Coastal Rheumatology Associates

A member of
Southeastern Rheumatology Alliance, LLC

Coastal Rheumatology-Savannah
5400 Waters Ave.
Savannah, GA 31404
Office: (912) 349-4227
Fax: (912) 349-4457

Coastal Rheumatology-Bluffton
23 Plantation Park Drive. Suite 101
Bluffton, SC 29909
Office: (843) 815-6555
Fax: (843) 815-6553

We are looking forward to seeing you on this date: _____at this time: _____ at our _____ location.

You are scheduled with: ☐ Dean Stephens, M.D. ☐ Charles Degenhardt, M.D. ☐ Sarah Tarplin, M.D. ☐ Gustavo Carbone, M.D. ☐ Elizabeth Antoon, PA ☐ Vanessa Thomas, PA ☐ Cindi Boderman, NP ☐ Trevor Brown, PA

We are delighted that you have chosen us for your medical needs. At Coastal Rheumatology, we take great pride in the relationships that we establish with our patients, and the ability to provide a personalized approach to difficult problems.

As a patient of Coastal Rheumatology, we appreciate you following the guidelines of the practice to help us maintain our goals. Please read through our policies carefully and call us with any questions.

New patients:

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

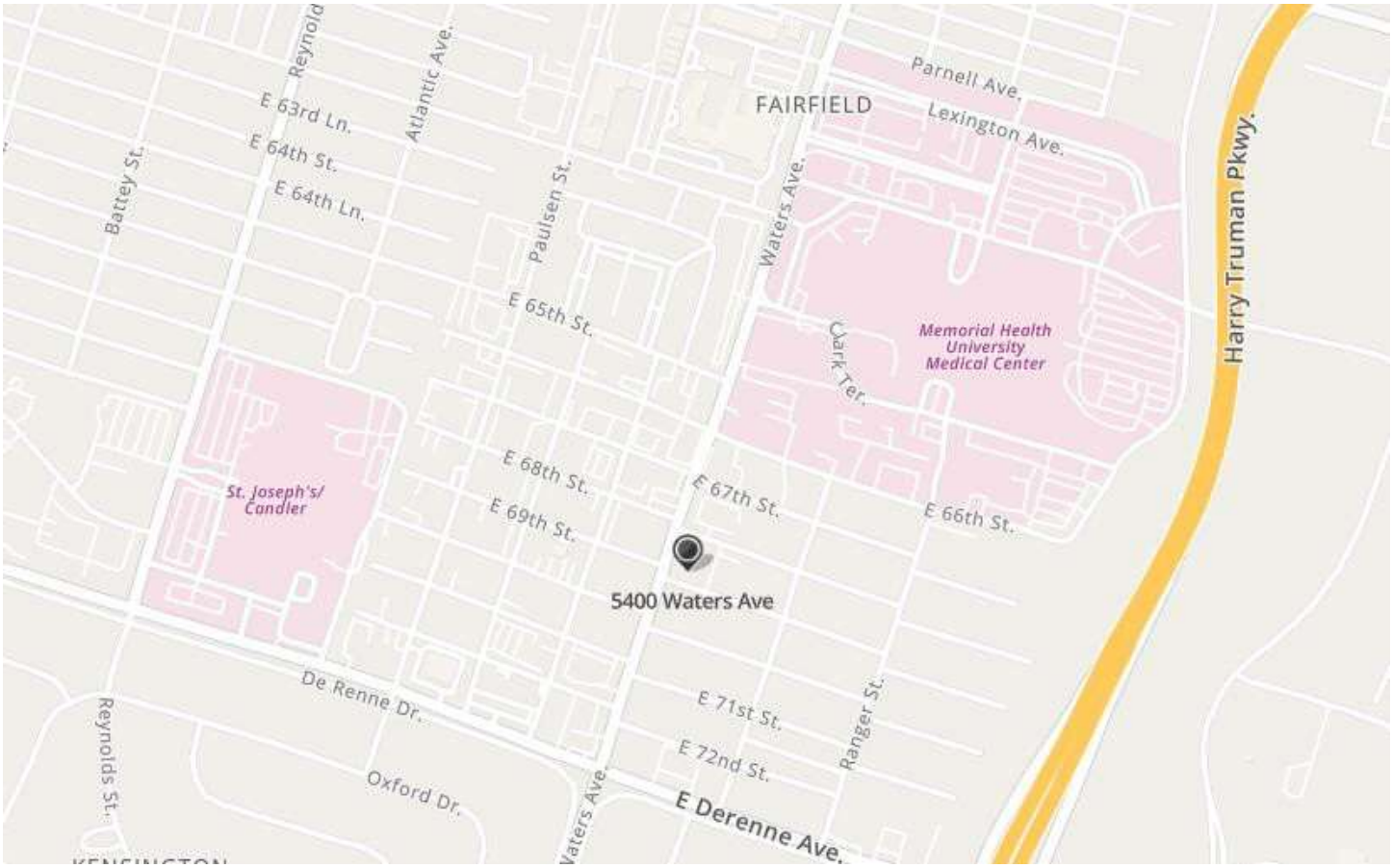
- There is a $25 no-show and cancelation fee for all appointments not kept or not canceled within 72 hours prior to your appointment date, except for emergencies.
- Cash payments, deductibles and co-payments must be paid at the time of service. Payments for medical services not covered by insurance plans are the patient's responsibility.
- It is the patient's responsibility to ensure we have a current and valid referral on file. Otherwise, you will be financially responsible for the visit charges in full.

Please bring attached forms, your photo ID, and insurance cards to your visit.

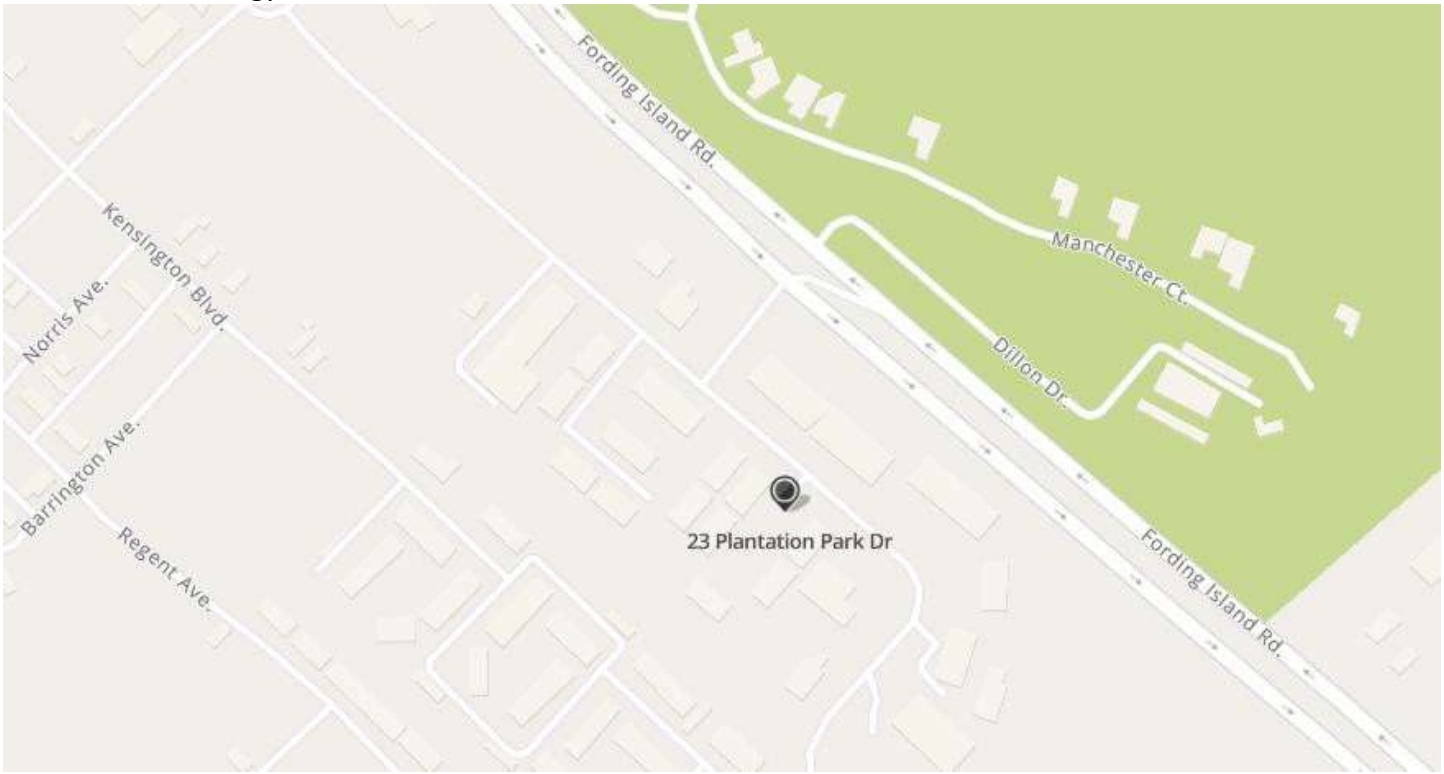
Please bring a typed or written medication list, your photo ID, and insurance cards to EVERY visit.

Please be aware that if you arrive late to your appointment, you will be asked to reschedule.

Coastal Rheumatology Associates – Savannah Office.



Costal Rheumatology Associates – Bluffton office.



Coastal Rheumatology Associates.

PATIENT INFORMATION **Referred By:**

Name: _____ Soc Sec #: _____
First Mid Last

Address: _____
Street / PO Box City State Zip

Telephone: Mobile (_____) _____ Work (_____) _____ Home(_____) _____

Sex at birth: M F Date of Birth: _____/_____/_____ E-Mail: _____
Email is required for our Patient Portal and other educational communication

Primary Care Physician: _____
Name Phone Address

Marital Status: _____ Race: _____ Ethnicity: Hispanic_____ Non-Hispanic_____

Emergency Contact: _____

Spouse Info (*If Applicable*): _____

EMPLOYMENT INFORMATION

Employed By _____ Occupation _____
Business Address _____ Business Telephone _____
Employment Status: FT_____ PT_____ Disabled____ Retired____ Military____ Not Employed_____ Student_____

PRIMARY INSURANCE ____Medicare ____Medicaid ____Self Pay _____Commercial

Insurance Company: _____
Name HMO / PPO / OPEN ACCESS
Policy # _____ Group # _____ Specialist Co-Pay _____
Address _____ City _____ State _____ Zip _____
Name of Insured _____ Insured SS # _____
Relationship to Patient _____ Date of Birth of Insured _____
Patient Preference: _____
Hospital Laboratory Pharmacy/Address

SECONDARY INSURANCE ____Not Applicable _____Medicare ____Medicaid _____Commercial

Insurance Company: _____
Name HMO / PPO / OPEN ACCESS
Policy # _____ Group # _____ Specialist Co-Pay _____
Address _____ City _____ State _____ Zip _____
Name of Insured _____ Insured SS # _____
Relationship to Patient _____ Date of Birth of Insured _____

ASSIGNMENT AND RELEASE

Authorization to treat and release information to insurance carrier for direct payment to the provider: I authorize treatment and the release of any medical information (acquired in my treatment) to process claims to my insurance carrier. I authorize direct payment from my insurance company to my provider. At any time should I decide that I want to file my own claims, I understand that payment in full will be required at the time of service. I also understand that I will be financially responsible for all charges incurred. In the event it becomes necessary to collect the amount due on my account by legal litigation, the handling fees, service charges or court costs will be paid by the guarantor listed above, which could include a 25% collection fee. In order to prevent the application of the above, fees should be paid timely upon completion of rendered services. I authorize the release of medical records to Coastal Rheumatology as necessary for continuity of care. Also, I understand that the practice will provide, at my request, a copy of the HIPAA Notice of Privacy, which is clearly posted in the lobby area.

_____ _____ _____
PATIENT'S SIGNATURE PRINT NAME DATE

_____ _____ _____
GUARANTOR'S SIGNATURE (If other than patient) PRINT NAME DATE

NOTICE OF PRIVACY POLICIES
Coastal Rheumatology Associates

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

Introduction

At Coastal Rheumatology Associates, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 15, 2013 and was updated 9/23/2020, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

I,_____, understand that as part of my healthcare, Coastal Rheumatology Associates originates and maintains paper and/or electronic records describing my health history, symptom examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that the information serves as:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although, your health record is the physical property of Coastal Rheumatology Associates, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request.
- Inspect and copy your health record.
- Request that your record be amended.
- Obtain an accounting of disclosures of your health information: To do this, please contact Coastal Rheumatology Associates Privacy Officer. This information will be provided to you within 30 days.
- Request a restriction on certain uses and disclosures of your information.
- Revoke your authorization to use or disclose your health information.
- You may request that we not submit your information to your health insurance carrier if you have paid for the service.
- You may request an electronic copy of your health record.
- Choose someone to act on your behalf.
- File a complaint if you believe your privacy rights have been violated.

Our Responsibilities

Coastal Rheumatology Associates is required to:

- Maintain the privacy and security of your health information.
- Provide you with this notice about our privacy practices.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction and accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- We must promptly notify you of a breach of health information privacy or security.

We will not use or disclose your health information without your authorization, except as described in this notice. To revoke your authorization, please put your request in writing to Coastal Rheumatology Associates.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer at (912)349-4227.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, D.C. 20201
Phone: 1-877-696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints/

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.
For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your other physicians or a subsequent health care provider with copies of various reports that should assist him or her in treating you.

We will use your health information for payment.
For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations.
For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.
Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.
Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.
Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.
Marketing: We may contact you to provide appointment reminders or information about treatment alternatives of other health-related benefits and services that may be of interest to you.
Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability, or in a disaster relief situation.
Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
Business Associates: We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services.
For example: We may use another company to do our billing or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.
Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) f or the institution to provide you with healthcare; (2) to protect your health and safety or the health and safety of others; or (3) the safety And security of the correctional institution.
Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers the public.
Changes to the Terms of This Notice:
We may change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I hereby acknowledge that (participating organization) will share my medical information, as permitted under federal law (H.I.P.A.A.) and Georgia and South Carolina state law, with my healthcare providers through a health information exchange. I fully understand and accept/decline the terms of this consent.

_____ _____

Patient's Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of the Notice of Privacy Practices for Coastal Rheumatology Associates detailing how my information may be used and disclosed as permitted under federal and state law.

Patient/Guardian Signed_____ Date:_____

Relation to patient:_____

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Medical Provider Services.

Medical services offered by Costal Rheumatology Associates will be provided by Physicians, as well as Physician Assistants, and Nurse Practitioners. As a patient of Coastal Rheumatology Associates, we may not always be able to schedule you with your physician. You may be scheduled with one of our Physician extenders or Advanced Practice Providers (APPs). We offer multiple practitioners that work hand in hand with our physicians and share the same access and care for our patients. This allows us to offer a higher level of care with more access for our patients.

By signing below, you acknowledge this policy with our practice.

_____ _____

Patient's Signature Date

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(This advises us of who we are allowed to discuss your medical treatment with)

Patient's Name: _____ Date of Birth: _____

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment for my care:

Name	**Relationship**	**Phone Number**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This authorization applies to (check only ONE box):

☐ **All Healthcare information**

☐ **Healthcare information relating to the following treatment, condition or dates:**

_____

☐ **Other: (Please be specific in directions)**

_____

Authorization Statement: *I understand that Protected Health Information (PHI) used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my revocation to the Coastal Rheumatology Associates location where I received care. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that Coastal Rheumatology Associates cannot require me to sign this authorization as a condition of treatment unless the provision of health care by Coastal Rheumatology Associates is solely for the purpose of creating PHI for disclosure to a third party legally authorized to receive such information. I understand that I will be given a copy of this authorization.*

Signature/Date: *(date authorization signed by patient or Legal Guardian/Personal Representative)* _____
Month/Day/Year

_____ _____
Print Patient Name or Name of Legal Guardian/Personal Representative *Signature of Patient or Legal Guardian/Personal Representative*

_____
Indicate relationship to patient (required)

Expiration Date: *This authorization is valid until written notice is provided to revoke this authorization.*

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MEDICAL RECORDS RELEASE

(This allows records to be sent)

Patient Information *(please print clearly)*:

_____ _____
Last Name *First Name* *Middle Initial* *Date of Birth (Month/Day/Year)*

_____
Street Address Apt #/P.O. Box # (Please include complete mailing address)

_____ _____
City *State* *Zip Code* *Primary Contact Number*

I authorize Costal Rheumatology Associates to ***disclose*** the above-named individual's health information to:

☐ Facility:

_____
Name

_____
Street Address

_____
City *State* *Zip Code*

☐ I would like to pick up my records in person.

☐ I authorize _____ to pick up my medical records in person.
(Name of person authorized to receive the records)

The information to be disclosed:

☐ All Billing Records
☐ Complete Medical Record
☐ Partial Medical Record *(please specify records below)*

Information	Dates
☐ Office Notes	_____
☐ Lab Results	_____
☐ X-Rays	_____
☐ Other	_____

The purpose of the disclosure:

☐ My personal records ☐ Disability
☐ Attorney ☐ Other _____

I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees. The fee is $0.65 per page for the first 30 pages and $0.50 for each page after 30

_____ _____
Patient Signature **Date**

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MEDICAL RECORDS REQUEST RELEASE

(This allows us to request records)

Patient Information *(please print clearly)*:

_____ _____

Last Name *First Name* *Middle Initial* *Date of Birth (Month/Day/Year)*

_____

Street Address Apt #/P.O. Box # (Please include complete mailing address)

_____ _____

City *State* *Zip Code* *Primary Contact Number*

I authorize Costal Rheumatology Associates to ***obtain*** the above-named individual's health information on their behalf from:

☐ Facility:

_____

Name

_____

Street Address

_____

City *State* *Zip Code*

Information to be ***obtained****:

☐ Referral ☐ Clinical notes ☐ Recent labs and imaging reports ☐ Demographics

☐ All of the above ☐ Other: _____

*Please fax information above to our Medical Records department at (912) 349-4457

Right to Revoke Authorization:

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present written revocation to Costal Rheumatology Associates. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

Refusal to Authorize Use and/or Disclosure:

I understand that authorizing the use or disclosure of the information above is voluntary. I need not sign this form to ensure healthcare treatment.

Release and Waiver:

If the health information that I have requested Coastal Rheumatology Associates to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), Immunodeficiency Syndrome Related Complex (ARC), human immunodeficiency virus (HIV), venereal disease, tuberculosis, or hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Coastal Rheumatology Associates from any and all liabilities, damages, and claims which might arise from the release of the health information authorized by me above.

_____ _____

Patient Signature **Date**

Coastal Rheumatology Associates

HEALTH HISTORY QUESTIONNAIRE

DATE: _____ NAME: _____ DATE OF BIRTH: _____

Which physician referred you to our clinic? _____

What is the main reason for the referred to our clinic? _____

When did your symptoms begin? _____

Which local pharmacy do you use? _____

Which mail order pharmacy do you use? _____

Rheumatologic History: (Current or Prior diagnosis)

Rheumatoid Arthritis	☐Yes ☐No	☐Osteoporosis or ☐Osteopenia	☐Yes ☐No
Osteoarthritis	☐Yes ☐No	Sjogren's syndrome	☐Yes ☐No
☐Psoriasis or ☐Psoriatic Arthritis	☐Yes ☐No	Sarcoidosis	☐Yes ☐No
Gout	☐Yes ☐No	Vasculitis	☐Yes ☐No
Lupus	☐Yes ☐No	Scleroderma	☐ Yes ☐ No
Fibromyalgia	☐Yes ☐No		
Ankylosing Spondylitis	☐Yes ☐No	List Any other Rheumatologic Diagnosis:	
Mixed Connective Tissue Disease	☐Yes ☐No		
Antiphospholipid Syndrome (APS)	☐Yes ☐No		
☐ Dermatomyositis or ☐Polymyositis	☐Yes ☐No		

Other History:

Cancer (Type & Year):	☐Yes ☐No	Eye Problems (Type):	☐ Yes ☐ No
☐Anxiety or ☐Depression	☐Yes ☐No	Kidney Disease	☐ Yes ☐ No
☐ADHD or ☐Bi-Polar disorder	☐Yes ☐No	Liver Disease	☐ Yes ☐ No
☐Asthma, or ☐COPD	☐Yes ☐ No	Lung Disease ☐Interstitial	☐ Yes ☐ No
Anemia	☐Yes ☐ No	☐ Crohn's / ☐Ulcerative Colitis	☐Yes ☐No
Allergies	☐Yes ☐ No	Stroke	☐ Yes ☐ No
☐ Back Pain or ☐Neck Pain	☐Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No
Bleeding Disorder	☐Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Diabetes	☐Yes ☐ No	Shingles	☐ Yes ☐ No
Diverticulitis - ☐Hospitalized	☐Yes ☐No	Sleep Apnea	☐ Yes ☐ No
Epilepsy / Seizure Disorder	☐Yes ☐ No	Hepatitis B	☐ Yes ☐ No
GERD (or heartburn)	☐Yes ☐ No	Hepatitis C	☐ Yes ☐ No
Heart Disease	☐Yes ☐ No	HIV/AIDS	☐ Yes ☐ No
Heart Arrhythmia or A-Fib	☐Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Hypertension	☐Yes ☐ No	Other Diagnosis:	
High Cholesterol	☐Yes ☐ No		
Skin Disease (Type)	☐Yes ☐ No		

Are you currently on blood thinning medication? ☐Yes ☐No

If so, What Medication and Why? _____

Coastal Rheumatology Associates

DATE: _____ NAME: _____ DATE OF BIRTH: _____

Please list all physicians that are currently involved in your care:

Physician Name	Practice/Office Name	Type of Physician/Specialty

Past Surgical History:

Procedure / Surgery	Performing Physician or Practice	Date

Medication Allergies:

Medication Name	Type of Reaction

Social history:

Do you currently or have you ever smoked? _____ If so, how much? _____

If you have quit smoking, how long did you smoke and when did you quit? _____

Do you currently or have you ever used a Vape device? _____ If so, how often? _____

Do you currently consume alcohol? _____

If so, what type, how much, and how often? _____

Do you currently or have you ever used any recreational drugs? _____

If so, what type, how much, and how often? _____

What is your current occupation? _____

Coastal Rheumatology Associates

DATE: _____ NAME: _____ DATE OF BIRTH: _____

Family History: *Have any of your close **family members** been diagnosed with the following?*

Disease		*Relationship to you*
Rheumatoid Arthritis	☐ Yes ☐No	
Osteoarthritis	☐ Yes ☐No	
Psoriatic Arthritis	☐ Yes ☐No	
Osteoporosis	☐ Yes ☐No	
Lupus	☐ Yes ☐No	
Gout	☐ Yes ☐No	
Vasculitis	☐ Yes ☐No	
Heart Disease	☐ Yes ☐No	
Hypertension	☐ Yes ☐No	
Diabetes	☐ Yes ☐No	
Cancer (what type?)	☐ Yes ☐No	
Other:		

Current prescription medications:

**Patient may skip this form and bring an accurate medication list.*

Medication Name	Dose / Strength	How often per day	Prescribing MD

Current over the counter medications and Vitamins.

Medication Name	Dose / Strength	How often per day	Physician recommended?

Rheumatology Medication History:

Have you tried ANY of the following medications?

Medication Name	Did it help?	Describe any side effects or problem with the medication.
Actemra	☐ Yes ☐No	
Azathioprine (Imuran)	☐ Yes ☐No	
Cimzia	☐ Yes ☐No	
Enbrel	☐ Yes ☐No	
Humira	☐ Yes ☐No	
Ibuprofen or other NSAID. (ex: Naproxen, Mobic, Celebrex, Aleve)	☐ Yes ☐No	
Ketvara	☐ Yes ☐No	
Leflunomide (Arava)	☐ Yes ☐No	
Methotrexate	☐ Yes ☐No	
Orencia	☐ Yes ☐No	
Otezla	☐ Yes ☐No	
Plaquenil (hydroxychloroquine)	☐ Yes ☐No	
Remicade	☐ Yes ☐No	
Rinvoq	☐ Yes ☐No	
Rituxan	☐ Yes ☐No	
Skyrizi	☐ Yes ☐No	
Simponi	☐ Yes ☐No	
Simponi Aria	☐ Yes ☐No	
Sulfasalazine	☐ Yes ☐No	
Stelara	☐ Yes ☐No	
Tremfya	☐ Yes ☐No	
Xeljanz	☐ Yes ☐No	
Other medication:		