PRIOR TO YOUR APPOINTMENT, PLEASE:

1. COMPLETE THIS PAPERWORK. It must be brought in to your appointment. Do NOT mail or fax it back to us.

2. FIND OUT YOUR PREFERRED LABORATORY. If you do not know which one to use, please call your insurance company to find out. Quest draws labs in our office, so we need to know if you or your insurance company prefers a different lab. (If you have Medicare, they will cover any lab, we just need to know which one you prefer.)

BRING WITH YOU TO YOUR APPOINTMENT:

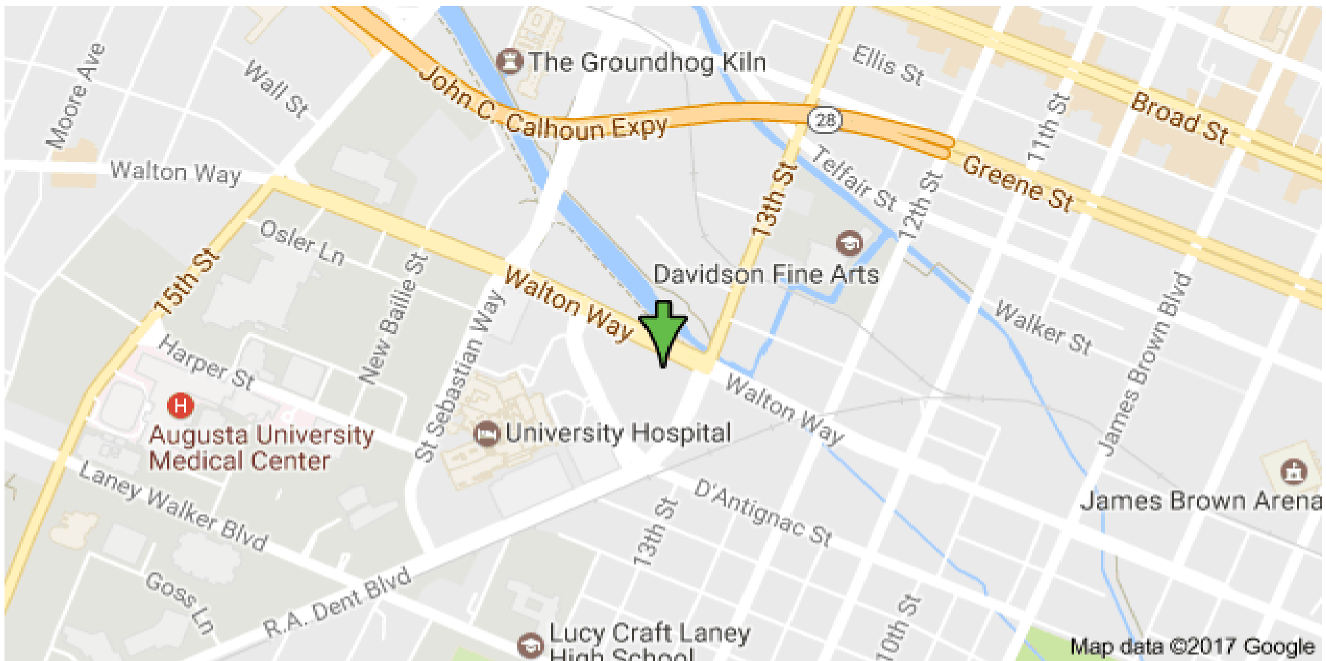
1. This completed paperwork
2. Photo ID
3. Insurance Card(s)
4. Prescription Card (if separate from your insurance card)

PLEASE ARRIVE ON TIME AND BE PREPARED TO BE IN THE OFFICE FOR SEVERAL HOURS.

IF YOU DO NOT ARRIVE AT THE REQUESTED TIME WITH THE REQUIRED ITEMS, YOUR APPOINTMENT MAY BE CANCELLED AND YOUR $50.00 DEPOSIT FORFEITED.

IN ORDER TO RESCHEDULE, YOU WILL HAVE TO PAY A NEW DEPOSIT FOR A NEW APPOINTMENT.

Directions to Augusta Arthritis Center



Our office is located on the first floor of Professional Building 3 in the Piedmont (previously University) Hospital Professional Center, at the intersection of Walton Way and 13th Street. Free parking is available in the adjacent parking lot.

811 13th Street, Suite 14
Augusta, GA 30901-2771
Phone: 706-828-0043 | Fax: 706-828-0450

Richard S. Field, M.D. **Renée Peterkin-McCalman, M.D.** **Ian M. Ward, M.D.**

Please arrive for your appointment with Dr.________________on _______________ at _________.

(Your appointment time will be 30 minutes after the arrival time listed above. Please be sure to arrive no later than the given arrival time to allow for our registration process.)

Welcome to our practice!

Our staff would like to take this opportunity to welcome you to our practice. We are delighted that you have chosen us for your medical needs. At Augusta Arthritis Center, we take great pride in the relationships that we have established with our patients and the ability to give a personalized approach to difficult problems.

As a patient of Augusta Arthritis Center, Inc., we appreciate you following the guidelines of the practice which helps us maintain our goals.

Please arrive at your scheduled appointment time with the completed paperwork to allow for the registration process.
PLEASE DO NOT MAIL PAPERWORK.

- There is a $50 no-show and cancellation fee for all new patient appointments not kept or not cancelled 48 hours prior to your appointment date. A credit/debit card number is required at the time of scheduling to secure all new patient appointments.
  Your card will be charged a deposit of $50 on ______________________.

The $50.00 Deposit will be refunded AFTER your insurance processes your claim and there is no remaining balance. It will Not be refunded at the time of your visit.

- 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.
- Self-Pay patients are required to bring $300 to their initial visit.
- Our Prescription Refill Policy is as follows: Please request refills at your visit. If you call in for refills, they will be called in between the hours of 10am-6pm. Please have the pharmacy name and number on hand when you call. Controlled substances will not be called in or filled after hours. A 24-hour advanced notice is required for all written prescriptions. All patient phone calls or requests will be addressed by a nurse within 24 hours.
- Our Lab Results Policy is as follows: Please do not call asking to discuss lab results. Your doctor/staff will call only if labs are at critical values. Otherwise, any labs will be discussed at the next appointment. Additionally, if registered, your lab results will be available to view on the patient portal once they have been processed.

Please bring completed forms, your photo ID and insurance cards, including prescription drug cards to your visit.

Augusta Arthritis Center, Inc.
Patient Information

PLEASE PRINT LEGIBLY

Last Name		First Name		Middle Initial
Street Address			Apt/Lot #	
City		State	Zip	
SSN#		DOB	Circle One: Mr. Mrs. Ms. Dr.	
Cell Phone #		Home Phone #	PRIMARY PHONE: ( ) CELL ( ) HOME	
Email		Employment Full-time Part-time Retired Disabled		
Sex M F	Marital Status: S M W D	Race	Employer	
Referring Physician			Phone #	
Primary Care Physician			Phone #	
Spouse			Cell #	
Emergency Contact	Relationship		Phone #	
Primary Insurance Name				
Policy Holder Name		DOB	Relationship to Patient	
Policy #		Group#		
Secondary Insurance Name				
Policy Holder Name		DOB	Relationship to Patient	
Policy #		Group#		

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 Augusta Arthritis Center, Inc. for services rendered. I understand that I am financially responsible for all charges incurred at Augusta Arthritis Center, 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 Signature:________________________________ Date:__________________________

HEALTH QUESTIONNAIRE

Patient Name:_______________________________________ Date of Birth:__________________

Reason for visit:____

Preferred Laboratory: ____

Preferred Pharmacy:_________________________ Address:_________________________________

City/State: __________________________ Zip: __________________

Current medications:

Name of medication	**Strength**	**How often**	**Prescribing Doctor**
1 ____________________	/______mg	________________	Dr.______________________
2 ____________________	/______mg	________________	Dr.______________________
3 ____________________	/______mg	________________	Dr.______________________
4 ____________________	/______mg	________________	Dr.______________________
5 ____________________	/______mg	________________	Dr.______________________
6____________________	/______mg	________________	Dr.______________________
7 ____________________	/______mg	________________	Dr.______________________
8____________________	/______mg	________________	Dr.______________________
9 ____________________	/______mg	________________	Dr.______________________
10____________________	/______mg	________________	Dr.______________________
11 ____________________	/______mg	________________	Dr.______________________
12____________________	/______mg	________________	Dr.______________________
13 ____________________	/______mg	________________	Dr.______________________
14____________________	/______mg	________________	Dr.______________________

Medications you have **<u>tried in the past</u>** for your arthritis condition.

Name of medication	**Dates you took them**	**Why you stopped taking them**
1 __________________________	/________-________	______________________________
2 __________________________	/________-________	______________________________
3 __________________________	/________-________	______________________________
4 __________________________	/________-________	______________________________
5 __________________________	/________-________	______________________________
6 __________________________	/________-________	______________________________
7 __________________________	/________-________	______________________________
8 __________________________	/________-________	______________________________

Patient Name:____ Date of Birth;_____________________

Allergies:____

Prior surgeries: ____

Past medical history: Please list any other diseases or illnesses you have now or have had previously.

1 _____________________________________ 4 ______________________________________

2 _____________________________________ 5 ______________________________________

3 _____________________________________ 6 ______________________________________

Have you ever smoked cigarettes or used tobacco in other forms? **YES** **NO (**circle one)

If yes, when you were smoking your heaviest, how many packs per day did you smoke on average: ____________ pack(s).

What year did you start smoking?____________. If you subsequently quit, what year did you quit?____________.

Do you drink alcohol? **YES** **NO (**circle one)

If yes, do you drink BEER**, WINE** or **LIQUOR? ____________** On average, how many drinks per week? ____________.

What other physicians care for you; now or in the past?

1____ 4 ____

2____ 5 ____

3____ 6____

Is there a history of arthritis or rheumatic disease in your family? **YES** **NO (**circle one)

If yes, please indicate Father, Mother, or Grandparent.

Rheumatoid Arthritis: _____________________________________Gout: ___________________________

Lupus: ____________________________________Psoriasis: _____________________________________

Other: ____

Is your arthritis problem a result of an accident or trauma? **YES** **NO** (circle one)

Please note:

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

* **Disability or FMLA forms will NOT be completed until you have received SIX MONTHS of established care from our practice.**

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Medical Information Release Form (HIPAA Release Form)

I understand that Augusta Arthritis Center, 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

Name (Please Print):______________________________ Date of birth: _______________

Patient Signature: ______________________________________ Date: ________________

Witness Signature: ______________________________________ Date: ________________

Augusta Arthritis Center, Inc.
Patient Scheduling Policy

We are committed to providing our patients with the best possible medical care and minimizing administrative costs. This scheduling policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for professional services.

New Patients

- Our physicians are very thorough with each and every patient. Please be prepared for the possibility that you will be in our office for several hours. We will need to review all of your medical history at your first visit.
- Due to an increased number of no-shows and cancellation of New Patient appointments, we are now charging a $50 fee for all appointments that have not been cancelled 48 hours prior to the scheduled appointment date. A payment of $50 will be required to schedule and secure all New Patient appointments. This payment will be taken over the phone when scheduling the appointment and will be applied to your account for your copayment, deductible and/or coinsurance. If you are owed a refund, it can be issued upon the payment of your first claim.
- If you are unable to keep your appointment, kindly call our office at least 48 hours prior to your appointment time. We will work with you to reschedule you to a more convenient time. The $50 fee will be applied and charged to all appointments cancelled and NOT rescheduled 48 hours prior to the appointment date. If you fail to cancel your appointment with 48-hour notice, your $50 deposit will be forfeited.
- Cash Payments and co-payments must be paid at the time of service.
- Self-pay patients are required to bring a remaining payment in the amount of $250 to their initial visit, which will be collected prior to being seen by the physician.

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.
- A $25 no-show/late cancellation fee will be applied to all follow-up visits that are not cancelled with a 48-hour notice. The fee must be paid prior to rescheduling.
- Any patient who no-shows or cancels 2 appointments without giving a 48-hour notice cannot be rescheduled without a $50 deposit by credit card.
- 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. Reminder calls are a courtesy.
- It is the patient's responsibility to obtain any referral required by their insurance for their office visit. If a patient shows up for their office visit without an updated referral, they can pay a $25 fee for our office to obtain the referral or reschedule after they receive the referral.
- All treatments given in the infusion center must be cancelled with a 48-hour notice. A $50 late cancellation fee will apply to all infusion/injectable treatment appointments not cancelled with the appropriate notification.

***If you are 15 minutes late to your appointment, you will be rescheduled. ***

Our practice firmly believes that a good physician-patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to the medical practice. We are here to help you.

Patient Name (PLEASE PRINT): ____

Patient Signature: ____ Date: ____________________

Augusta Arthritis Center, Inc.
Patient Financial Policy

We are committed to providing our patients with the best possible medical care and minimizing administrative costs. This financial policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for professional services.

- As the owner of your insurance policy, you are solely responsible for the policies regarding your plan.
- Our practice participates with numerous insurance companies. For patients who are beneficiaries of one of these insurance companies, our billing office will submit a claim for services rendered. 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 is happy to file the claim upon request; however, payment in full is expected at the time of service. If we are out of network with your secondary insurance (such as SC Medicaid), you will be responsible for any balances assigned as patient responsibility by your primary insurance.
- There is a mandatory deposit of $125 for all existing non-insured patients and $300 for new non-insured patients. This deposit will be applied to all charges incurred during your visit. If you are unable to make a deposit, your visit may be rescheduled.
- It is the patient's responsibility to pay any deductible, copayment, or any portion of the charges as specified by the plan at the time of visit. Payments for medical services not covered by an individual's insurance plan are the patient's responsibility and payment in full is due at the time of visit.
- Payment for professional services can be made with cash, check, or credit/debit card.
- Financial assistance is available for qualified patients. If a patient feels that he or she may qualify for assistance, the practice receptionist should be notified for referral to the appropriate individual. 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.
- It is the patient's responsibility to ensure that any required referrals or pre-certifications for treatment are provided to the practice prior to the visit. Visits may be rescheduled, or the patient may be financially responsible due to lack of the referral or authorization from their insurance company
- It is the patient's responsibility to provide us with current insurance information and bring his/her insurance card to each visit.
- Any patient who no-shows or cancels 2 appointments without giving a 48-hour notice cannot be rescheduled without a $50 deposit by credit card. Make sure we have proper documentation in the notes screen.
- Our staff is happy to help with insurance questions relating to how a claim was filed or regarding any additional information the payer might need to process the claim. Specific coverage issues, however, can only be addressed by the insurance company member services department. *(Telephone number is printed on your insurance card.)*
- If your insurance company requests additional information from you, it is important to reply with their requests in a timely manner considering that the balance of your claim and bill is ultimately the patient's responsibility whether your insurance company pays your claim or not. If the insurance company does not pay your claim in 45 days, the balance is billed to and becomes the responsibility of the patient.
- It is the patient's responsibility to notify us with any changes to insurance coverage and to make sure Augusta Arthritis Center has the proper insurance information. If we do not have the correct insurance information, the patient is responsible for the total bill.
- All labs drawn in our office will be processed by Quest. If you wish to have your labs processed by a different laboratory, please inform the physician during your visit.

Our practice firmly believes that a good physician-patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to the medical practice. We are here to help you.

Patient Name (PLEASE PRINT): ____

Patient Signature: ____ Date: ____________________

Augusta Arthritis Center, Inc.
Patient Refill Policy

We are committed to providing our patients with the best possible medical care and minimizing administrative costs. This prescription refill policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for professional services.

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

- Physicians will not accept refill requests after hours or on the weekends.
- Refill requests will be submitted to your pharmacy. Please allow 24 hours for this process. You may contact your pharmacy after 24 hours to check on your refill. If there are problems with your refill, you may call our offices only after you have spoken with your pharmacy.
- 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.
- Your prescription can only be discussed with a physician, nurse, or medical assistant.
- Our office is closed on Fridays. No prescription requests will be taken Friday, Saturday or Sunday.
- The requested medication has been ordered previously by an Augusta Arthritis Center, Inc. physician.
- The patient has been seen by the physician in the last **6 months** or it is documented that the physician has ordered a **1 year follow up**.
- The patient has kept the last scheduled appointment or has been rescheduled for a date within the next 4 weeks.
- 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.
- 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.

Our practice firmly believes that a good physician-patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to the medical practice. We are here to help you.

Only the following person(s) may be permitted to pick up prescriptions on my behalf:

1.______________________________ 2.______________________________

Patient Name (PLEASE PRINT): ____________________________________

Patient Signature: ____ Date: __________________