ARTHRITIS & OSTEOPOROSIS CLINIC OF BRAZOS VALLEY

1721 Birmingham Dr., Ste. 204, College Station, TX 77845 (979) 696-8000 (979) 696-8100 fax

Board Certified in Rheumatology

Ricardo Pocurull, MD, PA, FACR **Rajpreet Singh, DO, PA, FACR**

Kati Langston, PA-C **Laura Smith, PA-C**

Welcome to the Arthritis & Osteoporosis Clinic of Brazos Valley. We are pleased that you have scheduled an appointment with our Clinic. Enclosed you will find new patient information.

We ask that you please come in 30 minutes before your scheduled time to allow for mailed and in office paperwork to be completed. We apologize in advance for any inconvenience this may cause.

Please take the time to fill the paperwork out prior to your appointment and bring it with you to your first appointment. Please also bring the following to your appointment:

- Currently effective insurance card(s),
- A photo I.D.,
- A list of all medications that you are currently taking **(required at every visit)** and,
- **If your insurance requires a referral authorization, it must be available and in our office at the beginning of appointment or you will be asked to reschedule.** To obtain a referral authorization, contact your primary care physician in advance of your appointment.

If you are unable to keep your appointment, please kindly give a 24 hour advance notice.

Thank you for your cooperation and we look forward to seeing you.

Sincerely,

AOCBV

Appointment Date: ________________________________

Appointment Time: ____________________

ARTHRITIS & OSTEOPOROSIS CLINIC OF BRAZOS VALLEY

Pocurull 06.01.17

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) requires us to provide our patients with a notice of our privacy practices. This notice describes how your protected health information (PHI), or any health information which could be used to identify you as the individual patient who is associated with that health information, may be used and disclosed by the Arthritis & Osteoporosis Clinic of Brazos Valley (AOC), our duties to protect that information, your rights as a patient regarding your PHI, and who to contact if you believe your privacy rights have been violated.

Use and Disclosures: Your physician, the office staff of AOC, and others involved in your care and treatment outside of our office may collect, use and disclose your PHI via fax, telephone and email. AOC may disclose your PHI to other doctors, hospitals, or surgical or diagnostic facilities for the purpose of diagnosing or treating you; to insurance and third party payers for the purpose of obtaining payment for your health care bills; and to business associates we have contracted to perform services such as transcription, billing, collections, appointment reminder, and answering services. AOC may contact you and leave messages for you with appointment reminders and health-related treatment alternatives and services that may interest you.

Without your authorization AOC may use or disclose your PHI in the following situations: as Required By Law, Public Health Issues required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workersø Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to 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 HIPAA.

Your Rights: You have a right to inspect and copy your PHI, which is used to make decisions about your care. HIPAA allows us to charge a reasonable fee for copies and you may not inspect or copy the following records: psychotherapy notes; information compiled in anticipation of litigation; information that identifies the person who provided us information under a promise of confidentiality; information subject to Clinical Laboratory Improvements Amendments of 1988; and PHI that is subject to law that prohibits access to PHI. Texas law requires these requests to be in writing and you may do so by writing to the privacy officer listed at the end of this notice. You have the right to amend your PHI by writing to the privacy officer listed, if that information is inaccurate or incomplete. If we deny your request, we must provide you with a written denial and allow you to submit a statement of disagreement for inclusion in the record.

You have the right to request that we restrict how your PHI is used or disclosed, but we do not have to agree to your requests for restriction. However, if we do agree, we must comply with your request, except under emergency situations. Please send your requests in writing to the privacy officer listed at the end of this notice and include the following: the information to be restricted, what kind of restriction you are requesting (i.e. on the use of information, disclosure of information, or both) and to whom these limits apply.

You have the right to receive confidential communications. You may request that we communicate with you by alternate means or to an alternate location. We are required to accommodate reasonable requests. You may do so by writing to the privacy officer listed at the end of this notice and specify exactly how and where you want us to communicate with you.

Our Duties: We are required by law to protect the privacy of your PHI, to provide you with a notice of our privacy practices regarding that information, and to abide by the terms of the notice of the privacy practices in effect. Copies of our privacy practices are also available in our office lobby and online at www.aocbv.com.

Complaints: You may complain to our privacy officer at the address and number below or to the Department of Health and Human Services, if you believe your privacy rights have been violated. We will not retaliate against you for filing a complaint.

Privacy Officer:
Kim Zapata – Practice Manager
1721 Birmingham Dr., Ste. 204
College Station, TX 77845
(979) 696-8000

Leon Rodriguez, Director
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

Updated and Effective 3/18/15

PATIENT REGISTRATION FORM

Patient Name ____
Last **First** **Middle**

Birthdate ____/____/______ †**Male** †**Female** †**Married** †**Single** †**Widowed** †**Divorced**

Social Security _______-_____-_______ **Spouse Name:** ______________________

Street Address ______________________________ (____)______________
Home Phone

City, State, Zip______________________________ (____)______________
Cell or Pager

Employer______________________________ (____)______________
Work Phone

Insurance Information

Is your insurance an affordable care plan? †Y †N **If yes, you will immediately be cash pay.

*Did you sustain an injury at work? †**Y** †**N** Are you covered under an employer or union policy? †**Y** †**N**

We do not accept Workman's Compensation Insurance. If you answered Yes, STOP.

*Are your injuries accident related? †**Y** †**N** Is your spouse or other family member employed? †**Y** †**N**

*auto and personal injury claims are not filed by our office and the patient is responsible for payment.

Are you currently employed? †**Y** †**N** Do you have a secondary insurance policy? †**Y** †**N**

Are you the primary policyholder/subscriber †Yes †No **If no, please fill out the following:**

Name of primary policyholder/subscriber______________________________

Policyholder/Subscriber's Birthdate ____/____/______ **Social Security**______-_____-_____

Your relationship to policyholder †Spouse †Child †Stepchild †Other:__________________

Nearest friend or relative that does not live with you:

______________________(____)______________ ______________________
Name **Phone** **Relationship**

How will you pay for visit? ________________**Who referred you?**__________________

Who is your primary care physician?______________________________

What is the reason for today's visit?______________________________

Have you seen another physician for this condition? †Yes †No If yes, who?________________

Have you ever had a MEDICATION ALLERGY? †Yes †No If YES, list medications allergy:

____

I voluntarily authorize the rendering of medical care, including examination, diagnostic procedures, and medical treatment by Ricardo Pocurull M.D., Rajpreet Singh D.O., Kati Langston PA-C, Laura Smith PA-C, his/her staff and designees, as may in his professional judgment be deemed necessary or beneficial. I acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition. I understand that I have the right to make decisions concerning my health care, including the right to refuse medical and surgical procedures.

______________________________ ______________
Signature of Patient or Personal Representative Date

ARTHRITIS & OSTEOPOROSIS CLINIC OF BRAZOS VALLEY

Acknowledgement of Review of Notice of Privacy Practices

I acknowledge that I have had the opportunity to review the Arthritis & Osteoporosis Clinic of Brazos Valleyøs Notice of Privacy Practices. (Available on page 2 of the new patient registration packet.) This document explains how my medical information will be used and disclosed. I understand that diagnosis or treatment of me by my physician may be conditional upon my consent as evidenced by my signature on this document. I understand that I am entitled to receive a copy of this document. I am aware that copies are available in the lobby of the Arthritis and Osteoporosis Clinic of Brazos Valley and online at www.aocbv.com.

____ _______________

Signature of Patient or Personal Representative Date

____ _______________

Print Patient or Personal Representativeøs Name Date

Do you feel comfortable with your ability to read and write? † Yes † No

Authorization to Release/Discuss Medical Information

I, ____, authorize Ricardo Pocurull M.D., Rajpreet

Print Patient Name

Singh D.O., Kati Langston, PA-C, Laura Smith PA-C, or their designated representative to release or discuss information in my

health records to or with ____.

Print Name(s)

I realize that I have the right to rescind this designation at any time by writing the staff at Arthritis & Osteoporosis Clinic of Brazos Valley, PLLC.

____ _______________

Patient/Legal Representative Date

____

Printed Name, if signed on behalf of the patient

ARTHRITIS & OSTEOPOROSIS CLINIC OF BRAZOS VALLEY

Financial Policy

We are dedicated to providing the best possible care and service to you and regard the complete understanding of your financial responsibilities as an essential element of your care and treatment. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs. If you have any questions about the policy, please discuss them with the billing office at (979)696-8000 ext. 101. Please direct your questions about your financial responsibility *first* to your insurance company. However, do not hesitate to call us for questions about our statements to you.

Payment Options: For your convenience, we will accept cash, check, money order, VISA, MasterCard, and Discover. A $25.00 service charge will be added to your account for all returned checks and must be paid before additional appointments will be scheduled. Restitution of the check must be made within 10 days or check will be given to the County Attorney for prosecution.

Appointments: Broken appointments represent a cost to us, to you and to the other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed appointments. Currently, our no show fee is $50 and may increase at any time. Excessive abuse of scheduled appointments may result in discharge from the practice. Reminder phone calls are a courtesy to you; you are responsible for your appointment even if you do not receive a reminder phone call.

Insurance: You must provide proof of your currently effective insurance at each appointment. Unless you have health coverage, full payment is due at the time of service. We bill participating insurance companies as a courtesy to you. All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your health care provider, our relationship is with you, our patient, not with your insurance company. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

HMO's: HMOøs usually require authorization prior to all visits. It is the patientøs responsibility to get that authorization from your primary care physician with the dates of service of your appointments. If we do not have a copy of this authorization at the time of service, we will reschedule your appointment until that authorization is available or you may pay for your entire visit prior to being seen by your provider. Amounts that your insurance pays will be refunded to you.

Medicaid: Medicaid requires all recipients to present their card when seeking medical attention, failure to do so may result in the rescheduling of your appointment.

Cash Pay: We utilize a standard self-pay policy based off Medicare rates. 125% of Medicare allowable amount is our fee for services updated annually. Payment is due at the time services are rendered.

Controlled Substance: Due to recent law changes and increase in the number of prescriptions we write, effective Sept. 26, 2016, there will be a fee for all Schedule II triplicate refills. Paper triplicates will be $10.00 due at the time of pick-up for refills called in 2 business days ahead and $15.00 for refills called in to be picked-up the same day. Identification is required for paper pick-up. All electronic triplicates will be $25.00 sent directly to the pharmacy.

Services Rendered in the Hospital: We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

PRINT NAME:_______________________________________

ARTHRITIS & OSTEOPOROSIS CLINIC OF BRAZOS VALLEY

Financial Policy

Workmen's Compensation: We do not take Workmenøs Compensation. We do not treat injuries incurred at work.

Minor Patients: For all services rendered to a minor patient, we will look to the adult accompanying the patient and/or the parent or guardian with custody for payment.

Collection Agency: Any account that is given to our collection agency due to non-payment will have a 30% collection charge added to the account. Our collection agency will then collect the past due amount plus the 30% collection charge.

I understand that I am financially responsible for all charges for service to me, including the balance remaining after payment of possible insurance benefits. I authorize payment of medical benefits to Ricardo Pocurull, MD, PA, FACR, Kati Langston, PAC, Rajpreet Singh, DO, PA, FACR, Laura Smith, PA-C for professional services rendered. I authorize the release of any medical information needed to process claims. I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

____ ________________

Signature of Patient or Responsible Party Date

____

Printed Name

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Joint Aspiration and Injection Acknowledgement Form

Patient: ____

1. Arthrocentesis or aspiration and injection of a joint are procedures commonly used by the AOCBV to improve joint function and provide pain relief as well as evaluation measures. This is an acknowledgement form for patient record identifying my acknowledgement of such procedures.
2. I understand that these are procedures performed by placing a needle into the joint or surrounding area. The goal is to withdraw fluid from the joint to provide pain relief, analyze the fluid under the microscope, and, possibly, inject medication into the joint to provide additional pain relief. I understand that the removal of fluid may be needed to find out why the fluid was present. I understand that fluid may re-accumulate after the removal. I understand that the medication that may be injected is a corticosteroid and may not provide long-lasting or permanent relief, and that no guarantee can be made about the outcome of my planned procedure.
3. Risks associated with joint aspiration and injection include the following:
   - Pain associated with the procedure if the needle touches joint surfaces
   - Increased bleeding, especially for those patients on blood thinning medications.
   - Damage to a nerve or joint surface from the needle or medication
   - Rare introduction of infection into the joint
   - Increased joint pain after injection of medication, or post-injection flare reaction
4. **I understand that I can refuse any procedure that is offered to me during my care at AOCBV.**

Initials: ________________

Date: __________________

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Controlled Substance Agreement For Narcotics Prescribed by AOCBV

I, _______________________________, agree if AOCBV is prescribing a controlled substance that they will be the only physicians prescribing this medication for me and that I will obtain all of my prescriptions for controlled substances at one pharmacy. I will not seek controlled substances from another physician.

- I will not take controlled substances in larger amounts or more frequently than is prescribed.
- I will not give or sell my medication to anyone else, including family members; nor will I accept any controlled substances from anyone else. I agree to be responsible for the secure storage of my medication at all times. I understand that lost or stolen medication will not be replaced.
- I will attend all reasonable appointments, treatments and consultations as requested by my physician.
- I understand that the long-term use of controlled substances to treat chronic pain may result in physical dependence on this medication, and that sudden decreases or discontinuation of the medication will lead to the symptoms of controlled substances withdrawal. I understand that controlled substances withdrawal is uncomfortable but not life threatening.
- I understand that there is a risk that I may become addicted to the controlled substances I am being prescribed. The risk is small where medication is taken as prescribed for pain.
- I understand that my physician will require that I have urine monitoring monthly for *Schedule II* medications, every 3 months for *Schedule III* medications. Should a concern about addiction arise during my treatment my physician may ask me to see a specialist in addiction medicine. I will comply with all requests for laboratory tests including random or scheduled urine monitoring for appropriate narcotic management as ordered by my physician.
- I understand that the use of any mood altering substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as cannabis, cocaine, heroin or hallucinogens), can cause adverse effects or interfere with opioid therapy. Therefore I agree to refrain from the use of all of these substances without prior agreement from my physician.
- I consent to open communication between my doctor and any other health care professionals involved in my management, such as pharmacists, other doctors, emergency departments, etc.
- I understand that if I break this agreement, my physician reserves the right to stop prescribing controlled substances and I may be discharged from this practice.
- I will comply with requests by my physician to go to the office for a pill count between scheduled visits.

Refills Only:

- Please call ahead and leave message with patient name, date of birth, medication name, dosage and a phone number where you can be reached. Due to recent law changes and the number of prescriptions we write, we will assess a fee due either at the time of pick-up if paper or before submission if electronic. There will be a $10.00 charge for paper a refill called in 2 business days in advance and is due at the time of pick-up along with proof of identification. For same day paper triplicate prescriptions, messages must indicate same day paper prescription. The charge for Same Day paper triplicate prescriptions is $15.00 also due at the time of pick-up with proof of identification. For all electronic prescriptions there will be a charge of $25.00 for any electronic prescriptions sent directly to pharmacy and payment is due before it will be submitted. Triplicate prescriptions may only be picked-up by the patient, spouse or caregiver. We cannot mail this prescription to you. We will **NOT** write these prescriptions on weekends or Holidays. Please allow time for refill needs based on in-office process times and holidays accordingly.

____ _____________

Signature of Patient or Personal Representative Date

Epworth Sleepiness Scale

Use the Scale below and circle the appropriate number for each situation.

Situation	**Chance of dozing**			
	Would never doze	**Slight chance**	**Moderate chance**	**High Chance**
Sitting and reading	**1**	**2**	**3**	**4**
Watching T.V.	**1**	**2**	**3**	**4**
Sitting inactive in a public place	**1**	**2**	**3**	**4**
As a passenger in a car for 1hr straight	**1**	**2**	**3**	**4**
Lying down to rest in the afternoon	**1**	**2**	**3**	**4**
Sitting and Talking to someone	**1**	**2**	**3**	**4**
Sitting quietly after lunch	**1**	**2**	**3**	**4**
In a car, stopped in traffic	**1**	**2**	**3**	**4**

Total Score (Office use only):

FREQUENTLY ASKED QUESTIONS CONTøDí

1. Where do I find information about my condition?
   There is plenty of information on our website. We recommend you read about the condition and then ask any further questions on your next visit. If you want to get answers or clarification prior to your next visit, we recommend you use the online function. You will have a better understanding of your condition this way.
2. How do I find out about my blood test?
   Please allow 2 weeks for results. A letter will be mailed with results or you will be contacted by phone call from our office. If there are any questions regarding your lab results they will be handled by appointment only. No phone calls please.
3. How do I get refills?
   a. Refills may be obtained through your pharmacy, calling us for a new prescription, or using the online refill request.
   b. No refill will be done on weekends or after office hours.
   c. ABSOLUTELY NO NARCOTIC REFILLS ON WEEKENDS OR AFTER HOURS, ESPECIALLY WHEN ANOTHER DOCTOR IS ON CALL. NO EXCEPTIONS. Please do not contact us for after hourøs refills on narcotics because it will be denied.
   d. Narcotics are only refilled once a month. õI lost my prescription,ö õmy medication was stolen,ö I accidently spilled them into the toilette,ö etcí , are not excuses. The only way to obtain a narcotic refill prior to one month is to see the doctor and be assessed.
4. What happens if I have a problem after hours?
   A Provider is on call 24/7. We do ask for your consideration and that you try to contact us during office hours. This is where the online function is especially helpful. For emergencies please call any time.

NEXTGEN Patient Portal

What is the Online Patient Portal?

The Online Patient Portal is a secure, intuitive website that enables patients and providers to quickly access and manage health information. It provides easy communication tools, promoting patient-provider interaction and improving patient care.

With the Online Patient Portal, you can:

- Quickly and securely access your health information
- Instantly request and schedule appointments
- Send secure messages to billing and clinical staff
- Easily request prescription refills
- Reduce wait time by filling out forms online
- View and pay statements

Ask a staff member how to get started today!

Enrollment

- Request an **Enrollment Token** during your visit. (must have an email address)
- Visit www.NextMD.com
- Click Enroll Now and simply follow the steps