PLEASE PRINT AND FILL FORM OUT WITH BLACK INK ONLY.

Amanda H. Fowler, MD • Day S. Lennep, MD

Sherra Carr, FNP-C • Lindsay Page, FNP-C • Alice Shackelford, FNP-C • Michelle Smith, FNP-C • Jordan Morris, FNP-C • Lauren L. Rivers, FNP-C • Julie Harper, FNP-C

185 Medical Parkway, Suite 201, Flowood, MS 39232 • Phone 601-362-6900 • Fax 601-362-6111

PATIENT NAME ____________________________________ ARRIVAL TIME ____________________________________

We want to take this opportunity to welcome you to our clinic. We are privileged you have chosen our clinic for your health care needs. Our staff is dedicated to the care of our patients and to making each visit as pleasant as possible. Your feedback is important to us. If at any time you experience a problem, please talk with our office coordinator. Only through communication with our patients can we improve our quality of care.

We would also like to take this opportunity to explain our policies regarding phone calls, prescription refills, and payment policies to you.

Your phone calls are important to us and we will make every effort to return your calls in a timely manner. Our nurses and medical assistants take all calls. They report to the physician or nurse practitioner and will return your call within 24 hours.

Our office does not refill routine prescriptions over the phone. It is important that you request any medication refills at the **time of your visit.** If you need a refill before your next appointment, call your pharmacy to fax over refill request. Please check your medication supply carefully before your scheduled visit so we may assist you in remaining current with your prescription needs.

Our physicians participate in a number of contractual agreements with insurance companies, however, you are responsible for knowing the terms of **your** contract with **your insurance company.** If your insurance company has special requirements for diagnostic testing or requires a referral to our clinic by your primary care physician, it is important that you notify us in advance. With most insurance companies, a portion of the fees will ultimately be **paid by the patient.** This may be in the form of a “copay”, a “coinsurance” percentage of the fees allowed, or in the form of a deductible. We ask that you take care of your part of the fees **at the time the service is rendered.** If you have questions regarding your particular insurance coverage please call our office prior to your appointment. **Your bill is your responsibility.** We will be happy to assist you.

We feel it is important that our patients understand the responsibility for any remaining balance remains ultimately with the patient. However, we do recognize that there are times when our patients are unable to pay the entire amount due. **Please call our office to discuss any special arrangements needed before your appointment.**

If for some reason you are unable to keep this appointment, we would appreciate your help in notifying us no later than 24 hours in advance. We reserve 45 minutes for new patients and broken appointments are very costly. We will be happy to reschedule your appointment for a more convenient time. **YOU MUST BE IN OUR CLINIC AT YOUR ASSIGNED TIME.**

By signing this letter, I confirm that I have read and understand the above policies and give my consent for medical treatment by Mississippi Arthritis Clinic, PLLC. I understand that I am responsible for compliance with the terms of my health insurance contract, except where limited by specific agreements between my physician and my insurer. If your insurance changes before your appointment you must call and give us the new insurance. We do not take all insurances.

Patient Signature ____ Date ______________________

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Patient Registration Form

PATIENT INFORMATION

Patient's Name ______________________________ Social Security Number ______________
LAST FIRST MIDDLE INITIAL MAIDEN
Address ______________________________ **Email Address** ______________________
City ______________________ State ______________ Zip ______________
Employer ____
Is this a Work-Related Injury? ______________ Retired? __________ Disabled? __________
Home Phone ______________ Cell Phone ______________ Work Phone ______________
Birth Date ____________ Age ______ Sex ______ Marital Status ______ Race __________
Spouse Name ______________________________ Spouse DOB ______________
Spouse Employer __________________________ Spouse Work Phone ______________

PERSON RESPONSIBLE FOR BILL (If different from above, please complete.)

Guarantor's Name __________________________ Social Security Number ______________
Address ____
City ______________________ State ______________ Zip ______________
Home Phone ______________________ Work Phone ______________________
Employer ____

EMERGENCY CONTACT (other than spouse) ______________________ Relation ______________
Address ____
Home Phone ______________________ Work Phone ______________________

PRIMARY CARE PHYSICIAN ______________________ Phone ______________

INSURANCE INFORMATION (If insurance cards are available, please omit this part.)

Primary Insurance Company ____
Address ____
Insured Name ______________________ Relationship ______________ Date of Birth ______________
Policy Number ______________________ Group Number ______________________
Secondary Insurance Company ____
Address ____
Insured Name ______________________ Relationship ______________ Date of Birth ______________
Policy Number ______________________ Group Number ______________________

REFERRAL

Referred to our clinic by ____

BENEFITS AUTHORIZATION

I authorize treatment of the patient named above and agree to pay all fees and charges. I request that payment of authorized Medicare, Medicaid or other third-party insurances be made to Mississippi Arthritis Clinic, PLLC. if assignment is accepted, in which case I agree to pay any deductible, co-payment or disallowed charges. If assignment is not accepted, then I agree to pay the entire amount due. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or the Division of Medicaid or their Fiscal Agent or any third-party insurance any information needed to determine these benefits. (A copy of this assignment is as valid as the original.)

Patient or Guarantor Signature ______________________________ Date ______________

MISSISSIPPI
Arthritis
CLINIC

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Patient History Form

Describe briefly your present symptoms ____________________

Please shade all the locations of your pain over the past week on the **body figures** and **hands**.
Example:

LEFT RIGHT LEFT

LEFT RIGHT

Date symptoms began (approximate) ____________________

Diagnosis ____________________

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later)

Please list the names of other practitioners you have seen for this problem ____________________

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosino Spondylitis	
	Childhood Arthritis			Osteoporosis	
Other arthritis conditions:					

Patient's Name ____________________ Date ____________________ Physician Initials ________

MISSISSIPPI
Arthritis
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SOCIAL HISTORY

Do you drink caffeinated beverages?
Cups/glasses per day? _______
Do you smoke? ❏ Yes ❏ No ❏ Past- How long ago? ____
Do you drink alcohol? ❏ Yes ❏ No Number per week _____
Has anyone ever told you to cut down on your drinking?
❏ Yes ❏ No
Do you use drugs for reasons that are not medical? ❏ Yes ❏ No
If yes, please list ________________________________
____
Do you exercise regularly? ❏ Yes ❏ No
Type ____
Amount per week ________________________________
How many hours of sleep do you get at night? ___________
Do you get enough sleep at night? ❏ Yes ❏ No
Do you wake up feeling rested? ❏ Yes ❏ No

PAST MEDICAL HISTORY

Do you now or have you ever had (check if "yes")

❏ Cancer ❏ Heart problems ❏ Asthma
❏ Goiter ❏ Leukemia ❏ Stroke
❏ Cataracts ❏ Diabetes ❏ Epilepsy
❏ Nervous breakdown ❏ Stomach ulcers ❏ Rheumatic fever
❏ Bad headaches ❏ Jaundice ❏ Colitis
❏ Kidney disease ❏ Pneumonia ❏ Psoriasis
❏ Anemia ❏ HIV/AIDS ❏ High Blood Pressure
❏ Emphysema ❏ Glaucoma ❏ Tuberculosis

Other significant illness (please list) ______________________
____
Natural or Alternative Therapies (chiropracty, magnets, massage, over-the-counter preparations, etc.)
____
____
____

PREVIOUS OPERATIONS

Type		Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ❏ No ❏ Yes Describe : ______________________________
Any other serious injuries? ❏ No ❏ Yes Describe: ______________________________

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings _________ Number living _________ Number deceased ________
Number of children _________ Number living _________ Number deceased ________ List ages of each ____________
Health of children ____
Do you know of any blood relative who has or had (check and give relationship)

❏ Cancer ______________ ❏ Heart disease __________ ❏ Rheumatic fever ________ ❏ Tuberculosis ____________
❏ Leukemia ______________ ❏ High blood pressure ______ ❏ Epilepsy ______________ ❏ Diabetes ______________
❏ Stroke ______________ ❏ Bleeding tendency ______ ❏ Asthma ______________ ❏ Goiter ______________
❏ Colitis ______________ ❏ Alcoholism ______________ ❏ Psoriasis ______________

Patient's Name ______________________________ Date ______________ Physician Initials ___________

MISSISSIPPI Arthritis CLINIC

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Systems Review

As you review the following list, please check any of those problems which have significantly affected you.
Date of last mammogram _____________ Date of last eye exam ________________ Date of last chest x-ray _______________
Date of last Tuberculosis Test __________ Date of last bone densitometry _________

CONSTITUTIONAL
❏ Chills
❏ Fatigue
❏ Fever
❏ Night sweats
❏ Weight gain
❏ Weight loss
❏ Other_____________

HEENT
❏ Visual changes
❏ Vision loss
❏ Blurred vision
❏ Dental cares
❏ Double vision
❏ Dry mouth
❏ Dry eyes
❏ Dysphagia
❏ Epistaxis
❏ Eye pain
❏ Facial pain
❏ Hearing loss
❏ Hoarseness
❏ Jaw pain
❏ Nasal drainage
❏ Nasal sores
❏ Oral ulcers
❏ Red eye
❏ Sinusitis
❏ Sore throatTinnitus
❏ Other____________

RESPIRATORY
❏ Apnea
❏ Cough
❏ Dyspnea on exertion
❏ Frequent URI
❏ Hemoptysis
❏ Orthopnea
❏ Paroxysmal nocturnal dyspnea
❏ Pleuritic pain
❏ Shortness of breath
❏ Wheezing
❏ Other____________

CARDIOVASULAR
❏ Chest pain
❏ Claudication
❏ Edema
❏ Palpitations
❏ Raynaud's
❏ Substernal chest pain
❏ Tachycardia
❏ Thrombophlebitis
❏ Varicose veins
❏ Other____________

GASTROINTESTINAL
❏ Abdominal cramping
❏ Abdominal pain
❏ Bloating
❏ Blood in stools
❏ Constipation
❏ Diarrhea
❏ Dysphagia
❏ Early satiety
❏ Epigastric pain
❏ Heartburn
❏ Hemorrhoids
❏ Loss of appetite
❏ Nausea
❏ Vomiting
❏ Other____________

GENITOURINARY
❏ Dysuria
❏ Genital lesions
❏ Genital ulcers
❏ Hematuria
❏ Impotence
❏ Kidney stones
❏ Mentral irregularities
❏ Nocturia
❏ Pelvic pain
❏ Peri-menopausal
❏ Post-menopausal
❏ Polyuria
❏ Recurrent UTI
❏ Scrotum/testicular pain
❏ Urinary frequency
❏ Urinary incontinence
❏ Other____________

For Women Only:
Age when periods began______
Periods regular ❏ Yes ❏ No
How many days apart?______
Date of last period?______
Date of last pap?______
Bleeding after menopause?
❏ Yes ❏ No
Number of pregnancies?______
Number of miscarriages?______

METABOLIC/ENDOCRINE
❏ Cold intolerance
❏ Gynecomastia
❏ Hair loss
❏ Heat intolerance
❏ Hirutism
❏ Hot flashes
❏ Polydipsia (incr. thrist)
❏ Other____________

NEUROLOGICAL
❏ Confusion/disorientation
❏ Dizziness
❏ Extremity numbness
❏ Extremity weakness
❏ Gait distrubance
❏ Headache
❏ Memory loss
❏ Seizures
❏ Syncope (fainting)
❏ Tingling
❏ Tremors
❏ Other___________

PSYCHIATRIC
❏ Anxiety
❏ Depression
❏ Emotionally labile
❏ Hallucinations
❏ Insomnia
❏ Suicidal ideation
❏ Other____________

IMMUNOLOGIC
❏ Allergic rhinitis
❏ Frequent infections
❏ Food allergies
❏ Other____________

INTEGUMENTARY
❏ Acne
❏ Bruising
❏ Discoid rash
❏ Hives
❏ Itching
❏ Nail changes
❏ Photosensitivity
❏ Psoriasis
❏ Rash
❏ Scalp tenderness
❏ Skin lesion
❏ Other____________

MUSCULOSKELETAL
❏ Back pain
❏ Height loss
❏ Joint pain
❏ Joint swelling
❏ Joint tenderness
❏ Low back pain
❏ Morning stiffness
❏ Muscle cramping
❏ Muscle weakness
❏ Musular atrophy
❏ Myalgia
❏ Neck pain
❏ Neck stiffness
❏ Other____________

HEMATOLOGIC/LYMPH
❏ Easy bleeding
❏ Easy bruising
❏ Lymphadenopathy
❏ Other____________

Patient's Name ____ Date ________________ Physician Initials __________

MISSISSIPPI Arthritis CLINIC

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Medications

Drug Allergies ❏ No ❏ Yes To What Medication? ____________________

Symptoms Of Reaction ____________________

PAST ARTHRITIS MEDICATIONS (Please list any medications you have taken for arthritis or joint pain. Try to remember how long you took the medication and the results of taking the medication.)

Name of Drug	Dose (strength & # of pills)	How long was medication taken?	How did medication help? A- A Lot, S-Some, N- None

CURRENT MEDICATIONS: (Please list all medications you are taking now. Include vitamins, laxatives, calcium, herbal or other supplements.)

Name of Drug	Dose (strength & # of pills)	How long was medication taken?	How did medication help? A- A Lot, S-Some, N- None

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Receipt of Notice of Privacy Practices: Written Acknowledgment Form

I, ____ have received a copy of the privacy practices of

❏ Dr. Amanda H. Fowler

❏ Dr. Day S. Lennep

Patient Signature ____ Date _________________________

Birth Date ____

Food and Drug Administration
We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, monitor product defects or problems, report biologic product deviations, track products, enable product recalls, make repairs or replacements or to conduct post-marketing surveillance, as required.

Legal Proceedings
We may disclose protected health information in the course of any judicial or administrative proceeding, in response to on order of a court or administrative tribunal (to the extent such disclosure is expressly authorized,) in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement
We may also disclose protected health information, as long as applicable legal requirements are met, for law enforcement purposes.

Coroners, Funeral Directors and Organ Donation
We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Cases of Criminal Activity
Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security
When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits and to foreign military authority if you are a member of that foreign military service.

Workers' Compensation
Your protected health information may be disclosed, by us as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmate
We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures
Under the law, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

Complaints
You may address complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Manager of your complaint.

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Protected health information about you is maintained as a record of your contacts or visits for healthcare services with our clinic. Specifically, "protected health information" is information about you, including demographic information (name, address, phone. etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

We are required to follow specific rules on maintaining the confidentiality of your protected health information, using your information and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow applicable rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law. If you have any questions about this Notice, please contact our Privacy Manager.

Your Rights Under the Privacy Rule
Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our staff.

Copy of Notice of Privacy Practices
You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices. We are required to follow the terms of this notice. We reserve the right to change the terms of our notice at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices. You may call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

Authorize Other Use and Disclosure
You have the right to authorize or deny any other use or disclosure of protected health information that is not specified within this notice. You may revoke an authorization at any time, in writing, except to the extent that your healthcare provider or our office has taken action in reliance on the use or disclosure indicated in the authorization.

Delegate a Personal Representative
You have the right to designate a person with the delegated authority to consent to or authorize the use or disclosure of protected health information.

Inspect and Copy Your Protected Health Information
You have the right to inspect and obtain a copy of protected health information about you that is contained in your patient record.

Restriction of Your Protected Health Information
You have the right to ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases, we may deny your request for a restriction.

Amendment to Your Protected Health Information
You have the right to request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

Disclosure Accountability
You have the right to request a listing of disclosures that we have made of your protected health information to entities or persons outside of our office other than for the purposes of treatment, payment, healthcare operations, or a purpose authorized by you.

How We May Use or Disclose Protected Health Information
Following are examples of uses and disclosures of your protected healthcare information that we are permitted to make.

Treatment
We may use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescription. We will also disclose protected health information to other healthcare providers who may be involved in your care and treatment. We may also call you by name in the waiting room when your healthcare provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office.

Payment
Your protected health information will be used as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities.

Healthcare Operations
We may use or disclose as-needed, your protected health information in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services and auditing functions. It also includes education, provider credentialing, certification, underwriting, rating or other insurance-related activities. Additionally, it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets and creating de-identified information.

Other Permitted and Required Uses and Disclosures
We may also use and disclose your protected health information in the following instances as outlined below. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

Others Involved in Your Healthcare
Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your healthcare will be disclosed.

Required by Law
We may use or disclose your protected health information to the extent that the use or disclosure is required by law.

Public Health
We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

Communicable Diseases
We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight
We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections.

Cases of Abuse or Neglect
We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made in a manner that is consistent with the requirements of applicable federal and state laws.

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Authorization to Release Medical Information

I ______________________________ give permission to Mississippi
(Name of Patient)

Arthritis Clinic to release any and all of my medical records to the person(s) named below.

Name(s) or person(s) who may acquire my medical records:

1. Name ______________________________

   Relationship ______________________________

   Phone Number ______________________________

2. Name ______________________________

   Relationship ______________________________

   Phone Number ______________________________

______________________________ ______________________________
Signature of Patient Date