RHEUMATOLOGY ASSOCIATES OF OKLAHOMA

Latisha Heinlen, M.D.

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IT IS THE POLICY OF THIS OFFICE THAT ALL PAYMENTS ARE DUE AT THE TIME OF VISIT!

Today's Date : _____

PATIENT INFORMATION

Patient's Full Name _____ Social Security Number _____

Date of Birth _____ Age _____ Sex ❑ Male ❑ Female

Race _____ Ethnicity ❑ Hispanic ❑ Non - Hispanic Preferred Language _____

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Patient's Current Address _____

City _____ State _____ Zip _____

Home Phone # _____ Cell # _____ E-mail _____

Is this Patient a Student? ❑ Yes ❑ No If Yes ❑ Full Time or ❑ Part Time

EMPLOYEE STATUS

❑ Full Time ❑ Part Time ❑ Retired ❑ Unemployed

Patient's Employer _____ Position _____

Employer's Address _____ City _____ State _____ Zip _____

Employer's Phone # _____

EMERGENCY CONTACT INFORMATION

Spouse's Name _____ Phone # _____

Emergency Contact • Next of Kin

Name _____ Phone # _____ Relation _____

INSURANCE INFORMATION

Primary Insurance Coverage _____ Policy ID # _____

Cardholder's Name _____ D.O.B. _____ SS# _____

Cardholder's Employer _____

Is this a Primary Insurance for all family members? ❑ Yes ❑ No

If NO, Please Explain _____

Secondary Insurance Coverage _____ Policy ID # _____

Cardholder's Name _____ D.O.B. _____ SS# _____

Cardholder's Employer _____

Is this a Secondary Insurance for all family members? ❑ Yes ❑ No

If NO, Please Explain _____

THIS PAGE MUST BE SIGNED & DATED

I hereby apply for treatment by the physician of this practice and/or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled to this practice. I understand that payment is due at the time of service and I am financially responsible for all charges, whether or not paid by the insurance.

_____

Signature Date

MEDICARE PATIENTS ONLY

I understand in Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the non-covered services. Co-Insurance and the deductible are based on the charge determination of the Medicare carrier.

_____

Signature Date

MEDICATIONS AND ALLERGIES

Please answer every question

Patient Name: _____ Date of Birth: _____

ALLERGIES

Please indicate if you have allergies to any of the following:

☐ I HAVE NO KNOWN ALLERGIES

☐ Sulfa Drugs
☐ Codeine / Codeine Derivatives
☐ Morphine Derivatives
☐ Erythromycin
☐ Penicillin
☐ Latex
☐ Adhesive Tape / Bandages
☐ Betadine / Iodine
☐ Seasonal Allergies (Hay Fever)

Please list any additional allergies you have. If possible, include your reactions.
(e.g., hives, rash, itching, nausea, diarrhea, fainting, headaches, shock, shortness of breath, etc.)

Name	Reaction

MEDICATIONS

What medications are you currently taking?
(Include prescriptions, over the counter medications, herbal supplements and vitamins.
e.g., Aspirin, Motrin, Vitamin E, St. John's Wort, etc.)

☐ **I AM NOT CURRENTLY TAKING ANY MEDICATIONS** (prescription or over the counter)

Name	Dosage	Frequency

Name	Dosage	Frequency

PHARMACY

Please list the pharmacy you would like us to use when calling in your prescriptions (if needed):

Pharmacy: _____ Location: _____

RADIOLOGY PROCEDURES

Have you had any orthopedic complaints resulting in radiology procedures in the last year? Example: Xray, MRI, CT Scan

Procedure	Date

OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Patient Name:_____ Medical Record #:_____

Date of Birth:_____ Social Security #:_____

I hereby authorize _____
Name of Person/Organization Disclosing PHI

to release the following information to Latisha Heinlen, M.D. 6516 N. Olie, Suite G Oklahoma City, OK 73116
Name and Address of Person/Organization Receiving PHI

Information to be shared:

☐ Psychotherapy Notes (if checking this box, no other boxes may be checked) ☐ Entire Medical Record

☐ Billing Information for_____ ☐Mental Health Records

☐ Substance Abuse Records ☐ Medical information compiled between_____ and _____

☐ Other:_____

The information may be disclosed for the following purpose(s) only:

☐ Insurance ☐ Continued Treatment ☐ Legal ☐ At my or my representative's request

☐ Other:_____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event:_____

_____

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Description of Legal Representative's Authority Expiration date (if longer than one year from date of signature or no event is indicated)

Chart No. _____

Rheumatology Associates of Oklahoma
Authorization to Release Information via phone/Family/Friends

Patient Name: _____ DOB: _____

I hereby authorize confidential communications from the physicians or staff of Rheumatology Associates of Oklahoma regarding my health, care, treatments, appointments, prescriptions, etc… to be received at any of the numbers given below. I authorize the staff to leave messages on the voice mail or with the individual who answers the phone at any of the below numbers:

Home Phone: _____ Work Phone: _____ Cell phone: _____

Other: _____

I authorize the following individuals to call the office on my behalf to verify the status of appointments, treatment plan, medications, and account information. These individuals may also pick up prescriptions and/or samples that I have requested:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

I understand this authorization will remain in effect until I revoke the authorization in writing.

_____ _____
Patient Signature Date

Rheumatology Associates of Oklahoma, LLC STAFF ONLY:

Documented by:

_____ _____
Initials Date

Rheumatology Associates of Oklahoma

A division of The Physicians' Group

MEDICATION REFILLS

1. Refill requests may be made Monday-Thursday, 8:00 am to 4:00 pm. Please have the pharmacy fax refill requests to 405-608-8070.

2. Refills *will not* be made after hours, at night, on weekends or holidays. On call physicians will not answer calls regarding medication refills.

3. All prescriptions require a *3-day notice* to be refilled.

4. If the prescription is to be picked up, you may do so Monday-Thursday, 8:00 am to 12:00 noon or 1:00 pm to 4:00 pm.

5. Please check your bottles for refills. If you have refills you *do not* need to call the doctor's office, only call the pharmacy.

6. Patients are responsible for their controlled substance medication. Your doctor will closely monitor controlled substance medication.

7. Please remember to discuss any medication concerns you have with your doctor at your regular scheduled appointments.

8. Please be aware we do not always have medication samples in stock.

9. Our office hours are Monday-Thursday, 8:00 am to 12:00 noon and 1:15 pm to 5:00 pm. Friday 8:00 am - 12:00 noon.

10. After hours or in case of emergency, you may call 405-608-8060 and you will be given instructions on how to contact the doctor on call.

Patient signature:_____ Date:_____

Appointment No Show and Late Policy

APPOINTMENT NO SHOWS

A **NO SHOW** appointment is a missed appointment without notifying our office 24 hours prior to scheduled appointment. If your appointment is scheduled for a Monday, we require notification no later than Friday prior to your appointment.

- The first no show will result in a call or email reminding you that you have missed your appointment and will need to reschedule for another day.
- The second no show will result in a call or email and a $50.00 charge to the patient, not your insurance company. This must be paid prior to scheduling your next appointment.
- The third no show will result in a dismissal from the practice.

LATE POLICY

We understand that even the most punctual person can occasionally run late. If that is the case, please call us prior to your appointment time so we can get you rescheduled. If the schedule allows, the appointment time will simply be shifted to accommodate the delay. However, if the tardiness can't be accommodated, we will reschedule your appointment time, we will then give your time away to another patient.

- Patients arriving early or on time will be seen in the order they were scheduled.
- Any patient arriving more than 15 minutes late will be asked to reschedule.

Signature of Patient _____

Signature of Parent or Guardian (if applicable) _____

Print Name of Patient _____

Print Name of Parent or Guardian _____

Dated: _____

DISCLOSURE OF PHYSICIAN OWNERSHIP
NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

As a prospective patient of Community Hospital or Northwest Surgical Hospital, we are pleased to inform you of the following:

1. Dr. Latisha Heinlen, MD, has an ownership interest in Community Hospital and Northwest Surgical Hospital.

2. In addition, other physicians that may treat you at the hospital may have an ownership interest in the hospital.

3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a healthcare facility other than Community Hospital or Northwest Surgical Hospital. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician or any representative of Community Hospital or Northwest Surgical Hospital. For a full list of our physician owners and additional information about our healthcare facilities, please visit our website at communityhospitalokc.com or nwsurgicalokc.com.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Community Hospital and Northwest Surgical Hospital.

_____	_____
Signature of Patient	Signature of Parent or Guardian (if applicable)
_____	_____
Print Name of Patient	Print Name of Parent or Guardian

Dated:_____

HPI COMMUNITY HOSPITAL

HPI NORTHWEST SURGICAL HOSPITAL

HPI COMMUNITY HOSPITAL IMAGING CENTER

HPI COMMUNITY HOSPITAL OUTPATIENT THERAPY

HPI NORTHWEST SURGICAL HOSPITAL LAKEPOINTE IMAGING CENTER

RHEUMATOLOGY ASSOCIATES OF OKLAHOMA

NEW PATIENT SURVEY

Answer each line and question in the space provided. Check the best answer. ***Fill out both sheets of this form.***
This survey will help the doctor evaluate, diagnose and treat you. Write your comments & questions on the next page.

Patient's Name _____ Age _____ D.O.B. _____ E-mail _____

Referred by _____ My Primary Care MD _____

Emergency Contact _____ Relationship _____ Phone # _____ Work # _____

ABOUT YOUR ARTHRITIS OR PROBLEM

What is your problem/concern/Any specific joints bothering you today. _____

When Did Your Symptoms First Begin? Month _____ Year _____

Initial Symptoms? _____

Where? ❑ Fingers ❑ Hands ❑ Wrist ❑ Elbow ❑ Shoulder ❑ Knee ❑ Feet ❑ Hip ❑ Back ❑ Neck

First Diagnosed as? _____ By Dr. _____ Where? _____

What Tests Were Abnormal? ❑ ANA ❑ Sed Rate ❑ RF(rheumatoid factor) ❑ Uric Acid ❑ Biopsy

This Week I am Doing... ❑ Very Good ❑ Good ❑ Fair ❑ Poor ❑ Very Poor ❑ Better ❑ Much Worse

I am Mostly Concerned About? _____

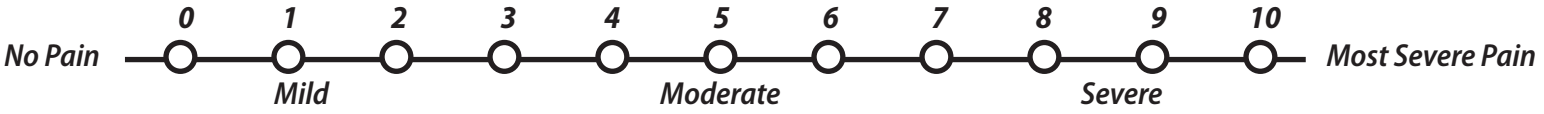
I'm Having... ❑ Pain ❑ Stiffness ❑ Aching ❑ Soreness ❑ Muscle Pain ❑ Swelling ❑ Weakness ❑ Numbness

How long is your morning stiffness? ❑ None ❑ 15 min ❑ 30 min ❑ 45 min ❑ 1 hr ❑ 2 hr ❑ 4 hr ❑ All Day

My Sleep is... ❑ Great ❑ Normal ❑ Fair ❑ Poor ❑ Very Poor ❑ Pain ❑ Sleeping Aids Used? ❑ Yes ❑ No

❑ Can't Fall Asleep ❑ Can't Stay Asleep ❑ Early Waking ❑ Snoring ❑ Sleep Apnea ❑ Restless Legs

In the PAST WEEK, How Much Pain Have You Had?



Have You Ever Taken Any of These Medications?

❑ Antacids	❑ Bextra	❑ Orudis Etodolac	❑ Gold	❑ Cortisone	❑ Buspr Wellbutrin	❑ Vicodin
❑ Axid	❑ Celebrex	❑ Voltaren	❑ Enbrel	❑ Prednisone	❑ Effexor Pristiq	❑ Baclofen
❑ Cytotec	❑ Clinoril	❑ Colchicine	❑ Humira	❑ Ambien	❑ Lexapro	❑ Flexeril
❑ Pepcid	❑ Daypro	❑ Allopurinol	❑ Ilaris	❑ Ativan	❑ Pamelor	❑ Norflex
❑ Prevacid	❑ Disalcid	❑ Uloric Febuxostat	❑ IVIG	❑ Halcion	❑ Paxil	❑ Parafon Forte
❑ Prilosec	❑ Dolobid	❑ Krystexxa	❑ Imuran	❑ Klonopin	❑ Prozac	❑ Robaxin
❑ Protonix	❑ Ecotrin	❑ Actemra	❑ Kineret	❑ Lunesta	❑ Savella	❑ Skelaxin
❑ Nexium	❑ Feldene	❑ Arava	❑ Methotrexate	❑ Restoril	❑ Seroquel	❑ Soma
❑ Tagamet	❑ Ibuprofen	❑ Atabrine	❑ Orencia	❑ Valium	❑ Zoloft	❑ Zanaflex
❑ Zantac	❑ Indocin	❑ Auranofin	❑ Otezla	❑ Xanax	❑ Codeine	❑ Cholesterol/ Statins
❑ Advil	❑ Lodine	❑ Azathioprine	❑ Penacillamine	❑ Celexa	❑ Hydrocodone	❑ Flu Vaccine
❑ Aleve	❑ Mobic	❑ Azulfidine	❑ Plaquenil	❑ Desyrel	❑ Lortab/Lorcet	❑ Hepatitis Vaccine
❑ Anacin	❑ Motrin	❑ Beniysta	❑ Remicade	❑ Elavil	❑ Oxycontin	❑ Pneumovax
❑ Anaprox	❑ Naproxen	❑ Cimzia	❑ Rituxan	❑ Trazodone	❑ Percocet/dan	❑ Shingles Vaccine
❑ Ansaid	❑ Relafen	❑ Cosentyx	❑ Simponi	❑ Cymbalta	❑ Tramadol	❑ Tetanus
❑ Arthrotec	❑ Tolectin	❑ Cyclosporine	❑ Sulfasalazine	❑ Lyrica	❑ Tylenol #3	❑ Drug Study
❑ Aspirin	❑ Vioxx	❑ Cytoxan	❑ Xeljanz	❑ Neurontin	❑ Ultram/Ultracet	❑ Injections

Have you had any side effects from any of these drugs? ❑ Yes ❑ No Which Medication? What side effect?

_____