ATTENTION – regarding insurance

Please be aware that we are not in-network for the following plans and are **unable to accept the insurance plans listed below:**

- Caresource Just4me
- Medicaid, Caresource or Molina for new patients'
- Molina Marketplace or Molina MyCare Ohio (we do accept the dual plan for Molina MyCare)
- Anthem Exchange (ID starts with JWR, JWS, JWT, & JWV)
- OSU PrimeCare
- UHC Community Plan Medicaid *(we do accept the dual plan*)
- Buckeye
- Paramount Medicaid
- No Exchange products purchased either thru your employer or the government, *these are recognizable by bronze, silver, platinum, or gold written on your card.*
- Aetna Better Health (Dual and Medicaid only) or Aetna QHP Ohio Exclusive
- Tricare PRIME – you must see an in-network provider

DOES YOUR INSURANCE REQUIRE A REFERRAL? Please check with your insurance company to see if they require your family physician to send in a referral require to the insurance prior to being seen. This is usually on the front of your card however, not always. If you arrive with no referral you visit will be rescheduled until one is obtained by you. If you do not have a referral and your insurance requires you to the claim will not be paid and you would be held responsible for the cost.

If you have one of the plans listed and would like to see one of our providers, please be aware that we require payment at the time of service. Please see our financial policy in the enclosed packet.

Please call our office at (614) 486-5200 option "0" if you have any questions, or you need to cancel your appointment. We understand that you have many choices when it comes to finding a healthcare provider, and we are pleased you have chosen Columbus Arthritis Center, Inc. We are sorry for any inconvenience this may cause you!

Thank you
CAC Administration

Welcome to the Columbus Arthritis Center. Thank you for choosing our physicians for your rheumatology services. Our goal is to meet your individual needs and to provide quality medical care in a convenient, comfortable setting.

Our Physicians are Board Certified Rheumatologists and Fellows in the American College of Rheumatology. Our staff is highly qualified, efficient, courteous, and they work very hard to do their best for our patients.

Our office is open five days a week, Monday through Friday, from 8:00 a.m. until 4:30 p.m. Should you need to contact us during regular hours, just dial 614-486-5200 and follow the prompts for your Doctor's Nurse, for appointments, for billing questions, etc.

Once you have had your first visit with your doctor and you have an urgent medical need after regular hours of operation, your doctor is available to you. Just call 614-486-5200, follow the prompts to leave a message for your doctor. This will page your doctor automatically. He/She will return your call within a short period of time.

Enclosed you will find a number of papers for you to read, complete, and sign. We ask that you bring these papers with you for your scheduled appointment:

- Financial Policy
- Map
- Patient Registration
- Preliminary History Form
- Notice of our Privacy Policies and your Rights as a Patient (These are required by the federal government and yours to keep)
- Acknowledgement of Your Receipt of the Notice (Must be signed and kept in our office in your personal record)
- Medication List
- Pharmacy information

We ask that you **arrive at our office at 30 mins prior** to your scheduled appointment time. **Please bring your insurance card(s), your copay, a photo ID, all of the papers in this packet, and any results from recent lab work or x-rays.**

We look forward to meeting you and providing you with high quality medical care.

For this information and more please visit our website **www.columbusarthritis.com**

Financial Policy

Thank you for choosing us as your health care provider. We are committed to providing you with quality medical care. Please understand that payment of your bill is considered part of your obligation as a patient. The following information is provided to avoid any misunderstanding or disagreement concerning payment of services provided by our office.

1.) Our office participates with a variety of insurance plans. It is your responsibility to:
   - Bring your current insurance card to every visit and notify us of changes in coverage
   - Pay your co-pay at each visit. Payment can be made by cash, check, MasterCard, Visa or Discover.
   - Obtain any referrals your insurance carrier requires. Your appointment may be rescheduled if a referral is required and is not in place at the time of service.

2.) We will submit a claim to your insurance company for you. Balances not paid, per our contract by your primary insurance company, may be billed to your secondary payer. A monthly statement will be sent to you. **Ultimately, you are responsible for payment of charges.**

3.) **If you do not have insurance coverage** or are insured by a company with which we are not contracted; a deposit of $150.00 for new patients or $50.00 for established patients is expected prior to delivery of services. If you do not have insurance coverage we offer a discount of 30% when balance due is paid in full on the date of service. We understand the financial burden that this may present and therefore will be offering an additional credit option for those interested.

4.) If you have questions about your insurance, we will be happy to assist you. Specific coverage issues however, should be directed to your insurance company's member services department (the contact number is on your insurance card).

5.) All balances billed are due within 30 days of the statement date. Unpaid balances greater than 30 days are subject to our collection process. Accounts sent to our collection agency are subject to a 35% surcharge.

6.) A finance charge will be added to any balance over 60 days at the rate of 1.5% per month or 18% per annum.

7.) A fee of $125.00 for a new patient or $25.00 for an established patient will be charged for all appointments that are not kept or cancelled within 24 hours prior to the appointment time. Upon request, your physician may agree to waive this fee for unforeseen circumstances.

8.) There is a fee of $25.00 on all returned checks.

9.) There is a fee to copy any and all medical records based on the number of pages copied, after a one time courtesy.

10) Your physician may order a procedure to be performed either in our office or outside the office; you will need to contact your insurance provider to check your benefits for outpatient procedures. This coverage determination is not a guarantee of payment and is subject to coverage and benefits at the time of service. You may also ask our office for the procedure/diagnosis codes to verify that the procedure is a covered benefit.

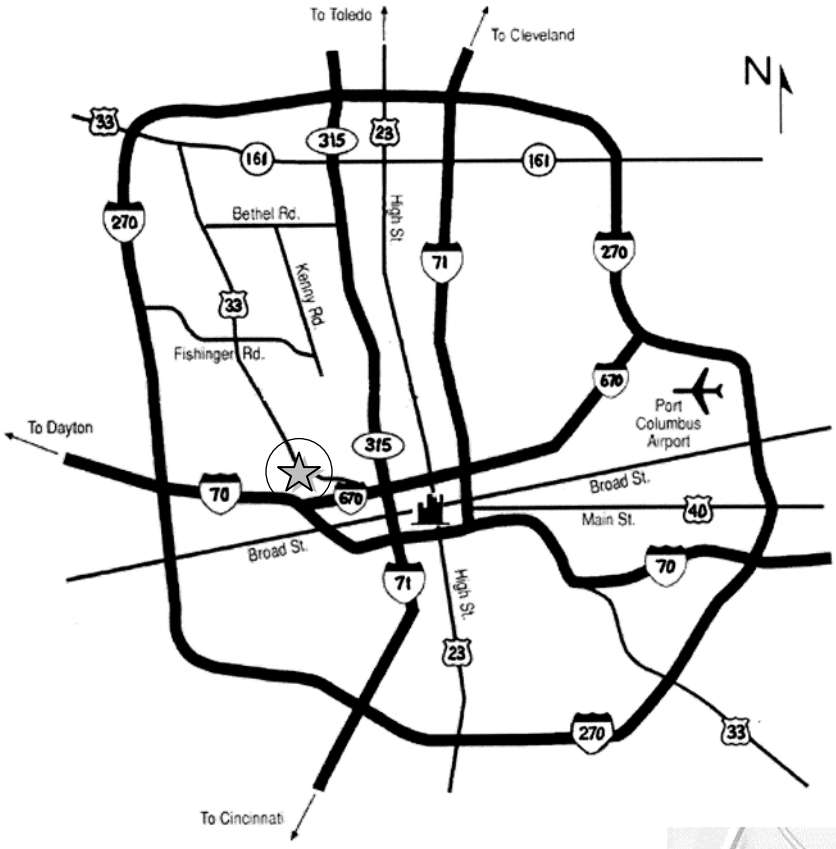
Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

By signing the detached paper, I certify that I will pay The Columbus Arthritis Center any co-payments, co-insurances, deductibles or non-covered services. I will immediately pay to The Columbus Arthritis Center any payment that I receive from my insurance company or reimbursement service for services provided to me. I will also be responsible for any amounts not paid by insurance due to not providing the appropriate insurance information for billing purposes.

DIRECTIONS

Columbus Arthritis Center

1211 Dublin Road
Columbus, Ohio 43215



From the North:
71 South to 670 West
Take the Grandview Ave. Exit
Turn right onto Grandview Ave.
Turn left onto Dublin Rd/US-33

From the East:
70 West to 315 North
Take the Dublin Rd/Long St. Exit
Take a left onto Dublin Rd/US-33
OR
Take W. Broad St.
Turn right on Souder Ave.
Turn left onto Dublin Rd/US-33.

From Marysville/Dublin:
Route 33 East to 270 South
Exit left on Fishinger Rd.
Turn Right on Riverside Dr.
Riverside Dr. becomes Dublin Rd.
after the 5th Ave. intersection.

From the West:
270 N to 70 East to 670 East
Take the Grandview Ave. Exit
Turn right onto Grandview Ave.
Take a left onto Dublin Rd/US-33

OR

Take Central Ave. North
Turn left onto McKinley Ave.
Turn left onto Grandview Ave.
Turn left onto Dublin Rd/US-33.

From the South:
23 North to 270 West to 71 North
Follow the 315 North Exit
Take the Dublin Rd/Long St. Exit
Turn left onto Dublin Rd./US-33

OR

270 West to 70 East to 670 East
Take the Grandview Ave. Exit
Turn right onto Grandview Ave.
Turn left onto Dublin Rd/US-33.

Columbus Arthritis Center, Inc.
Letterhead

FINANCIAL INTEREST DISCLOSURE FORM

To Our Patients Being Referred for MRI:

We wish to notify you that the physicians of the Columbus Arthritis Center, Inc. are owners of the MRI services located at:

1211 Dublin Rd
Columbus, OH 43215

We refer our patients to this location because we believe our staff provides quality medical care and excellent service to our patients. The services are convenient to our patients in terms of location, access, scheduling, hours of operation, and continuity of care.

We believe that our patients have a choice in the selection of the facility where they may receive their care. If you prefer to obtain radiology services at another facility, please let us know and we will refer you to a facility of your choice. Below is a list of other facilities providing MRI services in this area. Please note that inclusion in this list is not an endorsement or recommendation of these providers or suppliers by Columbus Arthritis Center, Inc.

Advantage Diagnostics
1430 South High Street
Columbus, OH 43207
614-220-0001

Center for Diagnostic Imaging
866 West Broad Street
Columbus, OH 43222
614-221-4860

Polaris Open MRI
2141 Polaris Parkway
Columbus, OH 43240
614-841-0800

ProScan Imaging Dublin
4351 Dale Drive, Suite 100
Dublin, OH 43017
614-855-8740

ProScan Imaging Pickerington
417 Hill Rd N
Pickerington, OH 43147
614-855-8740

Riverside Methodist Hospital
3535 Olentangy River Rd
Columbus, OH 43214

614-566-1111

Dublin Methodist Hospital
7500 Hospital Drive
Dublin, OH 43016
614-566-1111

Ohio State University Medical Center
410 W 10th Ave
Columbus, OH 43210
800-293-5123

Mount Carmel Health – West
793 West State Street
Columbus, OH 43222
614-234-5000

OhioHealth Doctors Hospital
5100 West Broad Street
Columbus, OH 43228
614-544-1000

To Our Patients:

The Columbus Arthritis Center shall comply with federal and state laws that require health care facilities to inform patients of their rights to execute advance directives, such as a Living Will, Health Care Power of Attorney, or Do-Not Resuscitate Directive.

If you have advance directives that you would like added to your medical record or if you would like more information about them please let us know.

Thank you!

Additional information may also be found on the internet at:
http://www.ohpco.org/aws/MCA/pt/sp/livingwills
http://www.caringinfo.org

COLUMBUS ARTHRITIS CENTER, INC.

Patient Registration

PATIENT INFORMATION- ***DO NOT MAIL BACK PLEASE BRING TO YOUR APPOINTMENT***

Last Name _____ First _____ MI _____

Street Address _____ City _____ State _____ Zip_____

Social Security #_____-_____ -_____ **(required)** Home Phone (_____) _____

Cell Phone (_____) _____ Work Phone (_____) _____

You have my permission to leave a detailed personal message on my: Home Y / N Cell Y / N Work Y / N

Age _____ Date of Birth _____/_____/_____ Gender _____ Marital Status _____

Preferred Language_____ Race_____ Ethnicity ____ Hispanic ____ Latino ____Other

Employer Name _____ Occupation _____

To Be Notified In Case of Emergency _____ Phone (_____) _____

Your e-mail address:_____

Referring Doctor_____ Phone (_____) _____

Referring Doctor Address_____ City_____State _____ Zip _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ Address _____

Policy # _____ Group # _____

Name of Policy Holder:_____ Date of Birth _____/_____/_____ Relationship to Patient __ _____

Policy Holder's Social Security #_____-_____-_____ **(required)**

Employer Name_____ Phone (_____) _____

Employer Address_____ City_____State _____ Zip _____

SECONDARY INSURANCE _____ Address _____

Policy # _____ Group # _____

Name of Policy Holder:_____ Date of Birth _____/_____/_____ Relationship to Patient __ _____

Policy Holder's Social Security #_____-_____-_____ **(required)**

Employer Name_____ Phone (_____) _____

Employer Address_____ City_____State _____ Zip _____

RX Insurance Policy # Phone (_____) _____

OTHER PHYSICIANS

Identification of other physicians involved with my medical care whom I authorize ongoing release of information for continuity of care:

Provider _____ Phone (_____) _____

Address _____ City _____ State _____ Zip_____

Type of physician / health care provided: _____

Provider _____ Phone (_____) _____

Address _____ City _____ State _____ Zip_____

Type of physician / health care provided: _____

FAMILY AND FRIENDS RELEASE OF MEDICAL INFORMATION

At the **Columbus Arthritis Center**, we understand that your medical information is private and it is our responsibility to protect this information. However, there may be times when you want us to provide your results, information about your diagnosis, treatment options, etc. to your spouse, significant other, parents, children, or a friend. If you wish to allow us to share your medical information with any family members or friends, please complete the information below.

I, _____, authorize the **Columbus Arthritis Center** to release my records and any medical information to the following individuals:

- _____ Relationship to patient:_____
- _____ Relationship to patient:_____
- _____ Relationship to patient:_____
- _____ Relationship to patient:_____
- _____ Relationship to patient:_____

_____ _____

Your signature Date

- You have a right to revoke this consent in writing at any time. This document will be filed in the correspondence section of your medical record.
- Mark *"NONE"* on the form and sign to indicate you do not wish your information shared with any family or friends.

Patient' name: _____ DOB: _____

Patient Name:_____ Date of Birth ____/____/____

Preliminary History Sheet

Please check if you have any of these medical problems.

Allergies __	Cancer __ Type_____	Hepatitis__	Renal Disease__
Anemia __	COPD __	High Cholesterol__	Peptic Ulcer __
Anxiety __	Coronary Disease __	High Blood Pressure__	Seizures __
Arthritis __	Crohn's Disease __	IBS__	Stroke __
Asthma __	Depression__	Liver disease __	Thyroid Disease __
Atrial Fibrillation __	Diabetes __	MI __	Shingles_____
BPH__	Gall Bladder Disease __	Osteoarthritis __	Other_____
Blood Clots__	GERD__	Osteoporosis __	Other_____

Please check if you have had any of these procedures and list the year of the procedure.

Procedure	Year	Procedure	Year	Procedure	Year
Angioplasty__	____	Hernia Repair __	____	Breast Biopsy __	____
Angioplasty with a stent__	____	Hip Replacement __	____	Cesarean Section __	____
Appendectomy__	____	Knee Replacement__	____	D & C __	____
Back surgery__	____	Knee Arthroscopy __	____	Hysterectomy __	____
CABG__	____	LASIK __	____	Mastectomy __	____
Carpal tunnel release__	____	Liver Biopsy__	____	Prostate Biopsy __	____
Cataract Extraction__	____	ORIF __	____	Tubal Ligation __	____
Gall Bladder Removed__	____	Pacemaker __	____	TAH/BSO __	____
Colectomy__	____	Small Bowel Resection__	____	TURP __	____
Colostomy__	____	Thyroidectomy __	____	Vasectomy __	____
Gastric Bypass __	____	Tonsilectomy __	____	Other_____	

Preliminary History Sheet

Patient Name:_____ Date of Birth: ____/____/_____ Today's Date___/____/_____

Medication	Dose	Instructions	Year started		Medication	Dose	Instructions	Year started

Allergies: **No Known Allergies** ☐

Name	Reaction	Name	Reaction

Social History:

Tobacco Use: Yes ☐ No ☐ Former ☐ Year Quit____

Type_____ Amount per day _____

Drinks Alcohol: Yes ☐ No ☐ Former ☐ Year Quit____

Type_____ Frequency_____

Amount_____

Drinks Caffeine: Yes ☐ No ☐ Amount_____

Females only:

Are you currently breast feeding? Yes ☐ No ☐

Vaccinations:

Name	Result	Year
Hepatitis B Vaccine		
Influenza Vaccine		
Shingles Vaccine		
BCG Vaccine		
TB Skin Test		
Pneumovac		
Chest X-ray		

Columbus Arthritis Center, Inc.

Medical History Sheet

Name: _____ Date:____/____/_____

Are you taking or have you ever taken any of the following? If you answer yes, please list the stop

Allopurinol (Zyloprim)		Ansaid (Flurbiprofen)	
Arava (Leflunomide)		Arthrotec (Diclofenac Sodium)	
Auranotin (Gold Tablets)		Aspirin / Ecotrin / Trilisate / Disalcid	
Azulfidine (Sulfasalazine)		Bextra (Valdecoxib)	
Colchicine (Probenecid)		Celebrex (Celecoxib)	
Cuprimine, Depen (Penicillamine)		Clinoril (Sulindac)	
Cytoxan (Cyclophosphamide)		Daypro (Oxaprozin)	
Enbrel (Etanercept)		Feldene (Piroxicam)	
Humira (Adalimumab)		Indocin (Indomethacin)	
Remicade (Infliximab)		Lodine (Etodolac)	
Imuran (Azathioprine)		Meclomen (Meclofenamote)	
Methotrexate (Methotrexate Sodium)		Motrin / Nuprin / Advil (Ibuprofen)	
Plaquenil (Hydroxychloroquine)		Mobic (Meloxicam)	
Solganol, Myochrisine (Gold Shots)		Nalfon (Fenoprofen)	
Cortisone, Prednisone, or Deltasone		Naprosyn (Naproxen / Aleve)	
a. Tablets		Orudis / Oruvail (Ketaprofen)	
b. Injections in the Joints		Relafen (Nabumetone)	
c. IM Injections		Tolectin (Tolmetion Sodium)	
Hyalgan Injections		Toradol (Ketorolac Tromethamine)	
Supartz Injections		Vioxx (Rofecoxib)	
Synvisc Injections		Voltaren (Diclofenac Sodium)	
Oral Bonvia		Actonel or Actonel w/ Calcium	
Atelvia (risedronate)		Didronel (etidronate)	
Skelid (tiludronate		Fosamax or Fosamax plus D	
Tamoxifen (nolvadex)		Evista (raloxifene)	
Femara (letrozole)		Fareston (toremifene)	

Below, please list the medications stopped because of allergy, contraindication, failure or intolerance.

_____ _____

_____ _____

_____ _____

Patient Name:_____ Date Of Birth:____/_____/____

Family History

Please check if any member of your immediate family had or has had any of these conditions.

	Family Member	Cause of Death: Y/N
Alzheimer ’s disease __	_____	_____
Coronary Artery Disease __	_____	_____
Premature Coronary Artery Disease__	_____	_____
Cancer__ Type_____	_____	_____
Depression__	_____	_____
Diabetes__	_____	_____
Eczema__	_____	_____
Fibromyalgia __	_____	_____
Hypertension__	_____	_____
Irritable Bowel Syndrome __	_____	_____
Lupus__	_____	_____
Mental Illness __	_____	_____
Migraines __	_____	_____
Obesity __	_____	_____
Osteoarthritis __	_____	_____
Osteoporosis__	_____	_____
Peripheral Artery Disease__	_____	_____
Psoriasis__	_____	_____
Renal Disease__	_____	_____
Rheumatoid Arthritis__	_____	_____
Stroke __	_____	_____

Patient Name:_____ Date of Birth:____/____/____

Preliminary History Sheet

Where is most of your pain? Please Check. Please Circle Right, Left or Both where appropriate.

Neck___	Elbows___ R L B	Knees___ R L B	Fingers___
Mid Back___	Wrist___ R L B	Ankles___ R L B	Toes___
Low Back___	Hand___ R L B	Mid-foot___ R L B	Other_____
Shoulders___ R L B	Hip___ R L B	Forefoot___ R L B	Other_____

Is your pain aggravated by any of the following? Please Check.

Activity___	Gripping___	Arising from a chair___
Rest___	Standing___	Cold or rainy weather___
Sleep___	Walking___	Other_____
Reaching___	Climbing Stairs___	Other_____

Is your pain relived by any of the following? Please Check.

Activity___	Heat___	Rest___	OTC Medication____ Type?
Bracing___	Rest___	Sitting___	Prescription Medication___
Cold___	Injection____	Other____	Other_____

Do you have any of these related symptoms? Please Check.

Abdominal Pain___	Fatigue___	Morning Stiffness___	How long?____
Activity Limitations___	Headaches___	Rashes___	Where?_____
Anorexia___	Weakness___	Joint swelling___	Where?_____
Eye symptoms___	Limping___	Weight loss/gain___	

When did your pain start? Please Circle.

1 2 3 4 5 6 7 8 9 10 Months Years Days ago

Specific date ____/____/____

On a scale of 1-10, with ten being the highest, what is the level of your pain? Please Circle.

1 2 3 4 5 6 7 8 9 10

How often do you have pain? Please Check.

Frequent__ Occasional__ Intermittent__ Persistent__ Rare__

The Columbus Arthritis Center

Patient Disease Activity and Symptom Form

OVER THE PAST WEEK were you able to (Check only one):	*No Difficulty*	*Some Difficulty*	*Much Difficulty*	*Unable to do*
Dress yourself, including tying shoes and doing buttons?	☐	☐	☐	☐
Get in and out of bed?	☐	☐	☐	☐
Lift a full cup or glass to your mouth?	☐	☐	☐	☐
Walk outside on flat ground?	☐	☐	☐	☐
Wash and dry your entire body?	☐	☐	☐	☐
Bend down to pick clothing from the floor?	☐	☐	☐	☐
Turn regular faucets on and off?	☐	☐	☐	☐
Get in and out of the car, bus, train or plane?	☐	☐	☐	☐
Walk two miles, if you wish?	☐	☐	☐	☐
Participate in recreational activities and sports as you would like, if you wish?	☐	☐	☐	☐

How much pain have you had because of your condition OVER THE PAST WEEK? Please indicate below how severe your pain has been:

NO PAIN	0	0.5	1	1.5	2	2.5	3	3.5	4	4.5	5	5.5	6	6.5	7	7.5	8	8.5	9	9.5	10	*PAIN AS BAD AS IT COULD BE*
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Considering all the ways in which illness and health conditions may affect you AT THIS TIME. Please indicate how you are doing:

VERY WELL	0	0.5	1	1.5	2	2.5	3	3.5	4	4.5	5	5.5	6	6.5	7	7.5	8	8.5	9	9.5	10	*VERY POORLY*
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Please check **Yes or No** if you have any of the following symptoms:

No	Yes	
○	○	Joint pain
○	○	Back pain
○	○	Broken bone
○	○	Joint swelling
○	○	Morning stiffness

If yes how many hours

No	Yes	
○	○	Unusual fatigue
○	○	Chronic fever
○	○	Weight loss

No	Yes	
○	○	Body rash
○	○	Face rash
○	○	Rash from the sun
○	○	Dry eyes or mouth
○	○	Mouth ulcers
○	○	Raynaud's (blue fingers)
○	○	Pleurisy Pericarditis
○	○	History blood clots

No	Yes	
○	○	Weakness
○	○	Chronic headaches
○	○	Numbness or tingling

No	Yes	
○	○	Shortness of breath
○	○	Chest pain
○	○	Abdominal pain
○	○	Diarrhea
○	○	Constipation
○	○	Difficulty swallowing

Dear Patient: Please only check the symptoms that you are experiencing at this time. If no symptoms apply please mark all negative, an unchecked box indicates a negative response. Thank you!

Constitutional ○ **All Neg**

Neg	Positive
○	○ Chills
○	○ Fatigue
○	○ Fever
○	○ Malaise
○	○ Night sweats
○	○ Weight gain
○	○ Weight loss

other pos:_____

HEENT ○ **All Neg**

Neg	Positive
○	○ Ear drainage
○	○ Ear pain
○	○ Eye discharge
○	○ Eye pain
○	○ hearing loss
○	○ Nasal drainage
○	○ Sinus pressure
○	○ Sore throat
○	○ Visual changes

other pos: _____

Respiratory ○ **All Neg**

Neg	Positive
○	○ Chronic cough
○	○ Cough
○	○ Known TB exposure
○	○ Shortness of breath
○	○ Wheezing

other pos: _____

Cardiovascular ○ **All Neg**

Neg	Positive
○	○ Chest pain
○	○ Claudication *pain in limbs from exertion
○	○ Edema *swelling from fluid
○	○ Palpitations

other pos:_____

Gastrointestinal ○ **All Neg**

Neg	Positive
○	○ Abdominal pain
○	○ Blood in stool
○	○ Changes in stools
○	○ Constipation
○	○ Diarrhea
○	○ Heartburn
○	○ Loss of appetite
○	○ Nausea
○	○ Vomiting

other pos: _____

Genitourinary ○ **All Neg**

Neg	Positive
○	○ Dribbling (male)
○	○ Dysuria (painful urination)
○	○ Hematuria (blood in urine)
○	○ Polyuria (excessive urine)
○	○ Slow stream (male)
○	○ Urinary frequency
○	○ Urinary incontinence
○	○ Urinary retention

other pos: _____

Psychiatric ○ **All Neg**

Neg	Positive
○	○ Anxiety
○	○ Depression
○	○ Insomnia

other pos: _____

Metabolic/Endocrine ○ **All Neg**

Neg	Positive
○	○ Cold intolerance
○	○ Heat intolerance
○	○ Polydipsia (great thirst)
○	○ Polyphagia (excessive hunger)

other pos: _____

Neurological ○ **All Neg**

Neg	Positive
○	○ Dizziness
○	○ Extremity numbness
○	○ Extremity weakness
○	○ Gait disturbance
○	○ Headache
○	○ Memory loss
○	○ Seizures
○	○ Tremors

other pos: _____

Hematologic/Lymphatic ○ **All Neg**

Neg	Positive
○	○ Easy bleeding
○	○ Easy bruising
○	○ Lymphadenopathy

other pos: _____

Integumentary ○ **All Neg**

Neg	Positive
○	○ Brittle hair
○	○ Brittle nails
○	○ Hair loss
○	○ Hirsutism
○	○ Hives
○	○ Pruitis
○	○ Mole changes
○	○ Rash
○	○ Skin lesion

other pos: _____

Musculoskeletal ○ **All Neg**

Neg	Positive
○	○ Back pain
○	○ Joint pain
○	○ Joint swelling
○	○ Muscle weakness
○	○ Neck pain

other pos: _____

30s
PRIVACY
SECURITY

Note this is a NPP that reflects Omnibus changes as of March 2013

Columbus Arthritis Center, Inc.

NOTICE OF PRIVACY PRACTICES

Effective Date: 9-23-13

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.

If you have any questions about this Notice of Privacy Practices ('Notice'), please contact:

Privacy Officer: Sarah Smith
Phone Number: 614-485-2631

Section A: Who Will Follow This Notice?

This Notice describes Columbus Arthritis Center, Inc. (hereafter referred to as 'Provider') Privacy Practices and that of:

Any workforce member authorized to create medical information referred to as Protected Health Information (PHI) which may be used for purposes such as Treatment, Payment and Healthcare Operations. These workforce members may include:

- All departments and units of the Provider.
- Any member of a volunteer group.
- All employees, staff and other Provider personnel.
- Any entity providing services under the Provider's direction and control will follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for Treatment, Payment or Healthcare Operational purposes described in this Notice.

Section B: Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the Provider. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated or maintained by the Provider, whether made by Provider personnel or your personal doctor.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the Notice that is currently in effect.

Section C: How We May Use and Disclose Medical Information About You

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, health care students, or other Provider personnel who are involved in taking care of you at the Provider. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the Provider also may share medical information about you in order to coordinate different items, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside the Provider who may be involved in your medical care after you leave the Provider.

- **Payment.** We may use and disclose medical information about you so that the treatment and services you receive at the Provider may be billed and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about surgery you received at the Provider so your health plan will pay us or reimburse you for the procedure. We may also tell your health plan about a prescribed treatment to obtain prior approval or to determine whether your plan will cover the treatment.

- **Healthcare Operations.** We may use and disclose medical information about you for Provider operations. These uses and disclosures are necessary to run the Provider and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many Provider patients to decide what additional services the Provider should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, health care students, and other Provider personnel for review and learning purposes. We may also combine the medical information we have with medical information from other Providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning a patient's identity.

- **Appointment Reminders.** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the Provider.

- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

- **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

- **Fundraising Activities.** We may use information about you to contact you in an effort to raise money for the Provider and its operations. We may disclose information to a foundation related

to the Provider so that the foundation may contact you about raising money for the Provider. We only would release contact information, such as your name, address and phone number and the dates you received treatment or services at the Provider. If you do not want the Provider to contact you for fundraising efforts, you must notify us in writing and you will be given the opportunity to 'Opt-out' of these communications.

- **Authorizations Required**
  We will not use your protected health information for any purposes not specifically allowed by Federal or State laws or regulations without your written authorization; this includes uses of your PHI for marketing or sales activities.

- **Emergencies.** We may use or disclose your medical information if you need emergency treatment or if we are required by law to treat you but are unable to obtain your consent. If this happens, we will try to obtain your consent as soon as we reasonably can after we treat you.

- **Psychotherapy Notes**
  Psychotherapy notes are accorded strict protections under several laws and regulations. Therefore, we will disclosure psychotherapy notes only upon your written authorization with limited exceptions.

- **Communication Barriers.** We may use and disclose your health information if we are unable to obtain your consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.

- **Provider Directory.** We may include certain limited information about you in the Provider directory while you are a patient at the Provider. This information may include your name, location in the Provider, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they do not ask for you by name. This is so your family, friends and clergy can visit you in the Provider and generally know how you are doing.

- **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care and we may also give information to someone who helps pay for your care, unless you object in writing and ask us not to provide this information to specific individuals. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the Provider. We will almost always generally ask for your specific permission if the researcher will

have access to your name, address or other information that reveals who you are, or will be involved in your care at the Provider.

- **As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law.

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

- **E-mail Use.**
  E-mail will only be used following this Organization's current policies and practices and with your permission. The use of secured, encrypted e-mail is encouraged.

Section D: Special Situations

- **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs.

- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:
  - to prevent or control disease, injury or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify people of recalls of products they may be using;
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
  - to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
    - in response to a court order, subpoena, warrant, summons or similar process;
    - to identify or locate a suspect, fugitive, material witness, or missing person;
    - about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
    - about a death we believe may be the result of criminal conduct;
    - about criminal conduct at the Provider; and
    - in emergency circumstances, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Provider to funeral directors as necessary to carry out their duties.

- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

Section E: Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

- **Right to Access, Inspect and Copy.** You have the right to access, inspect and copy the medical information that may be used to make decisions about your care, with a few exceptions. Usually, this includes medical and billing records, but may not include psychotherapy notes. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

- We may deny your request to inspect and copy medical information in certain very limited circumstances. If you are denied access to medical information, in some cases, you may request that the denial be reviewed. Another licensed health care professional chosen by the Provider will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Provider. In addition, you must provide a reason that supports your request.

- We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
    - Is not part of the medical information kept by or for the Provider;
    - Is not part of the information which you would be permitted to inspect and copy; or
    - Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an 'Accounting of Disclosures'. This is a list of the disclosures we made of medical information about you. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the accounting (for example, on paper or electronically, if available). The first accounting you request within a 12 month period will be complimentary. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure or both, and to whom you want the limits to apply (for example, disclosures to your spouse). We are not required to agree to these types of request. We will not comply with any requests to restrict use or access of your medical information for treatment purposes.

  You also have the right to restrict use and disclosure of your medical information about a service or item for which you have paid out of pocket, for payment (i.e. health plans) and operational (but not treatment) purposes, if you have completely paid your bill for this item or service. We will not accept your request for this type of restriction until you have completely paid your bill (zero balance) for this item or service. We are not required to notify other healthcare providers of these restrictions, that is your responsibility.

- **Right to Receive Notice of a Breach.** We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by email), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

    - a brief description of the breach, including the date of the breach and the date of its discovery, if known;
    - a description of the type of Unsecured Protected Health Information involved in the breach;
    - steps you should take to protect yourself from potential harm resulting from the breach;

- a brief description of actions we are taking to investigate the breach, mitigate losses, and protect against further breaches;
- contact information, including a toll-free telephone number, e-mail address, Web site or postal address to permit you to ask questions or obtain additional Information.

In the event the breach involves 10 or more patients whose contact information is out of date we will post a notice of the breach on the home page of our website or in a major print or broadcast media. If the breach involves more than 500 patients in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 patients, we are required to immediately notify the Secretary. We also are required to submit an annual report to the Secretary of a breach that involved less than 500 patients during the year and will maintain a written log of breaches involving less than 500 patients.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or hard copy or e-mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a copy of this Notice at our website. www.columbusarthritis.com

To exercise the above rights, please contact the individual listed at the top of this Notice to obtain a copy of the relevant form you will need to complete to make your request.

Section F: Changes to This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice. The Notice will contain on the first page, in the top right hand corner, the effective date. In addition, each time you register at or are admitted to the Provider for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current Notice in effect.

Section G: Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Provider or with the Secretary of the Department of Health and Human Services;
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

To file a complaint with the Provider, contact the individual listed on the first page of this Notice. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Section H: Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by

your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Section I: Organized Healthcare Arrangement

The Provider, the independent contractor members of its Medical Staff (including your physician), and other healthcare providers affiliated with the Provider have agreed, as permitted by law, to share your health information among themselves for purposes of treatment, payment or health care operations. This enables us to better address your healthcare needs.

Revision Date: March 03, 2013, to be compliant with HIPAA Omnibus Privacy Rules.

Original Effective Date: April 14, 2003.

CAC DISABLITY/FMLA FORM POLICY

Effective 8/1/2016

Important

All patient and employer portions of the form need completed prior to submitting the form to Columbus Arthritis Center for completion. These portions of the form should include an authorization for release of information which CAC must have in order to provide information to your insurance carrier or employer.

Methods of Form Submission

- By mail: Columbus Arthritis Center
  1211 Dublin Road
  Columbus, Ohio 43215
  Attn: Disability Forms Completion

- By Fax: (614) 486-9665

Charges

There is a $20 fee per form. The fee is $10 to update the same form after that. This payment must accompany the form. Make the check payable to: Columbus Arthritis Center and mark ***"form fee"*** in the memo section of the check. You may also call (614) 486-5200, select the Billing Department prompt, and pay your form fee by phone.

Form Completion

Once we have confirmation that your payment has been made, we will complete forms within 10-14 business days. We make every effort to complete the forms as soon as possible. In an effort to expidite this process please ensure the patient and employer section is filled out completely and ask to sign the required release of the information page. We understand that emergent needs arise and we will do our best to accommodate each patient's needs.

Thank you,

The Columbus Arthritis Center

COLUMBUS ARTHRITIS CENTER

RECEIPT OF **NOTICE OF PRIVACY PRACTICES, PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION** AND **FINANCIAL POLICY**

I, _____, have received a copy of the
(Print) Patient Name Date of Birth ___/____/_____

Notice of Privacy Practices and Patient Consent for Use and Disclosure of Protected Health Information.

I understand that under Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Columbus Arthritis Center, Inc. (CAC) may use or disclose my protected health information for treatment, payment or health care operations- which means for providing health care to me, the patient; handling billing and payment, and taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

CAC has a detailed document called the "Notice of Privacy Practices". It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the "Notice" before signing this agreement. If I ask, CAC will provide me with the most current *Notice of Privacy Practices.*

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow CAC to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that CAC has taken action relying on this consent.

Financial Policies

PATIENT CONSENT FOR ASSIGNMENT OF BENEFITS

I hereby consent to assign all payments for services rendered by the physicians of Columbus Arthritis Center to the Columbus Arthritis Center. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by my contract with my insurance plan. I further understand that my contract with my insurance plan may or may not cover some services.

_____ _____
Signature of Patient Date

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our "Notice" at any time by contacting: 614-486-5200 option 0 for the operator or stop by our front desk.

Consent for Information Sharing

Health Information Exchange is a **secure way** for your health care providers to get the most up-to-date medical information about you.

If you sign this consent, **your healthcare provider** may search for and get your test results, lab results, X-rays, medication list or any other health information that has been **electronically** collected from other participating providers.

Information that could help save your life in a medical emergency would be available to the healthcare providers treating you. Only health care providers who have a **treatment relationship** with you will be authorized to search for your records.

Consenting and Cancellation
If you consent, you only have to give your consent **one time**. You can withdraw your permission at **any time** by completing a *Cancellation Request* and submitting it to your health care provider. They will have the form or you can get it at www.clinisync.org.

Please **check one** of the boxes below.

☐ **I consent to have my records shared through the Health Information Exchange. I have read this form. I have had a chance to ask questions. I am satisfied with the answers.**

☐ **I do not want to have my records shared on a Health Information Exchange. I understand that this means that even in an emergency, my treating physicians may not have access to my previous records from other treating physicians. I have read this form and have had a chance to ask questions.**

Patient Name: _____ Parent/ Guardian: _____

Signature:_____ Signature:_____

Date: _____ Date: _____

All individuals **14 and over** must sign as a patient, and individuals **under 18** must **also** have a parent or guardian sign this form.

For more information, please visit www.clinisync.org/patients