**A. Patient Information**

1. Name (Last) (First) (Middle) 2. Date of Birth

**/ /**

3. Address (street) (Apt. No.) City ZIP

4. Phone (Home) (Work) (Cell)

( ) - ( ) - ( ) -

5. Social Security No. 6. Occupation (Employer)

- -

7. Driver License No. 8. Race/Ethnicity 9. Sex 10. Preferred Language

M / F

11. Primary Care Physician (Phone) (Fax)

( ) - ( ) -

12. Referred by (Phone) (Fax)

( ) - ( ) -

13. Do you have an ABN (Advance Directive) 14. Preferred Pharmacy (Phone)

Yes / No ( ) -

**B. Insurance Information**

1. Primary Insurance Company 2. Phone No.

( ) -

3. Address (street) (City) Zip

4. Policy Holder Name 5. Social Security 6. Member No.

- -

/ /

10. Secondary Insurance Company 11. Phone No.

( ) -

|  |  |  |
| --- | --- | --- |
| 12. Address (street)  13. Policy Holder Name |  | (City) Zip  14. Social Security 15. Member No. |
|  | - - |

/ /

**C. Responsible Person For Payment Not Covered By Insurance**

|  |  |  |
| --- | --- | --- |
| 1. Name (Last) (First) | | 2. Relationship to patient  (City) Zip |
| 3. Address (Street) |  |
|  |  |

( ) - ( ) - ( ) -

5. Date of Birth 6. Sex 7. Social Security No.

/ / M / F - -

8. Driver License No 9. Occupation 10. Employer

**D. Emergency Contact Information**

A. Name B. Relationship to patient

C. Phone (home) (Work) (Cell )

( ) - ( ) - ( ) -

**E. Appointment Reminder by E-mail**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Do you check your e-mail at least once a day? | | Yes / No | |  |
| 2. If yes, would you like to receive an appointment reminder by e-mail  a week before AND a day before your appointment | | | Yes / No |
| 3. If yes, Please provide your e-mail: | @ | | |

**Release of Medical Information:** I hereby consent and authorize Arthritis Clinic of Central Texas to release any medical information in connection with the services rend for determination of benefits or collection of said benefits from my health insurance carrier. **Date: / /**

|  |  |
| --- | --- |
| **Patient Name** | **Patient Signature** |
|  |  |

**Patient Contract for the Use of Opioid Pain Medication in Chronic Pain**

This is an agreement between (*Patient Name*) DOB / / and **Maria D. Salinas, M.D** concerning the use of opioid analgesics (narcotic pain-killers) for the treatment of chronic pain. The medication will probably not completely eliminate my pain, but is expected to reduce it

enough that I may become more functional and improve my quality of life.

Please read and initial each statement below:

1. I understand that opioid analgesics are strong medications for pain relief and I have been informed

of the risks and side effects involved with taking them.

2. In particular, I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweating, and chills) that may occur within 24-48 hours of the last dose. I understand that opioid withdrawal is quite uncomfortable but not a life-threatening condition.

3. I understand that if I am pregnant while taking these opioid medications, my child would physically dependent on the opioid, and withdrawal can be life-threatening for a baby.

4. Overdose on this medication may cause death by stopping my breathing; this can be reversed by emergency medical personnel if they know that I have taken narcotic pain-killers. It is suggested that I wear a medical alert bracelet that contains this information.

5. If the medication caused drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else’s life in danger.

6. I understand it is my responsibility to inform the prescriber of any and all side effects that I have from this medication.

7. I agree to take this medication as prescribed, and not to change the amount or frequency of the medication without discussing it with the prescriber. Running out early, needing early refills, escalating doses without permission and losing prescriptions may be signs of misuse of the medication, and may be reasons for the prescriber to discontinue prescribing to me.

8. I agree that the opioid will be prescribed by only one prescriber, and I agree to fill my prescriptions at one pharmacy. I agree not to take any pain medication or mind altering medication prescribed by any other prescriber without first discussing it with the above named prescriber. I give permission for the prescriber to verify that I am not seeing other prescribers for opioid medication or going to other pharmacies.

9. I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will

not be replaced.

10. I agree not to sell, lend or in any way give my medication to any other person.

11. I agree not to drink alcohol or take mood altering drugs while I am taking opioid analgesic medication. I agree to submit a urine specimen at any time that my prescriber requests, and give my permission for it to be tested for alcohol and drugs.

12. I agree that I will attend all required follow-up visits with the prescriber to monitor this medication, and I understand that failure to do so will result in discontinuation of this treatment. I also agree to practice in other chronic pain treatment modalities recommended by my prescriber.

13. I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically depend on the medication, using it to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addition. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program

for help with this problem.

I have read the above, asked questions and understand the agreement. If I violate the agreement, I know that the prescriber may discontinue this form of treatment.

Patient Signature Date

Prescriber Signature Date

**Form of Written Acknowledgment of Receipt of Arthritis Clinic of Central Texas Notice of**

**Patient Privacy Practices**

By signing this Written Acknowledgment of Receipt of Arthritis Clinic of Central Texas Notice of patient Privacy Practices (“Acknowledgment”), I hereby expressly acknowledge my receipt of Arthritis Clinic of Central Texas Notice of Patient Privacy Practices.

Patient/Legal Representative Name:

Patient/Legal Representative Signature:

Date: / /

Acknowledgment **NOT** obtained because:

Patient/Legal Representative declined Notice of Patient Privacy Practices.

Patient treated in emergency room and discharged before obtaining Acknowledgment.

Other. Please describe briefly:

Employee Name:

Employee Signature:

**Authorizations, Consents, and Agreements**

**Consent**

**Consent To Treatment:** As a patient at Arthritis Clinic of Central Texas, I voluntarily agree to care and treatment provided at ACCT as a clinical patient. As a part of the course of my care and/or diagnosis and treatment of administration of medications, tests and procedures (collectively “Services”) deemed advisable by physicians (“Physicians”) or other medical professionals practicing at ACCT, employees of ACCT, S\students/externs studying at ACCT and other personnel (collectively “Care Providers”). I further understand

that I may be referred for tests and procedures done at other facilities are not part of ACCT; therefore, charges

for those services are separate and apart from ACCT services. **INITIAL**

ARTHRITIS CLINIC OF CENTRAL TEXAS MARIA D. SALINAS, M.D

**Financial**

**Financial Agreement:** The undersigned agrees, as patient or agent of the patient, that the patient is accepting financial responsibility for services rendered and is obligated to pay the account balance in full. If there is verifiable Medical Insurance Coverage or other verifiable financial coverage, a claim will be filed as a convenience to the patient. However, it remains the responsibility of the patient/guarantor to follow up with his/her insurance company if the claim is not paid within 45 days. Pre-certification is the responsibility of the patient/guarantor and should be secure prior to services whenever possible, within policy limitations in case of emergencies. Payment for services not covered by the insurance or third party payer is the responsibility of the patient/guarantor. Our billing office will handle all self-pay portions after insurance payments. Should the account be referred to a collection agency, the undersigned may be assessed a collection fee and reasonable attorney fees and court costs. **INITIAL**

**Insurance**

**Assignment of Benefits:** I hereby authorize all insurance companies to pay direct to Arthritis Clinic of Central Texas. I understand that this order does not relieve me of my obligation to pay the account. Also, any deductibles and co-payments are my responsibility. **INITIAL**

**Release of Medical Information:** I hereby consent & authorize Arthritis Clinic of Central Texas and affiliates to release any medical information in connection with the services rendered for determination of benefits and/or collection of said benefits from my health insurance carrier. **INITIAL**

**\*\*\*\*Medicare Beneficiaries ONLY:** I certify that the information given in applying for payment under Title XVII of Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a health insurance deductibles and coinsurance.

**Medicare Supplements:** I further authorize Arthritis Clinic of Central Texas to claim and receive benefit thru my Medicare supplement, (Name of Insurance Company/ies). This authorization includes claims for Medigap benefits and shall remain in effect until and unless revoked in writing. **INITIAL**

I HAVE READ THE AUTHORIZATIONS, CONSENTS AND AGREEMENT, AND I ACCEPT THE TERMS AS DESCRIBED ABOVE. **DATE: / /**

|  |  |
| --- | --- |
| **Patient/Legal Representative Name** | **Patient/Legal Representative Signature** |
|  |  |

**Authorization to Use or Disclose Protected Health Information**

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual’s protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

**Patient for whom authorization is made:**

Name: Date of Birth:

**Health Care Provider or Health Care Entity authorized to disclose this information:**

Arthritis Clinic of Central Texas, Maria D. Salinas, M.D.

1340 Wonder World Dr. Bldg.2, Suite 2203

San Marcos, TX 78666

**Person or Entity that can receive and use this information:**

Name: Address: City: State: Zip Code: Phone: ( ) Fax:( )

**Specific information to be disclosed:**

□ Medical Record from (date) / / to (date) / /

□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.

□ Other:

**Include: (Indicate by Initialing)**

Drug, Alcohol or Substance Abuse Records

Mental Health Records (Except Psychotherapy Notes)

HIV/AIDS-Related Information (Including HIV/AIDS Test Results)

Genetic Information (Including Genetic Test Results)

**Reason for release of information: (Choose all that Apply)**

□ Treatment/Continuing Medical Care

□ Personal Use

□ Billing or Claims

□ Insurance

□ Legal Purposes

□ Disability Determination

□ School

□ Employment

□ Other (Specify):

**The individual signing this form agrees and acknowledges as follows:**

**Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

**Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date:

Month: Day: Year: .

**Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

**Special Information:** This authorization may include disclosure of information relating to DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, except psychotherapy notes, CONFIDENTIAL HIV/AIDS- RELATED INFORMATION, and GENETIC INFORMATION only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

**Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state privacy laws.

**Signatures:**

Patient/Legal Representative: Date: / /

If Legal Representative, relationship to patient:

A minor individual’s signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (If applicable): Date: / /

**Patient Name: DOB:** \_/ /

|  |  |  |  |
| --- | --- | --- | --- |
| **Do you have a history of:** | **Yes** | **No** | **Medication List of All Meds** |
| 1. Heart Attack |  |  |  |
| 2. Coronary Artery Disease (CAD) |  |  |  |
| 3. High Blood Pressure |  |  |  |
| 4. Vascular Aneurysm |  |  |  |
| 5. Cardiac Arrhythmia |  |  |  |
| 6. Heart Murmur |  |  |  |
| 7. Congestive Heart Failure (CHF) |  |  |  |
| 8. Transient Ischemic Attack (TIA) |  |  |  |
| 9. Stroke |  |  |  |
| 10. Seizures |  |  |  |
| 11. Peripheral Neuropathy |  |  |  |
| 12. Kidney Disease |  |  |  |
| 13. Bladder Disorder |  |  |  |
| 14. Sleep Apnea |  |  |  |
| 15. Asthma |  |  |  |
| 16. COPD |  |  |  |
| 17. Stomach or Duodenal Ulcers |  |  |  |
| 18. GERD or “Heart burn” |  |  |  |
| 19. Diverticulitis |  |  |  |
| 20. Liver Problems or Hepatitis |  |  |  |
| 21. Colitis |  |  |  |
| 22. Celiac disease |  |  |  |
| 23. Blood Clot in Veins |  |  |  |
| 24. Anemia |  |  |  |
| 25. Blood Disorders |  |  | allergies to medications |
| 26. Cancer? Type? |  |  |  |
| 27. Gout |  |  |  |
| 28. Diabetes |  |  |  |
| 29. Thyroid disorder |  |  |  |
| 30. Osteoporosis |  |  |  |
| 31. Menopause |  |  |  |
| 32. Depression |  |  |  |

|  |  |
| --- | --- |
| **Past Surgical History (Month / Year):** | **Past Surgical History (Month / Year):** |
|  |  |

**Rheum Complaint Template**

You do not have to fill out this survey if symptoms are unrelated to pain, stiffness, weakness, or swelling, otherwise please circle or write in to answer the following questions.

**Your complaint(s): Circle only one if possible. If you choose more than one, then they have to be of equal intensity or concern.**

|  |  |  |  |
| --- | --- | --- | --- |
| Pain | Swelling | Fatigue | Weakness |

**If it is pain, then what type?**

|  |  |  |  |
| --- | --- | --- | --- |
| Achy | Sharp | Throbbing | Burning |

**Location of the above complaint/symptom in the order of intensity: Give a number 1 to the most intense and 2 to the second in intensity and 3 for the least in intensity.**

|  |  |  |  |
| --- | --- | --- | --- |
| ( ) Neck  ( ) Mid back  ( ) Lower back  ( ) L / R Upper buttocks  ( ) L / R Lower buttocks | ( ) L / R Shoulders  ( ) L / R Arms  ( ) L / R Elbows  ( ) L / R Forearms  ( ) L / R Wrists | ( ) L / R Ankles  ( ) L / R Feet  ( ) L / R Toes  ( ) L / R Hands  ( ) L / R Fingers  ( ) L / R Knuckles | ( ) L / R Groins  ( ) L / R Sides of hips  ( ) L / R Thighs  ( ) L / R Knees  ( ) L / R Legs |

**When did it start, how long ago?**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Less than  6 weeks | One month | Less than  3 months | Less than  6 months | Less than a year | Less than  2 years | Less than  3 years | More than  3 years |

**How intense is the pain from on a scale from 0-10, 10 being the most intense?**

0 1 2 3 4 5 6 7 8 9 10

**Timing of the complaint?**

|  |  |  |  |
| --- | --- | --- | --- |
| Morning | During the Day | Evening | After activities |

**If it comes in bursts, then How Long does an episode last?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Minutes | Hours | Days | Weeks | Months |

**What do you think triggers the symptoms or make it worse?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Cold Weather | Activities | Warm Weather | Certain Food | Certain Drug |

**Are you stiff in the morning?**

**How long are you stiff in the morning?**

Yes No

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Less than  5 min | Less than  15 min | Less than  ½ hour | One hour | 2 hrs. | The entire  morning | The entire  day |

|  |  |
| --- | --- |
| **1. Who referred you? Provide name and fax.** | **2. Who is your Primary Care Physician?** |
|  |  |
| **3. What prescription medications have you**  **taken so far for the symptoms?** | **4. Who prescribed it?** |
|  |  |
| **5. Any change of your regular medications**  **within the last few months of the onset of**  **your symptoms?** | **6. Any intake of over the counter medications?** |
|  |  |
| **7. Any surgeries done in order to relief your symptoms? When and Where?** | **8. Any joint steroids injections?** |
|  |  |
| **9. What joint(s)? When and Where?** | **10.Any MRI, X-rays done? When and Where?** |
|  |  |

ARTHRITIS CLINIC OF CENTRAL TEXAS

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|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **11.Any Labs done? When and Where?** | | | | | | |
|  | | | | | | |
| **12.Do have any of the followings?** | | | | | | |
| A. Rash | Yes / No | | | B. Joint swelling | | Yes / No |
| C. Hair loss/ Alopecia | Yes / No | | | D. Mouth ulcers | | Yes / No |
| E. Sun sensitivity causing rash | Yes / No | | | F. Raynaud’s | | Yes / No |
| G. Dry eyes | Yes / No | | | H. Dry mouth | | Yes / No |
| I. Pleurisy | Yes / No | | | J. Parotid swelling | | Yes / No |
| K. Chronic diarrhea or  abdominal symptoms | Yes / No | | | L. Recurrent urine or genital  Infections/STD’s? | | Yes / No |
| M. Lymphadenopathy (swollen glands). If Yes, | | | | N. Psoriasis | | Yes / No |
| Where: - Ant. Cervical - Post. Cervical - Inguinal  - Supraclavicular - Axillary | | | | | | |
| **13.Any history of blood clot or thrombosis?** | | | | **14.Any history of bleeding?** | | |
| Yes / No | | | | Yes / No | | |
| **15.Any history of leukopenia (Low white cell**  **count)?** | | | | **16.Any history of thrombocytopenia (Low**  **platelets count)?** | | |
| Yes / No | | | | Yes / No | | |
| **17.Any history of miscarriages?** | | | | • How many? | | |
| Yes / No | | | | • Where they in a row? | | |
| • What trimester? | | |
| **18.Any history of travel in the last 2 years inside the U.S? Where?** | | | | | | |
| **19.Any history of travel in the last 2 years outside the U.S? Where?** | | | | | | |
| **20.Name of herbal supplements?** | | | | | | |
| **21.Any immunizations for:** | | **Flu** | **Pneumonia** | | **Shingles** | **others** |
| Yes / No | Yes / No | | Yes / No | Yes / No |
| **22.Any family history of autoimmune disease such as Rheumatoid arthritis, lupus …?** | | | | | | |
|  | | | | | | |

ARTHRITIS CLINIC OF CENTRAL TEXAS

MARIA D. SALINAS, M.D

**Patient Name: DOB: / / DOS: / /**

**A Multi-Dimensional Health Assessment Questionnaire (R785-NP2)**

This questionnaire includes information not available from blood tests, X-rays, or any source than you. Please try to answer each question, even if you do not think it is related to you at try to complete as much as you can yourself, but if you need help, please ask. **There are no wrong answers**. Please answer exactly as you think or feel. Thank you.

**1. Please check (√ ) the ONE best answer for your abilities at this time:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **OVER THE LAST WEEK**, were you able to: | WITHOUT  **ANY**  DIFFICULTY | WITH  **SOME**  DIFFICULTY | WITH  **MUCH**  DIFFICULTY | **UNABLE**  TO DO |
| a. Dress yourself, including tying shoelaces and doing  buttons? |  |  |  |  |
| b. Get in and out of bed? |  |  |  |  |
| c. Lift a full cup or glass to your mouth? |  |  |  |  |
| d. Walk outdoors on flat ground? |  |  |  |  |
| e. Wash and dry your entire body? |  |  |  |  |
| f. Bend down to pick up clothing from the floor? |  |  |  |  |
| g. Turn regular faucets on and off? |  |  |  |  |
| h. Get in and out of a car, bus, train, or airplane? |  |  |  |  |
| i. Walk two miles or three kilometers, if you wish? |  |  |  |  |
| j. Participate in recreational activities and sports as you  would like, if you wish? |  |  |  |  |
| k. Get a good night’s sleep? |  |  |  |  |
| l. Deal with feelings of anxiety or being nervous? |  |  |  |  |
| m. Deal with feelings of depression or feeling blue? |  |  |  |  |

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| NO | O | O | O | O | O | O | O | O | O | O | O | O | O | O | O | O | O | O | O | O | O | VERY |
| PAIN | 0 | 0.5 | 1.0 | 1.5 | 2.0 | 2.5 | 3.0 | 3.5 | 4.0 | 4.5 | 5.0 | 5.5 | 6.0 | 6.5 | 7.0 | 7.5 | 8.0 | 8.5 | 9.0 | 9.5 | 10 | PAINFUL |

**3. What is/are the MOST painful area(s)? Please check (√) one or two only:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ○ Neck | ○ Shoulders | ○ Mid-back | ○ Lower back | ○ Elbows | ○ Hands | ○ Wrists |
| ○ Hips | ○ Knees | ○ Thighs | ○ Legs | ○ Feet | ○ Ankles |  |

**How long is your morning stiffness?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ○ Less than 5 mins | ○ 5-10 mins | ○ 15 mins | ○ 30 mins | ○ 45 mins |
| ○ 1 hr. | ○ 2 hrs. | ○ More than 2 hrs | ○ All morning | ○ All day |

**4. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| VERY | O | O | O | O | O | O | O | O | O | O | O | O | O | O | O | O | O | O | O | O | O | VERY |
| WELL | 0 | 0.5 | 1.0 | 1.5 | 2.0 | 2.5 | 3.0 | 3.5 | 4.0 | 4.5 | 5.0 | 5.5 | 6.0 | 6.5 | 7.0 | 7.5 | 8.0 | 8.5 | 9.0 | 9.5 | 10 | POORLY |

**NEW & ESTABLISHED PATIENT POLICY AND PROCEDURE**

**Contacting the physician or other providers in the office**

1- The physician or any other provider at Arthritis Clinic of Central Texas (ACCT) is available to answer your questions at any time. You can reach them by calling or emailing via our secured email, using Patient Fusion, your electronic portal. Our usual turnaround time to answer calls or emails related to routine questions that do not involve acute pain or an urgent situation is 24-48 hrs.

2- For any urgent questions related to pain, we will answer you at the end of working day, unless the pain is so severe, in that case, you may elect to call and ask to speak to the doctor ASAP. Please do not email in a situation that requires immediate attention.

**Medication Refills**

3- Medication refills can be done by contacting your pharmacist or by calling us. If your pharmacist confirmed no refills available, then please call us for refills.

4- For your safety refills are only provided as long as you follow up with appointments. If you rescheduled your appointment once or did not show, you refills maybe extended to the next rescheduled appointment only. If you rescheduled twice or did not show up twice, then refills will not be provided until you are present for the follow up appointment. Please know that our medications are highly toxic and any continuation without physician’s supervision might involve risk to your health.

**Calling for Lab Results**

5- Results of labs will be available to you, by visiting your patient electronic portal (Patient Fusion) within 2 wks after the lab draw. We will only call if something needs an immediate attention, otherwise labs will be reviewed only in the next office visit.

6- New patients’ lab results will also be available electronically. Please be advised that if you call after your lab results are in, in order to get a diagnosis, we will not be able to provide you with a diagnosis over the phone. We feel it is unfair to you to do so, given a diagnosis may need a re-evaluation and further questioning of your medical history. You will only be called if further testing is needed prior to your second visit. Otherwise, all work up will be discussed at the follow up appointment.

**No Show Policy**

7- No shows, who do not call within 24 hours of their appointment to reschedule create a particular challenge. They end up being seen but as a double book, 2-3 weeks later. This makes it harder to see already scheduled patients, who regularly show up to their appointments in a timely manner and creates long wait times. In order to enforce our policy we have elected to charge a no show fee. This charge is $50 for established patient and $75 for new patients.

8- If your insurance requires a referral to see us, we will work with you to obtain it, however it ultimately remains your responsibility to make sure your referral is on file, otherwise your appointment will be rescheduled or you might end up being charged in full for the visit if seen without it.

**Late Policy**

9- New patients are expected to arrive 30 minutes prior to their scheduled appointment to fill out new patient paperwork if unable to complete it prior to their scheduled appointment or you will be rescheduled. Any patient arriving more than 15 minutes late will be rescheduled.

**FMLA/Disability paperwork**

10- Filling out FMLA or disability paperwork takes time and effort from the provider and the staff. Please be aware that there is a $25 service fee associated with filling out this type of paperwork for patients.

**Patient Code of Conduct**

At ACCT, we strive to provide a welcoming, respectful, and safe environment for all patients, families, and staff. To support this goal, we ask everyone who interacts with our team to follow these simple guidelines:

**Respectful Communication**

* Speak to staff, patients, and others with kindness and courtesy
* Avoid the use of offensive language, insults, or name-calling

**Safe Behavior**

* Refrain from any aggressive, threatening, or inappropriate actions
* Physical contact should always be respectful and appropriate
* Sexual harassment in any form is not tolerated

**Considerate Interactions**

* Be mindful when calling, emailing, or messaging—communications should be respectful in tone and frequency
* Follow clinic policies and staff guidance to help ensure smooth care

We believe mutual respect is the foundation of excellent care.

If concerns arise, we will address them thoughtfully and fairly. In rare cases of serious or repeated misconduct, we may take appropriate administrative action, which could include dismissal from the practice.

Thank you for helping us maintain a positive and professional care environment.

Respectfully,

Maria D. Salinas MD

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Records Release Form**

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the health care provider / supplier listed below:

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The information you may release subject to this signed release form is as follows:**

□ Complete Records □ History & Physical □ Progress Notes

□ Care Plan □ Lab Reports □ Radiology Reports

□ Pathology Reports □Treatment Record □ Operative Reports

□ Hospital Reports □ Medication Record □ Other (please specify below)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release my protected health information to the following health care provider / supplier and those directly associated with my medical care:**

Name: Arthritis Clinic of Central Texas

Address: 1340 Wonder World Dr.

Bldg. 2 Ste. 2203

San Marcos, Texas 78666

Phone: (512)667-7123

Fax: (512)667-7328

**The purpose/reason for this release of information is as follows:**

Continuum of care.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name and DOB Signature of Patient or Personal Representative:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient or Responsible Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_