Central Florida Rheumatology Consultants, LLC

Lance Feller, MD, FACR
Board Certified in Rheumatology

Patient History Form

Date of appointment: ____/____/_____ Birthplace: _____

Name: _____ Birthdate:_____/_____/_____

Address: _____Age_____ Sex: ☐ F ☐ M

_____ Telephone: Home: (___) _____

CITY STATE ZIP Work: (___) _____

Email Address:_____

Occupation (if retired, prior): _____

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

Referred here by: *(check one)*

Self ☐ Family ☐ Friend ☐ Doctor ☐ Other Health Professional ☐

Name of person making referral:_____ Primary Care Provider:_____

Preferred Lab:_____

Diagnosis (if known):_____

Describe briefly your present symptoms:

_____

_____

_____

_____

Date symptoms began (approximate):_____

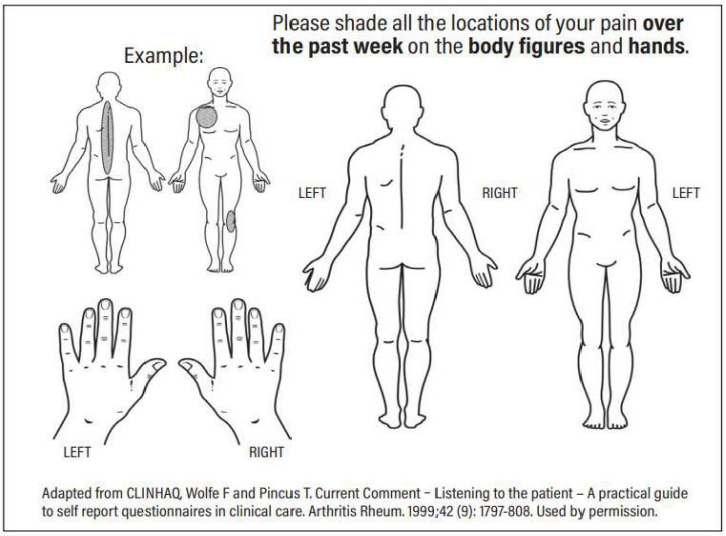
Previous treatment for this problem (include physical therapy, surgery and injections; medication to be listed later):

_____

_____

_____

_____



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.

FAMILY HISTORY

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

		Relationship			Relationship
Psoriasis	❑		Lupus or "SLE"	❑	
Osteoarthritis	❑		Rheumatoid Arthritis	❑	
Gout	❑		Ankylosing Spondylitis	❑	
Childhood Arthritis	❑		Osteoporosis	❑	

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SYSTEMS REVIEW

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

Constitutional		**Gastrointestinal**		**Skin**	
❑	Recent weight gain	❑	Nausea	❑	Easy bruising
❑	Recent weight loss	❑	Vomiting	❑	Redness
❑	Fatigue	❑	Persistent diarrhea	❑	Rash
❑	Weakness	❑	Heartburn	❑	Sun sensitivity
❑	Fever	**Genitourinary**		❑	Hair loss
❑	Night sweats	❑	Blood in urine	❑	Color change of hands/feet
Eyes		**Musculoskeletal**		**Neurological System**	
❑	Pain	❑	Morning stiffness	❑	Headaches
❑	Redness	How long? ___mins____hrs		❑	Dizziness
❑	Dryness	❑	Joint pain	❑	Muscle spasm
Ear-Nose-Throat		❑	Muscle weakness	**Hematologic/Lymphatic**	
❑	Loss of hearing	❑	Muscle tenderness	❑	Swollen glands
❑	Nosebleeds	❑	Joint swelling	❑	Anemia
❑	Sores in mouth	**For Women Only**		❑	Bleeding tendency
❑	Dryness of mouth	❑	Number of pregnancies? _____		
❑	Difficulty swallowing	❑	Number of miscarriages? _____		
Respiratory					
❑	Shortness of breath				
❑	Cough				

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SOCIAL HISTORY

Do you smoke? Yes ☐ No ☐ Past- How long ago?____

Do you drink alcohol? Yes ☐ No ☐ Number per week___

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 _____

MEDICAL HISTORY

Please check if you have or ever had:

☐ Cancer; type:_____year:_____

Treatment(s):_____

☐ Cataracts ☐ Epilepsy
☐ Diabetes ☐ Stroke
☐ Psoriasis ☐ Rheumatic fever
☐ Kidney disease ☐ Ulcerative Colitis
☐ Anemia ☐ Crohn's Disease
☐ Emphysema ☐ High blood pressure
☐ COPD ☐ Tuberculosis

☐ Heart disease; desc:_____
☐ Tuberculosis ☐ Hepatitis
☐ Stomach Ulcers ☐ Asthma

Have you been to the hospital recently?
If yes, when? _____
Other significant illness:
_____

Have you received Human Papillomavirus, Hep A, or Hep B vaccine? ❑ Yes ❑ No
If yes, what/when? _____
Are you at risk for contracting HIV or Hepatitis through blood exposures or sexual activities? ❑ Yes ❑ No
Have you ever been tested for HIV? ❑ Yes ❑ No
Would you like to be tested for HIV? ❑ Yes ❑ No
Would you like to be tested for other STIs? ❑ Yes ❑ No

PREVIOUS SURGERIES

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

Any previous fractures? ❑ Yes ❑ No
If yes, please describe (include time, treatment, etc.)
_____

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

_____

_____

FAMILY HISTORY

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

MEDICATIONS

Drug Allergies: ☐ No ☐ Yes If yes, please list: _____

_____

Type of reaction: _____

CURRENT 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
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

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PAST MEDICATIONS

Please review this list of Rheumatology medications. As accurately as possible, try to remember which medications you have taken, how long you were on the medication, the results of taking the medication and list any reaction you may have had. *Record your comment in the spaces provided.*

Drug names/ Dose	Length of time	Helped A lot	Helped Some	Did not help	Reactions
Non- Steroidal Anti-Inflammatory Drugs (NSAID)		☐	☐	☐	

Circle any you have taken in the past (circle):

Diclofenac Diflunisal Piroxicam Indomethacin Etodolac Meclofenamate

Flurbipofen Aspirin(including coated aspirin) Celebrex Sulindac

Oxaprozin Meloxicam Nabumetone Diclofenac +misoprostil Salsalate

Ibuprofen Fenoprofen Naproxen Ketoprofen Tolmetin Cholone magenesium trisalcylate

Treatment for Autoimmune Diseases (skip if not applicable)

Drug Name	IV, Injection, Both, or Oral	Did the medication help? (yes/no)	Why stopped?	Reactions
Certolizumab (Cimzia)				
Golimumab (Simponi)				
Hydroxychlorquine (plaquenil)				
Methotrexate				
Azazthioprine (Imuron)				
Sulfasalazine				
Cyclophosphamide				
Enbrel (etanercept)				
Infliximab (remicade)				
Actemra (tocilizumab)				
Taltz				
Cosentyx				
Otezla				
Mycophenolete				
Leflunomide (araua)				
Humira (adalimumab)				
Xeljanz (tofacitinab)				
Rituximab (rixutan)				
Orencia (abatacept)				

Rinvoq				
Olumiant				
Kevzara				
Saphnelo				
Benlysta (belimumab)				
Tremfya (guselkumab)				
Other:				

Treatment for Osteoporosis (skip if not applicable)				
Drug Name	**IV, Injection, Both, or Oral**	**Did the medication help? (yes/no)**	**Why stopped? Or "ongoing"**	**Reactions**
Estrogen				
Alendronate (fosomax)				
Raloxifene				
Calcitonin				
Risedronate				
Prolia (denosumab)				
Forteo				
Evenity				
Tymios				
Treatment for Gout (skip if not applicable)				
Probenecid				
Colchicine				
Allopurnol				
Uloric				
Krustexxa				

Please list supplements:

_____

_____

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

if yes, list:_____

_____

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PATIENT REGISTRATION

PATIENT

Full Name: _____ Age: _____ DOB: _____ Sex: _____

Mailing Address: _____City: _____State:_____ Zip: _____

Physical Address: _____ City: _____State:_____ Zip: _____

(IF P.O. BOX IS LISTED ABOVE)

SOCIAL SECURITIY

Number: _____Home #: _____Cell #:_____

Patient Employer: _____ Phone #:_____

Referring Physician: _____ Phone #: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy #:_____ Group #:_____

Primary Card
Holders Name: _____DOB: _____Social Security #:_____

Secondary
Insurance: _____ Policy #: _____ Group #: _____

Secondary Card
Holders Name: _____DOB: _____ Social Security #:_____

Central Florida Rheumatology Consultants, LLC

Authorization for disclosure of PHI to Families/Legal guardian

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW:

Patient Name: _____

Patient's Date of Birth: _____ Patient's SSN: _____

A. Person(s) or Organization(s) authorized to provide the information: Central Florida Rheumatology Consultants , LLC

B. Person(s) authorized to receive the information/instructions/results pertaining to your treatment:

1. _____ DOB _____
2. _____ DOB _____
3. _____ DOB _____
4. _____ DOB _____

C. Specific description of the information that may be used or disclosed (including date(s)):

D. Specific description of how the information will be used: To assist with the plan of treatment between the above listed patient and the Rheumatology Clinic.

E. Authorization to leave results and messages regarding appointments and care, with family members listed above or on Voicemail. Please circle: _____YES or _____NO

1. I understand that this authorization will **expire** on _____.
2. I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying cardiac clinic in writing.
3. I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4. I may **inspect or copy** any information used or disclosed under this agreement.
5. I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

_____ _____

Patient's Signature or Patient's Representative Date

_____ _____

Printed Name of Patient's Representative Relationship to Patient

NOTE:

You have the right to know specifically what information you are authorizing for release *(e.g., "results of a lab test performed on1/4/03" or, if your entire medical record is included, "all health information.").*

You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information *(e.g., the names of your health care provider(s)).*

You have the right to know who is going to use it and what it is going to be used for. *(e.g., John Smith, PhD / Research).*

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

HIPAA Authorization for Release of Information

This form does not constitute legal advice and covers only federal, not state, laws.

Central Florida Rheumatology Consultants, LLC

Cancellation Notice Agreement

Please be advised, that our office requires a 24 hour advance notice for all cancelled or rescheduled routine appointments. However, all diagnostic testing requires a 48 hour notice to cancel or reschedule your appointment.

Without the proper notice, you will be charged a $25.00 fee for a NO SHOW appointment and $125.00 fee for DIAGNOSTIC TESTING.

By signing below, I agree that I am financially responsible for any charged incurred for missed appointments that were not cancelled within the required time. Any emergencies with verification and proof will receive credit.

Patient Printed Name _____ Date _____

Patient Signature _____ D.OB _____

915 Harley Strickland Blvd., Orange City, FL
Phone: 386-561-9967

1319 S. International Pkwy. Suite 1171, Lake Mary
Fax: 844-815-1446

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RECORDS RELEASE REQUEST

To:

☐ **PCP:** _____

☐ **Other:** _____

_____

_____

I, _____, hereby request that you release my MEDICAL RECORDS to:

Central Florida Rheumatology Consultants, LLC
915 Harley Strickland Blvd
Orange City, FL 32763
Phone: (386) 561-9967 Fax: (844) 815-1446

This includes a report of my diagnosis, treatment, prognosis and recommendations, as well as any other data pertinent to your treatment of me. I request ALL of my records to be sent unless specific dates or specific tests are listed below. Thank you.

- Release records only for the following period.

FROM: _____/_____/_____TO: _____/_____/_____

: Present ☐

- Release records only for the following test(s) / report(s): (Please Include Dates)

☐ Labs:_____
☐ X-rays:_____
☐ MRI:_____
_____

☐ CT Scans:_____
☐ Last Visit Note:_____
☐ Other:
_____
_____
_____

REASON FOR REQUEST:

Date of Request_____

_____Continuity of care treatment
_____At the Request of individual please include all sensitive information

Patient Printed Name_____ Date of Birth_____

Patient's Telephone Number_____

I understand and give my permission for my records to be sent via facsimile (fax machine).

Patient Signature:_____ Faxed: _____/_____/_____

Central Florida Rheumatology Consultants, LLC

Notice Of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 01,2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Trish Persuade. Information on contacting us can be found at the end of this Notice.

Typical Uses And Disclosures of Health Information

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement

Disclosure: We may disclose and/or share your healthcare information with other health care professionals, who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

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915 Harley Strickland Blvd., Orange City, FL 32763
Phone: 386-561-9967

Fax: +1 844-815-1446
http://myrheumatology.com/

1319 S International Pkwy. Suite 1171, Lake Mary, Florida 32746
Tel: 407-268-3666

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information, when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

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Your Privacy Rights as Our Patient

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $ 1.00 for each page and the staff time charged will be $25.00 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

Questions and Complaints

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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http://myrheumatology.com/

1319 S International Pkwy. Suite 1171, Lake Mary, Florida 32746
Tel: 407-268-3666

Central Florida Rheumatology Consultants, LLC

FCC acknowledgement of receipt of notice of privacy practices

Notice to Patient: _____

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

_____

_____

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____ _____ _____

Please print your name here | Signature | Date

For office use only

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The patient refused to sign.

Due to an emergency situation it was not possible to obtain an acknowledgement.

We weren't able to communicate with the patient.

Other (Please provide specific details)

_____

_____

_____

_____ _____

Employee signature | Date

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