

Low Country Rheumatology



Phone (843) 572-4840

New Patient Dept. Phone (843) 572-4852

www.lowcountryrheumatology.com

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William M. Edwards, M.D.
Clarence W. Legerton III, M.D.
Jennifer K. Murphy, M.D.
Nicholas Holdgate, MD

Welcome to our practice!

We look forward to seeing you on this date: _____ at this time: _____ with
Dr. _____ at our **Summerville** location.

We are delighted that you have chosen us for your medical needs. At Articularis Healthcare we take great pride in the relationships that we establish with our patients and the ability to provide a personalized approach to difficult problems.

As a patient of the Articularis Healthcare Group, Inc., we appreciate you following the guidelines of the practice to help us maintain our goals. Please read through our policies carefully and call us with any questions.

New patients:

Please arrive 15 minutes before your schedule appointment time with the completed paperwork to allow for the registration process. Please do not mail paperwork.

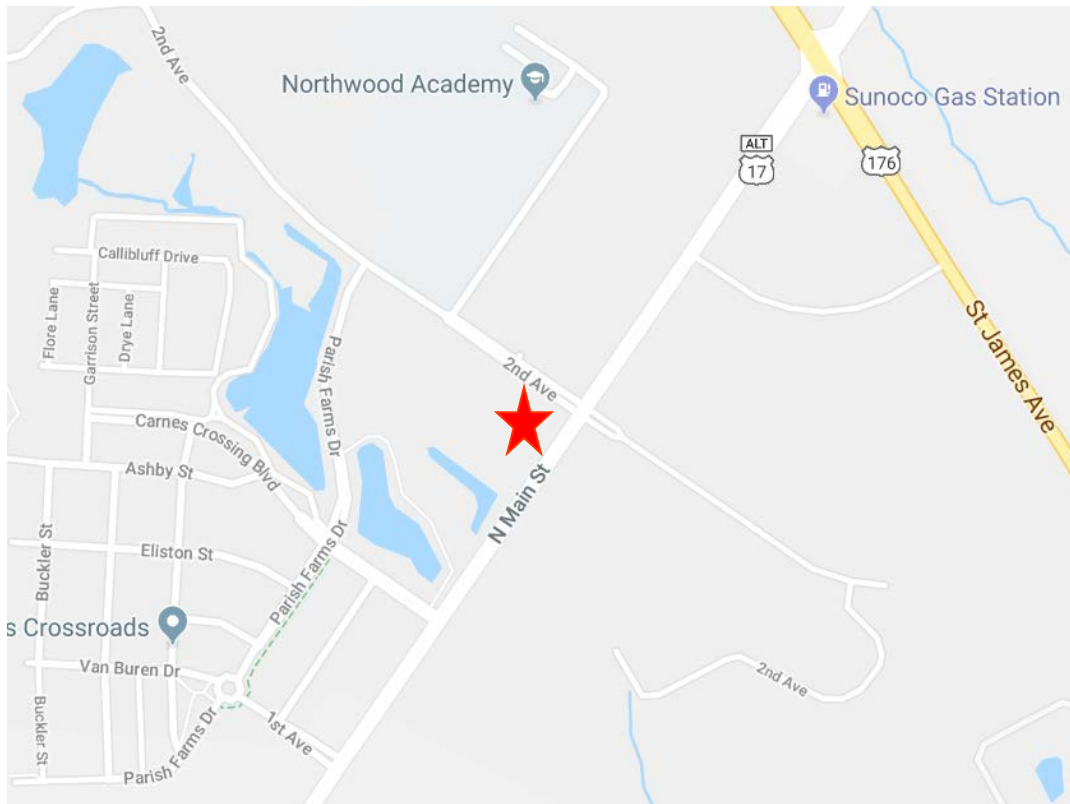
- There is a \$25 no-show and cancelation fee for all appointments not kept or not canceled within 72 hours prior to your appointment date, except for emergencies. A credit/debit card number is required at the time of scheduling to secure all new patient appointments.
- Cash payments, deductibles and co-payments must be paid at the time of service. Payments for medical services not covered by insurance plans are the patient's responsibility.
- We do not accept Medicaid as a secondary insurance to commercial plans.
- Self-Pay patients are required to bring \$250 to their initial visit. Additional financial assistance is available; please ask our Front Desk Receptionist for details.

Please bring attached forms, your photo ID and insurance cards to your visit.

Please be aware that if you arrive over 15 minutes late to your appointment you will be asked to reschedule.

Directions to the Summerville Office

2001 2nd Avenue, Suite 201, Summerville, SC 29486



From Mount Pleasant/Downtown—Take I-526 to I-26 West to Ladson exit 203 to College Park Rd/State Rd S-8-62. Continue on College Park Rd/State Rd S-8-62. Turn right on US-17 ALT N/N Main Street. Turn left on 2nd Avenue. Low Country Rheumatology will be on the left.

From Summerville – Head northwest on County Rd S-10-65/E Richardson Ave toward S. Main Street. Turn Right onto US-17 ALT N/S Main Street. Turn left on 2nd Avenue. Low Country Rheumatology will be on the left.

From Moncks Corner – Head southwest on US-17 ALT S/S Live Oak Dr. toward Bonnoitt Street. Turn right onto 2nd Avenue. Low Country Rheumatology will be on the left.

Low Country Rheumatology, A Member of Articularis Healthcare, Inc.
Patient Information

Last Name	First Name	Middle Initial
Street Address		Apt/Lot
City	State	Zip
SSN	DOB	Circle One: Mr. Mrs. Ms.
Email	Cell #	Home #
Circle One: Male Female	Marital Status S M W D	Student Yes No

Employment (Circle One): Full-Time Part-time Retired Disabled
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Referring Physician	Phone #
Primary Care Physician	Phone #
Spouse	Phone #
Emergency Contact	Phone #
Primary Insurance Name	Policy #
Policy Holder Name	DOB
Group #	Group Name
Secondary Insurance	Policy #
Policy Holder Name	DOB
Group #	Group Name

Consent for treatment, payment and acknowledgement of receipt of notice of privacy practices: I request that payment under the medical insurance program be made payable to Articularis Healthcare Group, Inc. I authorize disclosure of my personal health information to carry out treatment, payment or health care procedures. I have received the privacy policy and notice of information practices that provides a more complete description of information uses and disclosures. I agree to pay any and all charges that exceed or not paid/covered by my insurance. In the event my account is turned over to a collection agency, I will be billed the additional collection fees.

Patient/Guardian: _____
 Signature

Date: _____

Low Country Rheumatology, A Member of Articularis Healthcare, Inc. Health Questionnaire

Patient Name: _____ Date of Birth: _____

Reason for visit: _____

Preferred Pharmacy: _____ Address: _____

City: _____ State: _____ Zip: _____

Current medications: Please list **name** and **strength**.

1 _____ / _____ mg	8 _____ / _____ mg
2 _____ / _____ mg	9 _____ / _____ mg
3 _____ / _____ mg	10 _____ / _____ mg
4 _____ / _____ mg	11 _____ / _____ mg
5 _____ / _____ mg	12 _____ / _____ mg
6 _____ / _____ mg	13 _____ / _____ mg
7 _____ / _____ mg	14 _____ / _____ mg

Medications you have **tried in the past** for your arthritis condition.

1 _____	3 _____
2 _____	4 _____

Medical History: Please list any diseases or illnesses you have now or have had previously.

1 _____	6 _____
2 _____	7 _____
3 _____	8 _____
4 _____	9 _____
5 _____	10 _____

Medication or Latex allergies: _____

Prior Surgeries: _____

Have you ever smoked cigarettes, or tobacco in other forms? Yes No
 If yes, when you were smoking your heaviest, how many packs per day did you smoke, on average: _____
 What year did you start smoking? _____ If you subsequently quit, what year did you quit? _____
 Do you drink alcohol? Yes No If yes, please circle: Beer Wine Liquor

On average, how many drinks per week? _____

What other physicians care for you, now and in the past?

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

Please indicate the history of arthritis or rheumatic disease in your family:

	Father	Mother	Sibling
Rheumatoid Arthritis			
Gout			
Psoriasis			
Lupus			
Other:			

Is your arthritis a result of an accident or trauma? Yes No

*We **do not** provide care for problems related to accidents for which there is ongoing litigation for Workman's Compensation. Notify the office if you are unclear about your case.

*Disability forms **will not** be completed until you have received six months of established care from our practice.

Low Country Rheumatology



A MEMBER OF

Articularis
HEALTHCARE

Alan N. Brown, MD

Nicholas Holdgate, MD

Colin C. Edgerton, MD

Clarence W. Legerton III, MD

William M. Edwards, MD

Jennifer K. Murphy, MD

Gary E. Fink, MD

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Authorization to Release/Obtain Medical Records

Patient Name: _____ DOB: _____

Previous Name (if applicable): _____ SSN: _____

** This authorization expires ONE year from the date of signature**

Method of disclosure:

I authorize Articularis Healthcare to **release** my medical records to:

Name: _____

Fax #: _____

I authorize Articularis Healthcare to **obtain** my medical records from:

Name: _____

Fax #: _____

Health Information to disclose:

ALL health information

Healthcare information relating to the following:

Treatment, Condition, or Dates: _____

I understand I have the right to refuse to sign this form, and that I may revoke my authorization at any time (except to the extent that the information has already been released). When my information is disclosed, the federal HIPAA Privacy Rule may no longer protect it. This authorization will automatically expire one (1) year from the date of this request or on the following requested date:

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Articularis Healthcare Group, Inc.

2001 2nd Avenue, Suite 201, Summerville, SC 29486 / 1165 Chuck Dawley Mt. Pleasant, SC 29464 / 2291 Henry Tecklenburg Dr., Charleston, SC 29414



Medical Information Release Form (HIPAA Release Form)

I understand that Articularis Healthcare Group, Inc. maintains my personal records, medical history, symptoms, examinations, and test results as a part of my healthcare. This information is not to be given to any other person without my permission. Therefore, this is a written consent to authorize release of my medical information.

RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records, laboratory values, prescribed medications, treatment plan, examination rendered, and claims information. This information may be released to:

Spouse: _____

Child(ren): _____

Other: _____

Check if okay to leave detailed health information on voicemail

Information is **NOT** to be released to anyone

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Low Country Rheumatology, a Member of Articularis Healthcare Group, Inc.

Scheduling Policy

We are committed to providing our patients with the best possible medical care and minimizing administrative costs. Please read through this policy thoroughly. If you have any questions, please call our Front Desk prior to your visit.

New Patients

- A credit/debit card is required to be on file to schedule a and reserve a new patient appointment.
 - A \$25 fee will be charged to the card on file for all new patient appointments that are canceled less than 72 hours prior to the scheduled appointment date.
- If you are unable to keep your appointment, kindly call our office at least 72 hours prior to your appointment time. We will work with you to reschedule you to a more convenient time.
- We do NOT accept Medicaid as a secondary insurance.
- Self-pay patients are required to bring a payment in the amount of \$250 to their initial visit, which will be collected prior to being seen by the physician. Additional financial assistance is available after the first visit; please ask the Front Desk Receptionist for details.
- A physician will review the medical records of all Medicaid and self-referral patients before being scheduled.

Follow-up Appointments

- Established patients with a balance greater than \$100 must clear the outstanding balance with the billing department before scheduling any future appointments. Payment plans can be arranged if necessary.
- Any patient who no-shows or cancels 2 appointments without giving a 72-hour notice will receive a discharge warning letter in the mail.
- If a patient cancels or no-shows 3 times in a calendar year they will be discharged from the practice.
- It is the patient's responsibility to keep up with their appointment times. We send automated calls/text message appointment reminders as a courtesy.
- It is the patient's responsibility to obtain any referral needed for a Blue Choice/Tricare Prime insurance for their office visit.

Patient/Guardian Signature: _____ Date: _____

Low Country Rheumatology, a Member of Articularis Healthcare Group, Inc.

Patient Financial Policy

We are committed to providing our patients with the best possible medical care and minimizing administrative costs. Please read through this policy thoroughly. If you have any questions, please call our Billing Department prior to your visit.

- We will no longer send paper statements in the mail; statements can be viewed online through our Patient Portal.
- We will collect payments at the time of service based on the patient's insurance allowable amounts, deductible, co-payment, and any portion of charges as specified by the plan at the time of visit.
 - Payment for professional services can be made with cash, check, credit, or Care Credit.
 - Patients that carry a balance after insurance is processed will receive a statement via Patient Portal.
 - Statements must be paid within 30 days upon receipt via Patient Portal, over the phone, by mail, or in person.
 - Patients that do not pay their first statement within 30 days will be required to store a credit, debit, HSA card or account on file.
 - Payment plans are available to those whose services rendered total greater than \$200 after the new patient appointment. A credit, debit, HSA card, or bank account is required to be on file for all payment plans. For balances greater than \$200, 1/3 of the balance will be drafted on the 1st day of each of the next 3 consecutive months.
 - We do not have access to the patient's credit/debit/HSA/bank information. It is stored and encrypted by a certified company that is compliant with all federal privacy laws as well as the Payment Card Industry Data Security Standards (PCI DSS). Additionally, each of our offices are PCI DSS compliant.
- As the owner of the insurance policy, the patient is solely responsible for the policies regarding their plan, to provide us with current insurance information, to notify us with any changes to insurance coverage, and to bring his/her insurance card to each visit. If we do not have the correct insurance information, the patient is responsible for the bill.
- If the patient believes the insurance denied or processed the claim in error, please call us immediately.
- If the patient pays more than they are responsible for before insurance is processed, we will apply the credit to the patient's account and it may be used at the next visit or receive a refund of the overpayment.
- Our Billing Department will submit a claim for services rendered for patients who are beneficiaries of insurance companies our practice participates with. All necessary insurance information, including any forms, must be completed by the patient prior to leaving the office. If a patient has insurance in which we do not participate, our office will file the claim upon request; however, payment in full is expected at the time of service.
- If the patient's insurance company requests additional information from the patient, it is important to reply to their requests in a timely manner. If the insurance company does not pay the claim in 45 days, the balance is billed to and becomes the responsibility of the patient.
- Financial assistance is available for qualified patients. If a patient feels that he or she may qualify for assistance, the Front Desk Receptionist should be notified. Patients who do not have insurance are expected to pay for professional services at the time of service unless prior arrangements have been made with us.

Patient/Guardian Signature: _____ Date: _____

Low Country Rheumatology, a Member of Articularis Healthcare Group, Inc.
Prescription Refill Policy

Refill requests will only be accepted if the following appropriate criteria have been met:

- Your prescription can only be discussed with a physician, nurse, or medical assistant.
- The requested medication must have been ordered previously by an Articularis Healthcare Group, Inc. physician.
- Physicians will not accept refill requests after hours or on the weekends (Friday-Sunday).
- Refill requests will be submitted to your pharmacy. Please allow 24 hours for this process. You may call our offices only after you have spoken with your pharmacy.
 - **We do not accept refill requests from pharmacies.**
- All narcotic refill requests will take 48 hours to process. You may pick up your prescription at our office no sooner than 48 hours after it was called in.
- The patient has been seen by the physician in the last **6 months** or it is documented that the physician has order a **1 year follow up**.
- A patient requesting DMARDS must have had the **required** blood work within the last **6 – 8 weeks**. The nurse may arrange for the patient to get blood work completed if necessary.
- The patient has kept the last scheduled appointment or has been rescheduled for a date within the next 4 weeks.
- All prescriptions will be written for periods no longer than your next scheduled appointment.
- If a patient misses their appointment and calls in for a prescription, the nurse may only authorize enough medication to meet the patient's dosing requirement until the next scheduled appointment. If possible, patients may be worked in within 1 week.
- No further refills can be authorized unless the next scheduled appointment is kept.

Patient/Guardian Signature: _____ Date: _____

Multi-Dimensional Health Assessment Questionnaire (R808-NP2)

This questionnaire includes information not available from blood tests, X-rays, or any source other than you. Please try to answer each question, even if you do not think it is related to you at this time. Try to complete as much as you can yourself, but if you need help, please ask. **There are no right or wrong answers.** Please answer exactly as you think or feel. Thank you.

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, bus, 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 sports 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

2. How much pain have you had because of your condition OVER THE PAST WEEK?

Please indicate below how severe your pain has been:

NO PAIN 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 PAIN AS BAD AS IT COULD BE

3. Please place a check (✓) in the appropriate spot to indicate the amount of pain you are having today in each of the joint areas listed below:

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
a. LEFT FINGERS	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	i. RIGHT FINGERS	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
b. LEFT WRIST	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	j. RIGHT WRIST	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
c. LEFT ELBOW	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	k. RIGHT ELBOW	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
d. LEFT SHOULDER	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	l. RIGHT SHOULDER	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
e. LEFT HIP	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	m. RIGHT HIP	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
f. LEFT KNEE	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	n. RIGHT KNEE	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
g. LEFT ANKLE	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	o. RIGHT ANKLE	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
h. LEFT TOES	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	p. RIGHT TOES	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
q. NECK	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	r. BACK	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

4. 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 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 VERY POORLY

Please turn to the other side

FOR OFFICE USE ONLY

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):

4.PTGL (0-10):

RAPID 3 (0-30)

Cat:

HS = >12

MS = 6.1-12

LS = 3.1-6

R = ≤3

