Arthritis Treatment Center of the Lowcountry
23 Plantation Park Drive, Suite 101
Bluffton, SC 29910
(P) 843-815-6555
(F) 843-815-6553
The office of Dr. John Brittis

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 Arthritis Treatment 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 ATC, we appreciate you following the guidelines of the practice which helps us maintain our goals.

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

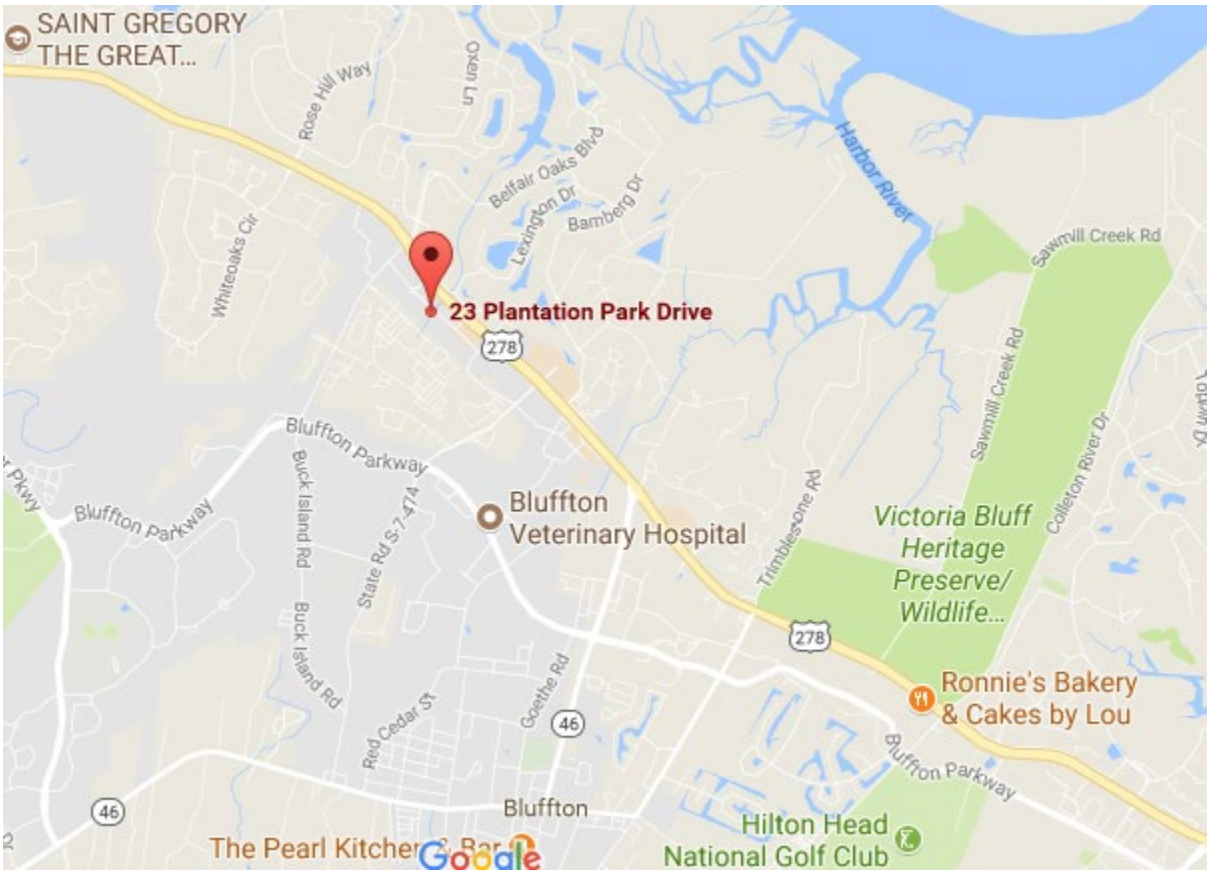
- Cash payments, deductibles and co-payments must be paid at the time of service. Payments for medical services not covered by insurance plans are the patient's responsibility.
- We do not accept Medicaid as a secondary insurance.
- Our Prescription Refill Policy is as follows: Please request refills at your visit. If you call in for refills, they will be called in between the hours of I0am-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 24-48 hour advanced notice is required for all written prescriptions. All patient phone calls or request will be addressed by a nurse within 24-48 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 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 Bluffton Office

23 Plantation Park Drive, Ste 101, Bluffton, SC 29910



PATIENT INFORMATION

Last Name	**First Name**	**Middle Initial**
Street Address		**Apt/Lot #**
City	**State**	**Zip**
SSN#	**D.O.B**	**Circle One: Mr. Mrs. Ms. Dr.**
Home Phone #	**Alt. Phone #**	
Email		**Employment** Full-time Part-time Retired Disabled
Sex M F	**Marital Status** S M W D	**Student** Yes No Full-Time Part-Time
Referring Physician		**Phone #**
Primary Care Physician		**Phone #**
Spouse		**Phone #**
Emergency Contact		**Phone #**
Primary Insurance Name		
Policy Holder Name	**D.O.B.**	
Policy #	**Group#**	**Group Name**
Secondary Insurance Name		
Policy Holder Name	**D.O.B.**	
Policy #	**Group#**	**Group Name**

SOCIAL INFORMATION (Circle one)

Live with: Spouse Alone Assisted Living Significant Other Nursing home
Nutrition: Poor Diet Average Diet Good Diet Excellent Diet
Exercise: Regular Irregular Cardio Walking None
Alcohol: Occasional Former Alcohol Dependency Recovering None
Tobacco: Never Current Smoker Former Smoker

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 Arthritis Treatment Center of the Lowcountry for services rendered. I understand that I am financially responsible for all charges incurred at Arthritis Treatment Center of the Lowcountry. 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:_____ Date: _____

MEDICAL HISTORY

Preferred Pharmacy: _____ Address:_____

City: _____ Zip: _____

Please list under illnesses, what you are currently taking medications for.

List Illnesses:_____

_____

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

Fractures: _____

Allergies: _____

Prior surgeries: _____

Pregnancies: Number of: _____ Number of children: _____
Miscarriage: Yes / No If yes, How many? _____

FAMILY HISTORY

Does a family member listed below have a history of any of the following: **Rheumatoid Arthritis, Lupus, Gout, Depression, Fibromyalgia, Autoimmune Diseases.**

Circle One:
Mother**: YES or NO**
Father**: YES or NO**
Siblings**: YES or NO**
Grandparents**: YES or NO**

Authorization to Release/Obtain Medical Records

To/From ARTHRITIS TREATMENT CENTER OF THE LOWCOUNTRY, The Office of Dr. John Brittis

(P) 843-815-6555 (F) 843-815-6553, Located at 23 Plantation Park Drive, STE 101, Bluffton, SC 29910

Patient Name:_____DOB: _____

Previous Name (if applicable): _____SSN: _____

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

Method of disclosure:

☐ **release** medical records **FROM** Arthritis Treatment Center of the Lowcountry to:

Name: _____

Fax #: _____

☐ **release** medical records **TO** Arthritis Treatment Center of the Lowcountry 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:_____

Medical Information Release Form (HIPAA Release Form)

I understand Arthritis Treatment Center of the Lowcountry 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: _____

Arthritis Treatment Center of the Lowcountry
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 avoid any misunderstanding 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.
- 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 card.
- 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.
- 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 the 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 Articularis Healthcare has the proper insurance information. If we do not have the correct insurance information, the patient is responsible for the total bill.

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

Patient/Guardian Signature: _____

Date: _____

Articularis Healthcare Group, 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 24-48 hours for this process. 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 closes at Noon on Fridays. No prescription request will be taken Friday afternoon, Saturday, or Sunday.
- The requested medication has been ordered previously by an Arthritis Treatment Center of the Lowcountry physician.
- 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**.
- 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 communications. Questions about financial arrangements should be directed to the medical practice. We are here to help you.

Patient/Guardian Signature**:** _____

Date**:** _____

Dear MEDICARE Patient:

Thank you for choosing ARTHRITIS TREATMENT CENTER OF THE LOWCOUNTY (ATC) for your medical care. As you know, ATC is participating with Medicare. This means we bill Medicare directly 80% of the bill. You are responsible for the remaining 20% of the allowable charges, as well as your annual deductible.

1. Please advise our staff if you have met some or all of your annual deductible at the time of the visit.
2. If your deductible has been met, then you must pay your bill based on Medicare's fee schedule.
3. The 20% not paid by Medicare is also your responsibility and should be paid at the time of service.
4. If your secondary carrier is not a Medigap Plan, it will pay you directly. Our office will print a claim form for you to file with your secondary insurance. Payment of the 20%, however, must still me made at the time of service.
5. If you have enrolled in Medicare HMO, please let our staff know. If we have contracted with that plan, you are only required to pay your Annual deductible (if any) and your co-payment.
6. If we have not contracted with your plan, you will be required to pay the bill in FULL at the time of service, based on the Medicare fee scheduled.

We kindly ask your cooperation in working with our policy, and we will endeavor to assist you in any way we can.

Please sign below and return this form to our office staff.

I have read the above and understand my obligations.

_____ _____

SIGNATURE OF PATIENT DATE SIGNED

Notice of Privacy Practices

Arthritis Treatment Center of the Lowcountry (ATC) recognizes the importance of protecting all personal and nonpublic information maintained in our practice. This notice describes the kind of information maintained and ways in which that information is protected. It also describes how ATC uses and shares that information and what your rights are regarding that information.

- ATC is required by federal and state law to protect the privacy of all personal and nonpublic information collected about you.
- ATC collects information – name, address, date of birth, social security number, insurance coverage and financial authorizations for use in your personal patient records and financial transactions.
- ATC does not share the information collected from you, except as permitted by law.
- ATC is permitted by law to share your patient information in the course of providing your health care, as well as in other special circumstances. Financial authorizations are kept confidential.
- ATC maintains internal safeguards to protect all your information, and any other entity with which it might share your information in order to administer health care is obligated to do the same.
- If ATC needs to share your information in any way other than what the law permits, it will do so only after obtaining your authorization.
- If identity theft is alleged, there is an action list that is referred to by employees of ATC that includes: advising the victim, completing an ID theft report, flagging the victims account and following all other bullets on the checklist in the red flag identity section of the HIPPA manual.

If you believe your privacy rights have been violated you may file a complaint with HIPPA/Red Flag compliance officer at Washington DC and/or with the Secretary of HHS.

_____ _____

PATIENT SIGNATURE DATE