



**Registration Form**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Preferred Name \_\_\_\_\_  
 D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender Assigned at Birth: Male Female Gender Identity: \_\_\_\_\_  
 Marital Status: S M WID DIV SEP  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Home Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_  
 Email: \_\_\_\_\_

I consent to allow a detailed message from the office to be left at provided phone number(s): **YES NO**

To comply with federal regulations, we are required to ask you to fill out the following:

**Race:** White \_\_\_\_ Black/African American \_\_\_\_ Asian \_\_\_\_ Asian Indian \_\_\_\_ Other \_\_\_\_\_

**Ethnicity:** Hispanic or Latino YES NO

**IF YOU DO NOT WISH TO SHARE THIS INFORMATION:** \_\_\_\_\_ Prefer Not to Disclose

**I have taken steps to secure a(an):** Advanced Directive \_\_\_\_ Living Will \_\_\_\_ Power of Attorney \_\_\_\_  
 I DO NOT have an Advanced Directive \_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_ Phone Number \_\_\_\_\_ Relationship \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Phone Number \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone Number \_\_\_\_\_

Local Pharmacy: \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Phone Number \_\_\_\_\_

Mail Away (Specialty) Pharmacy \_\_\_\_\_ Phone Number \_\_\_\_\_

I certify that all the information is accurate and acknowledge receipt of the Notice of Privacy Practices. I state that I have read and understand the terms and conditions of the Patient Financial Policy.

Signature \_\_\_\_\_ Date \_\_\_\_\_



## ADULT HISTORY FORM

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Please briefly explain the reason for today's visit: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patient Medical History: Please check all that apply:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> History of fractures     | <input type="checkbox"/> Ulcerative Colitis   |
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Thyroid disease          | <input type="checkbox"/> Cancer (type): _____ |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Other : _____        |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Crohn's Disease          |   |

**Patient Social History:**

Do you use tobacco products?  No  Yes If yes, what type of tobacco product? \_\_\_\_\_

Do you drink alcohol?  No  Yes If yes, please provide type and frequency. \_\_\_\_\_

Caffeine use?  No  Yes If yes, please provide type and frequency. \_\_\_\_\_

Level of Activity/Exercise:  Vigorous  Regular  Occasional  None Type of Exercise: \_\_\_\_\_

Illicit Drug Use:  No  Yes If Yes; please provide type, quantity, frequency: \_\_\_\_\_

**Patient Family History: Please check all that apply to your FAMILY history and provide relation to you:**

- |   |   |
|---|---|
| <input type="checkbox"/> Rheumatoid Arthritis (Relation): _____ | <input type="checkbox"/> Gout (Relation): _____               |
| <input type="checkbox"/> Psoriatic Arthritis (Relation): _____  | <input type="checkbox"/> Psoriasis (Relation): _____          |
| <input type="checkbox"/> Osteoarthritis (Relation): _____       | <input type="checkbox"/> Ulcerative Colitis (Relation): _____ |
| <input type="checkbox"/> Lupus (Relation): _____                | <input type="checkbox"/> Crohn's Disease (Relation): _____    |

**Surgical History:** Please list all past surgeries including the month and year:

_____	_____
_____	_____
_____	_____

**Allergies:** Please list all known allergies and reactions: Or check here if:  No Known Allergies

Allergy	Allergic Reaction

**Primary Local Pharmacy:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

**Specialty/Mail Away Pharmacy:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Arthritis & Osteoporosis  
Associates



# **Arthritis and Osteoporosis Associates**

## **Medication Policy**

It is important for your health that you follow the directions carefully on all medications that we prescribe. In addition, we must be informed of all other medications, prescriptions, over-the-counter drugs and supplements, that you are taking.

### ***CONTROLLED MEDICATIONS***

We will not refill controlled medications in advance of their refill date, **REGARDLESS OF THE SITUATION**, nor will we mail these prescriptions. They must be given in person to you at the time of your appointment. If there is an unavoidable reason that you cannot make an appointment, we require a two-day notice for a medication refill.

Please be advised you will be required to give a urine specimen for drug testing. **Automatic discharge** from the practice will occur for any of the following: forgery or diversion of the prescription, failure to comply with the recommendation of the physician, and any drug seeking behavior including but not limited to using the medication more frequently than recommended, repeated calling after hours to obtain prescriptions, repeated visits to the ER for the pain, use of medication beyond the expected treatment period and failure to notify your physician that you are receiving narcotics from other physicians. You may be referred to a pain management specialist or asked to have an evaluation by a mental health professional to help manage your pain.

### ***STAFF***

We require our staff to address our patients with professionalism, and we ask our patients to do the same. **If at any time our staff feels that your tone or language is offensive or abusive**, we expect them to terminate the conversation immediately and notify their immediate supervisor or practice administrator. We will document a record and depending on the severity of the situation, you may be discharged from the practice.

We are committed to providing the best possible treatment and ask for your cooperation in following these policies.

**I READ AND UNDERSTAND THE ABOVE POLICIES AND AGREE TO ABIDE BY THEM. I FURTHER UNDERSTAND THAT FAILURE TO DO SO MAY RESULT IN MY DISCHARGE FROM THE PRACTICE.**

Signature: \_\_\_\_\_

(Please sign form in office)

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

# **Arthritis and Osteoporosis Associates**

## **Patient Financial Policy**

Thank you for choosing Arthritis and Osteoporosis Associates as your medical provider. We are committed to building a successful physician-patient relationship. Your clear understanding of our Patient Financial Policy is important to this relationship. Our physicians require that you read and sign the Patient Financial Policy **prior to any treatment.**

**Patient Information:** It is your responsibility to notify our office of any patient information changes (i.e., Address, Name, Insurance Information, Pharmacy, etc.).

**Missed Appointments:** If you are unable to keep your scheduled appointment, our office requires a 24-hour notice of your cancellation. Missed appointments that were not previously cancelled may be charged a fee up to \$75.

**Insurance Coverage:** Insurance policies have become increasingly complex over the years, and it has become impossible for our office to know each specific plan and its limitations. Your insurance policy is a contract between you and your insurance company. Your failure to comply with your insurance company requirements, such as necessary referrals and pre-authorizations, may result in you being responsible for the payment of services. Remember that **YOU** are responsible for knowing your insurance benefits. Please bring your insurance card with you to **EACH** and **EVERY** appointment. In order to properly invoice your insurance company, we require that you disclose **ALL** insurance information, including primary and secondary and inform us of any change in your insurance. Failure to provide complete insurance information may result in you being responsible for the entire bill.

**No Insurance/Self-Pay Accounts:** Self-Pay accounts are patients without insurance coverage, or patients without an insurance card on file with us. For these patients, payment will be due at the time of service, or prior payment arrangements should be made with our office. Failure to pay the balance in full or failure to enter and remain current on a payment plan may result in your not being seen by a provider in our office. In addition, your account will be forwarded to our legal department for collections procedures.

**Out of Network:** If our office does not participate with your insurance, payment will be due at the time of service. If your coverage is a plan that we feel may cover office visits, we may elect to take your co-pay/co-insurance at the time of service and invoice your insurance company. You will remain responsible for any amount not covered by insurance. All testing for patients with insurance that our office does not participate with will be scheduled in an outside facility. You may be required to provide credit card information authorizing us to charge for any unpaid services. Our office can provide a list of fees upon request.

**Referrals:** If your insurance company requires a referral for services, you are responsible for obtaining it. Your failure to do so may result in you being responsible for the entire bill of services.

**Co-Pay, Deductibles, & Non-Covered Services:** For all insurance plans (including Medicare) that we contract with, your carrier requires that all co-pays be paid prior to any services being rendered. This cannot be waived by our practice as it is a requirement placed on you by your insurance carrier. You are responsible for any co-insurance, deductibles, or non-covered services as required by your insurance. You will receive a statement indicating what your insurance has paid, the remaining balance is due upon receipt of the statement. Failure to pay your co-insurance, deductible, or non-covered services, or failure to enter and remain current on a payment plan will result in you not being seen by a provider in our office and you will receive a letter giving you 30 days to choose another Rheumatology group.

**Health Share Plans:** It is this office's policy to collect full payment for services, unless otherwise specified by your health share plan.

**Deductible Health Plans:** There are consumer-drive health plans that have a minimum deductible and out-of-pocket limit that is reset each year. If you have a deductible or an out-of-pocket responsibility, Arthritis and Osteoporosis Associates may require you to pay any fee subject to the deductible at the time of your visit. The payment will be applied to whatever patient balance is not paid by your insurance plan, such as, deductibles, co-insurance, co-pays, and/or non-covered services.

**Returned Checks:** There will be a charge of \$50 for returned checks, which will be payable by cash, credit card, or money order. Returned checks may result in office refusal to accept that form of payment going forward.

**Outstanding Balances:** It is our office policy that all patient balances be paid in full upon receipt of the patient statement. If full payment cannot be made, payment arrangements can be made by calling our billing department, located in the Freehold office. Failure to pay your balance in full or failure to enter and remain current on a payment plan will result in you not being seen by a provider in our office and dismissed from the practice for financial non-compliance, you will receive a letter giving you 30 days to choose another rheumatology group. If an account is turned over to our collection agency, an additional 25% collection fee will be added to the balance, in addition to all court and legal fees.

**KEEP FOR YOUR RECORDS**

**Arthritis and Osteoporosis Associates**  
**Patient Financial Policy Agreement**

I, \_\_\_\_\_ (Print Name), have received a copy of the Patient Financial Policy from Arthritis and Osteoporosis Associates. I, \_\_\_\_\_, have read, fully understand, and agree with the expectations set forth.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# DESIGNATION OF DISCLOSURES

**You may disclose my health information as described below:**

List **ALL** phone numbers we may try to contact you on:

Phone #: \_\_\_\_\_ home/cell/work (**circle one**)

Phone #: \_\_\_\_\_ home/cell/work (**circle one**)

Phone #: \_\_\_\_\_ home/cell/work (**circle one**)

**Okay to leave messages:** (Check all that apply)

On my answering machine

With my spouse

Leave message with call back number only

**I designate the following people listed below** as persons involved with my healthcare, or payment relating to my healthcare, for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this at any time in writing. **I understand that Arthritis and Osteoporosis Associates will not disclose health information to any person not designated except in the case of an emergency.**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Please list **ALL** physicians you see, in addition to your Primary Care Physician, which may request your records in the future.

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**CHECK HERE TO AUTHORIZE THE RELEASE OF MEDICAL RECORDS TO ANY PHYSICIAN THAT MAY REQUEST IT**

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_