 15 minutes prior** to your scheduled appointment.
If you are more than 10 minutes late, for any reason, you may have to reschedule your appointment.

Office Hours

Monday – Thursday (7:30AM - 4:30PM) and Friday (CLOSED).
After hours, the doctor on call may be reached by calling (505) 857-3865.

Payment Policies

You are financially responsible for anything insurance does not cover. All copays are due and payable at each visit. The amount your insurance will allow and pay for, and your financial responsibility is determined by your insurance company and the policy you have chosen. Your claim will be processed according to the benefits of your insurance plan. The deductible, co-insurance and co-pays are your financial responsibilities. It is your responsibility to understand your insurance plan.

- **$5 Fee for Co-pays not paid at the time of service.**
- **$35 NSF charge for any returned check from the bank.**
- **If you are a patient without insurance, all charges are due at the time of the visit. We do not send statements to uninsured patients.**

Patient Signature ______________________ Date ______________________

Prescription Policy

There is 72 hours turnaround time for prescription refills. Please do not wait until your last pill to call for a refill. If you have not seen a Physician in 6 months, the prescription will be denied, and you will need to make an appointment.

Pharmacy Name ______________________ Pharmacy Phone Number ______________________

Emergency Contact

In the case of an emergency, you would like for us to contact the following person:

Name ______________________ Phone Number ______________________ Relationship ______________________

Patient signature ______________________ Date ______________________

Secondary Name ______________________ Phone Number ______________________ Relationship ______________________

Patient signature ______________________ Date ______________________

Primary Care Physician

Name ______________________ Phone Number ______________________ Fax Number ______________________

Address ______________________ City ______________________ State ______________________ Zip Code ______________________

Referring Physician (if different from the referring physician) ______________________

AMERICAN COLLEGE of RHEUMATOLOGY
Empowering Rheumatology Professionals

Patient History Form

Date of first appointment: ______/______/______ (MONTH DAY YEAR) Time of appointment: ____________ Birthplace: ____________

Name: ________________________________ (LAST FIRST MIDDLE INITIAL MAIDEN) Birthdate: ______/______/______ (MONTH DAY YEAR)

Address: ________________________________ (STREET APT#) Age ____________ Sex: ☐ F ☐ M

________________________________ (CITY STATE ZIP) Telephone: Home: (   ) ____________ Work: (   ) ____________

MARITAL STATUS: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse/Significant Other: ☐ Alive/Age ________ ☐ Deceased/Age ________ Major Illnesses: ____________

EDUCATION *(circle highest level attended):*

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School ____________

Occupation ____________ Number of hours worked/Average per work: ____________

Referred here by: *(check one)* ☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Other Health Professional

Name of person making referral: ____________

The name of the physician providing your primary medical care: ____________

Describe briefly your present symptoms: ____________

____

____

____

____

Date symptoms began *(approximate)*: ____________

Diagnosis: ____________

Previous treatment for this problem *(include physical therapy, surgery and injections; medications to be listed later)*:

____

____

____

Please list the names of other practitioners you have seen for this problem:

____

____

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands.**

Example:

LEFT RIGHT LEFT

LEFT RIGHT

Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9): 1797-808. Used by permission.

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? *(check if "yes")*

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood Arthritis			Osteoporosis	

Other arthritis conditions: ____________

Patient's Name: ____________ Date: ____________ Physician Initials: ____________

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SYSTEMS REVIEW

As you review the following list, please check any problems, which have significantly affected you:

Date of last mammogram: ____/____/____ Date of last eye exam: ____/____/____ Date of last chest x-ray: ____/____/____

Date of last Tuberculosis Test ____/____/____ Date of last bone densitometry ____/____/____

Constitutional
- ☐ Recent weight gain amount ______________
- ☐ Recent weight loss amount ______________
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever

Eyes
- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye
- ☐ Itching eyes

Ears-Nose-Mouth-Throat
- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Dryness in nose
- ☐ Runny nose
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness of mouth
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty swallowing

Cardiovascular
- ☐ Chest Pain
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat
- ☐ High blood pressure
- ☐ Heart murmurs

Respiratory
- ☐ Shortness of breath
- ☐ Difficulty breathing at night
- ☐ Swollen legs or feet
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing (asthma)

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting of blood or coffee ground material
- ☐ Stomach pain relieved by food or milk
- ☐ Jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools
- ☐ Heartburn

Genitourinary
- ☐ Difficult urination
- ☐ Pain or burning on urination
- ☐ Blood in urine
- ☐ Cloudy, "smoky" urine
- ☐ Pus in urine
- ☐ Discharge from penis/vagina
- ☐ Getting up at night to pass urine
- ☐ Vaginal dryness
- ☐ Rash/ulcers
- ☐ Sexual difficulties
- ☐ Prostate trouble

For Women Only:

Age when periods began: ______________

Periods regular? ☐ Yes ☐ No

How many days apart? ______________

Date of last period? ____/____/____

Date of last pap? ____/____/____

Bleeding after menopause? ☐ Yes ☐ No

Number of pregnancies? ______________

Number of miscarriages? ______________

Musculoskeletal
- ☐ Morning stiffness
  Lasting how long?
  ________ Minutes ________ Hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint swelling
  List joints affected in the last 6 mos.

____

____

____

____

____

Integumentary (skin and/or breast)
- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive (sun allergy)
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet in the cold

Neurological System
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle spasm
- ☐ Loss of consciousness
- ☐ Sensitivity or pain of hands and/or feet
- ☐ Memory loss
- ☐ Night sweats

Psychiatric
- ☐ Excessive worries
- ☐ Anxiety
- ☐ Easily losing temper
- ☐ Depression
- ☐ Agitation
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

Endocrine
- ☐ Excessive thirst

Hematologic/Lymphatic
- ☐ Swollen glands
- ☐ Tender glands
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Transfusion/when______________

Allergic/Immunologic
- ☐ Frequent sneezing
- ☐ Increased susceptibility to infection

Patient's Name: ______________________ Date: ______________ Physician Initials: __________

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SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day? ____________

Do you smoke? ☐ Yes ☐ No ☐ Past – How long ago? ____________

Do you drink alcohol? ☐ Yes ☐ No Number per week ____________

Has anyone ever told you to cut down on your drinking?

☐ Yes ☐ No

Do you use drugs for reasons that are not medical? ☐ Yes ☐ No

If yes, please list: ____________

Do you exercise regularly? ☐ Yes ☐ No

Type ____________

Amount per week ____________

How many hours of sleep do you get at night? ____________

Do you get enough sleep at night? ☐ Yes ☐ No

Do you wake up feeling rested? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Do you now have or have you ever had: *(check if "yes)*

☐ Cancer	☐ Heart problems	☐ Asthma
☐ Goiter	☐ Leukemia	☐ Stroke
☐ Cataracts	☐ Diabetes	☐ Epilepsy
☐ Nervous breakdown	☐ Stomach ulcers	☐ Rheumatic fever
☐ Bad headaches	☐ Jaundice	☐ Colitis
☐ Kidney disease	☐ Pneumonia	☐ Psoriasis
☐ Anemia	☐ HIV/AIDS	☐ High Blood Pressure
☐ Emphysema	☐ Glaucoma	☐ Tuberculosis

Other significant illness *(please list)* ____________

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

____

PREVIOUS SURGERIES

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ☐ No ☐ Yes *Describe:* ____________

Any other serious injuries? ☐ No ☐ Yes *Describe:* ____________

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings ________ Number living ________ Number deceased ________

Number of children ________ Number living ________ Number deceased ________ List ages of each ________

Health of children ____________

Do you know any blood relative who has or had: (check and give relationship)

☐ Cancer ______	☐ Heart disease ______	☐ Rheumatic fever ______	☐ Tuberculosis ______
☐ Leukemia ______	☐ High blood pressure ______	☐ Epilepsy ______	☐ Diabetes ______
☐ Stroke ______	☐ Bleeding tendency ______	☐ Asthma ______	☐ Goiter ______
☐ Colitis ______	☐ Alcoholism ______	☐ Psoriasis ______	

Patient's Name: ____________ Date: ____________ Physician Initials: ________

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MEDICATIONS

Drug allergies: ▢ No ▢ Yes If yes, please list: ____________________

____

Type of reaction: ____________________

PRESENT MEDICATIONS *(List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)*

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped? A Lot	Some	Not At All
1.			▢	▢	▢
2.			▢	▢	▢
3.			▢	▢	▢
4.			▢	▢	▢
5.			▢	▢	▢
6.			▢	▢	▢
7.			▢	▢	▢
8.			▢	▢	▢
9.			▢	▢	▢
10.			▢	▢	▢

PAST MEDICATIONS: Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the results of taking the medication and list any reactions you may have had. *Record your comments in the spaces provided.*

Drug names/Dose	Length of time	Please check: Helped? A Lot	Some	Not At All	Reactions
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		▢	▢	▢	
Circle any you have taken in the past Flurbiprofen, Diclofenac + misoprostil, Aspirin (including coated aspirin), Celecoxib, Sulindac, Oxaprozin, Salsalate, Diflunisal, Piroxicam, Indomethacin, Etodolac, Meclofenamate, Ibuprofen, Fenoprofen, Naproxen, Ketoprofen, Tolmetin, Choline magnesium trisalcylate, Diclofenac					
Pain Relievers					
Acetaminophen		▢	▢	▢	
Codeine		▢	▢	▢	
Propoxyphene		▢	▢	▢	
Other:		▢	▢	▢	
Other:		▢	▢	▢	
Disease Modifying Antirheumatic Drugs (DMArDS)					
Certolizumab		▢	▢	▢	
Golimumab		▢	▢	▢	
Hydroxychloroquine		▢	▢	▢	
Penicillamine		▢	▢	▢	
Methotrexate		▢	▢	▢	
Azathioprine		▢	▢	▢	
Sulfasalazine		▢	▢	▢	
Quinacrine		▢	▢	▢	
Cyclophosphamide		▢	▢	▢	
Cyclosporine A		▢	▢	▢	
Etanercept		▢	▢	▢	
Infliximab		▢	▢	▢	
Tocilizumab		▢	▢	▢	
Other:		▢	▢	▢	
Other:		▢	▢	▢	

Patient's Name: ____________________ Date: ____________________ Physician Initials: __________

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PAST MEDICATIONS *Continued*

Drug names/Dose	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not At All	
Osteoporosis Medications					
Estrogen		☐	☐	☐	
Alendronate		☐	☐	☐	
Etidronate		☐	☐	☐	
Raloxifene		☐	☐	☐	
Fluoride		☐	☐	☐	
Calcitonin injection or nasal		☐	☐	☐	
Risedronate		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Gout Medications					
Probenecid		☐	☐	☐	
Colchicine		☐	☐	☐	
Allopurinol		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Others					
Tamoxifen		☐	☐	☐	
Tiludronate		☐	☐	☐	
Cortisone/Prednisone		☐	☐	☐	
Hyaluronan		☐	☐	☐	
Herbal or Nutritional Supplements		☐	☐	☐	

Please list supplements:

____

____

Have you participated in any clinical trials for new medications? ☐ Yes ☐ No

If yes, list:

____

____

____

____

____

____

____

Patient's Name: ______________ Date: ______________ Physician Initials: ______________

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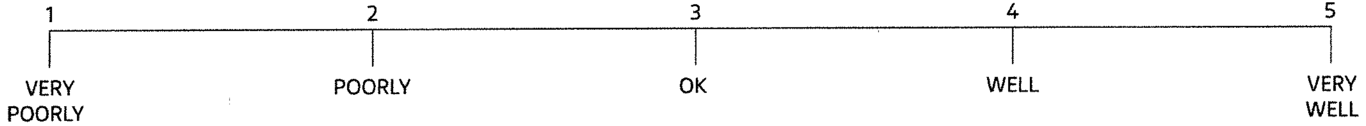
ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ☐ Yes ☐ No *If yes, how many?*

How many people in household? ____________ Relationship and age of each ____________

Who does most of the housework? ____________ Who does most of the shopping? ____________ Who does most of the yard work? ____________

On the scale below, circle a number which best describes your situation; *Most of the time, I function...*



Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)	☐	☐	☐
Walking?	☐	☐	☐
Climbing stairs?	☐	☐	☐
Descending stairs?	☐	☐	☐
Sitting down?	☐	☐	☐
Getting up from chair?	☐	☐	☐
Touching your feet while seated?	☐	☐	☐
Reaching behind your back?	☐	☐	☐
Reaching behind your head?	☐	☐	☐
Dressing yourself?	☐	☐	☐
Going to sleep?	☐	☐	☐
Staying asleep due to pain?	☐	☐	☐
Obtaining restful sleep?	☐	☐	☐
Bathing?	☐	☐	☐
Eating?	☐	☐	☐
Working?	☐	☐	☐
Getting along with family members?	☐	☐	☐
In your sexual relationship?	☐	☐	☐
Engaging in leisure time activities?	☐	☐	☐
With morning stiffness	☐	☐	☐
Do you use a cane, crutches, walker or wheelchair? *(circle one)*	☐	☐	☐

What is the hardest thing for you to do? ____________

Are you receiving disability? .... Yes ☐ No ☐

Are you applying for disability? .... Yes ☐ No ☐

Do you have a medically related lawsuit pending? .... Yes ☐ No ☐

Patient's Name: ____________ Date: ____________ Physician Initials: ____________

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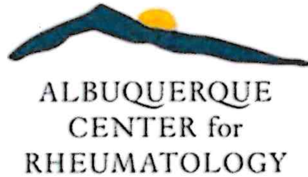


RELEASE OF PATIENT INFORMATION

Patient Name: ______________________________ **DOB:** ________________________________

I hereby authorize the release of medical information obtained in the Diagnosis and Treatment:

From: Albuquerque Center for Rheumatology
1617 University Blvd. NE
Albuquerque, NM 87102
Phone: (505)341-4148 Fax: (505)345-9914

To: ________________________________
____
____
____

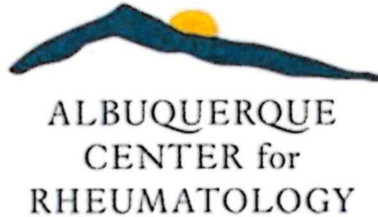
The disclosure of information is for the purpose of treatment.

- o **Office notes from date** ____________________to____________________
- o **Summary of all records**

1. This authorization is voluntary, and I may refuse to agree to its terms without affecting any of my rights to receive healthcare at the Practice.
2. This authorization may be revoked at any time by notifying the Practice in writing at the above address to the attention of "Privacy Officer".
3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
4. The information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and thus this information will no longer be protected by federal privacy regulations.
5. My health care and payment for my health care will not be affected if I do not sign this form.
6. I may see and copy the information described in this form, if I ask for it, and would be able to obtain a copy of this form after I have signed it.
7. This form was filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy.
8. This authorization is valid as of the date I have signed below and shall remain valid for a period of one year.
9. I understand that this authorization may include the release of information relating to communicable diseases such as MRSA, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral, developmental disabilities or mental health services or conditions. It may include the release of information pertaining to the treatment for alcohol and drug use.
   Initials of patient ___________

________________________________ ___________ ________________________

Patient Signature **Date** **Witness**



Assignment of Benefits (AOB) This AOB form is required to bill on your behalf.

My signature and date in the box below authorize each of the following:

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to Albuquerque Center for Rheumatology, LLC. (ACR), for medical supplies and/or medication(s), treatment and infusion furnished to me by ACR.

2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other Insurer(s).

3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other Insurers and their agents and assigns.

4 ACR to obtain medical or other information necessary to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medication(s), treatments or infusions provided.

5. ACR to contact me by telephone or mail regarding my medical supplies and/or medication(s) orders, treatment, or infusions.

6. I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

I request that payment of Medicare, Medicaid, Medicare Supplemental or other Insurance Company benefits be made on my behalf to Albuquerque Center for Rheumatology, LLC (ACR), for any treatment, medical supplies and/or medications furnished to me by ACR. I authorize any holder of medical information about me to be released by ACR, my physician(s), caregiver, CMS, its agents and to my primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible.

______________________	______________________	____________
Printed Name	**Signature**	**Date**

A. Notifier:
B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D.____________ below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**____________ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
1. Kenalog Injections are sometimes not covered. 2. Change of insurance or retirement status. 3. Denials and Denied Appeals	1. Not a covered benefit through Medicare. 2. Coordination of Benefits must be changed and completed. 3. Based on coverage through your Medicare plan.	1. $10.00 2. $ full visit or treatment. 3. $ partial to full visit or treatment.

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**________________ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**______________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____________ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.