Arthritis Associates

Specialized care for a better life.

Arthritis Associates, PLLC
7100 Highway 98 West, Suite 220
Hattiesburg, MS 39402
Phone 601 582-7655
Fax 601 582-3229
www.ArthritisAssociates.com

Dear New Patient,

We are pleased to welcome you to our practice at Arthritis Associates, PLLC. We look forward to meeting you and serving your rheumatology needs. Our staff has set aside an appointment time just for you. If for any reason you will be unable to come to your appointment, please notify us at least 48 hours in advance. Recently there have been a decrease in the number of Rheumatologists in our area, and we have many patients that need to be seen. This will allow us to help someone who needs to be seen in the event that you cannot keep your appointment. Also, we enclosed directions to help you find our office. We typically try to reach all patients with a reminder call a day or two before your appointment. However, once the appointment is set up you are responsible for contacting us if you need to cancel or reschedule. Please bring insurance cards, driver's license and a list of all medications to your appointment. All applicable co-pays, deductibles, etc. will be due at the time of service. If you have any questions prior to the appointment please feel free to contact us at 601-582-7655. Thank for trusting our staff with you healthcare needs.

With Regards,

Arthritis Associates, PLLC

Directions to
Arthritis Associates
Dr. David Weiss
7100 HWY 98 West
Suite 220
Hattiesburg, MS 39402
601-582-7655

Traveling from Laurel

Take I-59 South go approximately 29 miles merge onto US-98 West, exit 65 go approximately 6.6 miles. You will pass Turtle Creek Mall on your right, Petro Motors on your left, Lake Serene Grocery on your right, the Toyota dealership on your right. At the intersection of US-98 and Old Hwy 11 there is a traffic light, you will continue straight for 3 miles. Citizens Bank and Corner Market grocery will be on your right. Make a left turn across Hwy 98 onto Cumberland Pass. Arthrits Associates is on your left. We are located on the second floor. We have elevator access.

Traveling from Wiggins/Gulf Coast

Take US-49 North towards Hattiesburg go approximately 26 miles then merge onto US-98 West towards Columbia/Laurel/ I-59 go approximately 2.7 miles then merge onto I-59 North/US Hwy-98 West towards Columbia/Laurel go 6.2 miles then take Exit 65 B merging onto US 98-W towards Columbia, go approximately 6.6 miles.
You will pass Turtle Creek Mall on your right, Petro Motors on your left, Lake Serene Grocery on your right, the Toyota dealership on your right. At the intersection of US-98 and Old Hwy 11 there is a traffic light, you will continue straight for 3 miles. Citizens Bank and Corner Market grocery will be on your right. Make a left turn across Hwy 98 onto Cumberland Pass. Arthrits Associates is on your left. We are located on the second floor. We have elevator access.

Traveling from Columbia

Take US-98 East, go approximately 24.5 miles, you will go throught the intersection of Hwy 589 & 98 . Citizens Bank and Corner Market grocery will be on your left. You will pass the FastMart gas station and Priority One Bank on your right. Make a right turn onto Cumberland Pass. Arthrits Associates is on your left. We are located on the second floor. We have elevator access.

East
Hwy 49 S
Hwy 49 N
Hardy St
Hwy 59 N
North
South
Old Hwy 11
Hwy 98 W
CVS Cole Road
Corner Market & Citizens Bank
**7100
Hwy 98
Arthritis
Associates
Cumberland Pass
FastMark & Priority One Bank
Hwy 589 N to Sumrall
Hwy 589 S to Purvis
West

Arthritis Associates
Specialized care for a better life.

7100 Highway 98 West, Suite 220 • Hattiesburg, MS 39402 • Phone (601) 582-7655

PATIENT REGISTRATION

Please Print

Date _____

PATIENT

First Name _____ Middle Initial _____ Last Name _____

Mailing Address _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Alternate Phone _____ Ethnicity _____

Email Address _____

Date of Birth _____ Patient's Sex _____ Social Security # _____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated Primary Language _____

Employer Name _____ Work Phone _____

Employer Address _____

City _____ State _____ Zip Code _____

PATIENT'S SPOUSE

Name _____ Date of Birth _____ Social Security # _____

Employer Name _____ Phone Number _____

Employer Address _____

City _____ State _____ Zip Code _____

EMERGENCY INFORMATION – Name of someone not living with you.

Name _____ Phone Number _____

Address _____ Relationship _____

City _____ State _____ Zip Code _____

MEDICAL

Briefly describe your problem _____

_____

_____

Were you hurt on the job? ☐ Yes ☐ No Date of Accident _____

Name of Primary Care Physician _____

Arthritis Associates

Specialized care for a better life.

7100 Highway 98 West, Suite 220 • Hattiesburg, MS 39402 • Phone (601) 582-7655

REFERRAL

Refered By _____ Business Phone _____

Address _____

City _____ State _____ Zip Code _____

PAYMENT POLICY

Payment in full is expected following each office visit. We accept cash, personal checks, VISA and MasterCard.

As a courtesy to you, we prepare and mail your insurance form for you following each visit. We will be happy to assist you with your insurance claims, but this office is not responsible for collecting your insurance claims or settling disputed claims. Your insurance is a method for reimbursing you for fees that you paid to this office and is not a substitute for your payment at the time of each visit.

I understand that if my account should ever require action by a collection agency or attorney in order to insure payment, 33.3% will be added to the balance due and unpaid on my account.

To avoid any misunderstanding, please advise the receptionist in advance if you need to make financial arrangements. I have read, understand, and agree to this policy.

_____ _____

Signature Date

CLINIC POLICY

We feel that medical treatment is a mutual partnership between the physician and the patient. It is our policy to treat all patients with dignity and respect. Likewise, we expect our patients to show us respect when they are unable to make their appointment.

Missed Appointments: Due to the shortage of rheumatologists in Mississippi, it is important that we utilize every available appointment slot to serve the maximum number of patients. We require 48 business hour notice of a cancellation. When patients fail to cancel prior to the 48 hours as requested, or miss an appointment without notifying us, the slot cannot be filled by a patient who needs it. Effective April 4, 2019, we will impose a $25 Missed Appointment Fee for the first offense, $35 for the second offense and $50 for the third offense, which will be strictly enforced. After the third offense we can no longer book you an appointment and you may be dismissed from our practice. New patients that fail to give a 48 business hour notice will be charged $75.00. To cancel or change an appointment you may call us at 601-582-7655 or message us at www.arthritisassociates.com.

We appreciate your cooperation in an effort to ensure all patients obtain appointments within a reasonable time.

I have read, understand, and agree to this policy.

_____ _____

Signature Date

AUTHORIZATION

For the purpose of evaluation and administering claims of benefits, I authorize you to release to my insurance company any information concerning health care, advice, treatment, or supplies provided to me. I further authorize payment of medical benefits to Arthritis Associates, PLLC for any services furnished to me.

_____ _____

Signature Date

Arthritis Associates
Specialized care for a better life.

7100 Highway 98 West, Suite 220 • Hattiesburg, MS 39402 • Phone (601) 582-7655

HISTORY & PHYSICAL

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

LAST NAME	FIRST NAME	MIDDLE INITIAL	AGE	DATE OF BIRTH

ADDRESS	CITY	STATE	ZIP CODE

PRESENTING PROBLEM:

ILLNESS / INJURY: Please check if you have ever had:

Yes	No		Yes	No		Yes	No	
		High Blood Pressure			Cancer			Lung Problems / Asthma
		Diabetes			Hepatitis			Shortness of Breath
		Peptic Ulcers			Yellow Jaundice			Accidents / Broken Bones (list)
		Heart Attack			Gallstones			_____
		Chest Pain / Tightness			Kidney Stones			Mastectomy ☐ R ☐ L
		Pacemaker			Abdominal Bleeding			Gout
		History of Heart Murmur			Diverticulosis			Other_____
		Stroke			Thyroid Problem			_____

OPERATIONS: ☐ Yes ☐ No If yes, please list names and dates of all operations you have had:

Year	Type of Operation	Type of Anesthetic (if known)	Complications

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, when:_____

List any hospital admissions or medical conditions not listed above:_____

FEMALES ONLY: Are you pregnant? ☐ Yes ☐ No

DRUGS: ☐ Yes ☐ No If yes, please list all drugs you take and their dosages:

Name of Drug	Dosage	Name of Drug	Dosage

ALLERGIES: ☐ Yes ☐ No If yes, please list name and reaction:

Name of Drug	Reaction	Name of Drug	Reaction

The above information is true and accurate.

Patient's Signature_____

Arthritis Associates
Specialized care for a better life.

7100 Highway 98 West, Suite 220 • Hattiesburg, MS 39402 • Phone (601) 582-7655

HISTORY & PHYSICAL

Do you currently use tobacco? ☐ Yes ☐ No If yes, # per day _____ # of years smoking _____
Have you ever used tobacco? ☐ Yes ☐ No If yes, # of years quit _____
Do you currently drink alcohol? ☐ Yes ☐ No If yes, # per day _____ # of years drinking _____ Occasionally_____
Have you ever drank alcohol? ☐ Yes ☐ No If yes, # of years quit _____ Type_____
Do you currently live in a Nursing Home? ☐ Yes ☐ No Do you currently have Home Health? ☐ Yes ☐ No
Are you currently on Hospice? ☐ Yes ☐ No

HISTORY: Have you or any blood relative had:

	Yes	No	Who	Type	Year
Allergies – Asthma, Hay Fever, etc.					
Anemia					
Alcoholism					
Arthritis					
Bleeding Problems					
Birth Defects					
Cancer					
Emphysema					
Epilepsy or Seizures					
Gallstones					
Glaucoma					
Heart Trouble					
Mental Illness					
Migraine Headaches					
Osteoporosis					
Rheumatic Fever					
Stroke					
Suicide					
Thyroid Disease / Goiter					
Tuberculosis					
Ulcers					
Venereal Disease					
Other:_____					

Have you ever been turned down for military, job and/or insurance? ☐ Yes ☐ No Which one(s)? _____

Have you had the following shots, and if so, when? Pneumovax? ☐ Yes ☐ No _____ Flu Shot? ☐ Yes ☐ No _____
TB Test? ☐ Yes ☐ No _____ ☐ Positive ☐ Negative

Name of Other Physicians you are currently seeing:

Name_____ Last Visit _____
Name_____ Last Visit _____
Name_____ Last Visit _____
Name_____ Last Visit _____
Name_____ Last Visit _____
Name_____ Last Visit _____
Name_____ Last Visit _____
Name_____ Last Visit _____

The above information is true and accurate.

Patient's Signature_____

Patient Activity Scale (PAS)

We are interested in learning how your illness affects your ability to function in daily life. Place an X in the box which best describes your usual abilities OVER THE PAST WEEK:

Are you able to:	Without Any Difficulty	With Some Difficulty	With Much Difficulty	Unable To Do
Dress yourself, including shoelaces and buttons? Shampoo your hair?	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Stand up from a straight chair? Get in and out of bed?	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Cut your meat? Lift a full cup or glass to your mouth? Open a new milk carton?	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
Walk outdoors on flat ground? Climb up five steps?	☐ ☐	☐ ☐	☐ ☐	☐ ☐

Please place an X in the box beside any aids or devices that you usually use for any of the above activities:

☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ Built up or special utensils ☐ Special or built up chair

☐ Devices used for dressing (button hook, zipper pull, long handled shoe horn) ☐ Other (please specify) _____

Place an X in the box beside any categories for which you usually need HELP FROM ANOTHER PERSON:

☐ Dressing and Grooming ☐ Arising ☐ Eating ☐ Walking

Place an X in the box which best describes your usual abilities OVER THE PAST WEEK:

Are you able to:	Without Any Difficulty	With Some Difficulty	With Much Difficulty	Unable To Do
Wash and dry your body? Take a tub bath? Get on and off the toilet?	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
Reach and get down a 5 pound object (such as a bag of sugar) from just above your head? Bend down to pick up clothing from the floor?	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Open car doors? Open jars which have been previously opened? Turn faucets on and off?	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
Run errands and shop? Get in and out of a car? Do chores such as vacuuming or yard work?	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐

Please place an X in the box beside any AIDS or DEVICES that you usually use for any of the above activities:

☐ Bathtub bar ☐ Raised toilet seat ☐ Jar opener for jars previously opened ☐ Long-handled appliances for reach

☐ Long-handled appliances in bathroom ☐ Other (please specify) _____

Please place an X in the box beside any categories for which you usually need HELP FROM ANOTHER PERSON:

☐ Hygiene ☐ Reach ☐ Gripping and Opening Things ☐ Errands and Chores

Draft

We are also interested in learning whether or not you are affected by pain because of your illness.

How much pain have you had because of your illness in the past week? Place an X in the box that best describes the severity of your pain on a scale of 0-10.

	0																			10	
NO PAIN	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	SEVERE PAIN

Considering ALL THE WAYS THAT YOUR ILLNESS AFFECTS YOU, RATE HOW YOU ARE DOING on the following scale. Place an X in the box below that best describes how you are doing on a scale of 0-10.

	0																			10	
VERY WELL	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	VERY POOR

Arthritis Associates, PLLC

Consent to Treatment and Health Information Release

Consent to Treatment: The undersigned authorizes the Physicians assigned to furnish medical and/or procedural treatment by those means he/she considers necessary and proper in treatment of the patient identified below while a patient of Arthritis Associates, PLLC. Should additional treatment requiring diagnostics including but not limited to laboratory tests and blood drawings for these tests or services will be explained at that time. An Arthritis Associates provider may perform the recommended treatment, but you also have the freedom to choose another provider other than Arthritis Associates providers at any time to furnish treatment or to render a second opinion. I have been given the opportunity to ask questions and all such questions asked were answered in language I understand to my satisfaction.

Insurance: I hereby assign to Arthritis Associates, PLLC all rights, benefits and interest under any insurance policy, health plan, workers' compensation o other third party liable to me, in consideration for services rendered by Arthritis Associates, PLLC. I hereby authorize payment directly to Arthritis Associates, PLLC for medical expenses for treatment received at Arthritis Associates, PLLC.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION/POLICIES AND PROCEDURES/NARCOTIC/CONTROLLED SUBSTANCE CONSENT.

I have received and had an opportunity to ask questions concerning Arthritis Associates, PLLC 's Notice of Privacy Practices for Protected Health Information. I have and received an opportunity to ask questions concerning Arthritis Associates, PLLC's Narcotic/Controlled substance Informed Consent for Treatment.

Health Information Release

I hereby grant permission to Arthritis Associates, PLLC to discuss my health information with the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient (Self): Has the patient executed an Advance Directive? ____Yes ____No
Has the Advance Directive information been provided to the patient? ____Yes ____No

Determination Act: Is the Advanced Directive in the patient's medical record? ____Yes ____No
Do you want to discuss Advance Health Care Directives with staff? ____Yes ____No

Lifetime signature of patient or responsible party: _____
Date: _____

2020 Clinic Policies

Missed Appointments: Due to the shortage of rheumatologists in Mississippi, it is important that we utilize every available appointment slot to serve the maximum number of patients. We require 48 business hour notice of a cancellation. When patients fail to cancel prior to the 48 hours as requested, or miss an appointment without notifying us, the slot cannot be filled by a patient who needs it. Effective **April 4, 2019**, we will impose a **$25 Missed Appointment Fee for the first offense, $35 for the second offense and $50 for the third offense**, which will be strictly enforced. After the third offense we can no longer book you an appointment and you may be dismissed from our practice. New patients that fail to give a 48 business hour notice will be charged **$75.00.** To cancel or change an appointment you may call us at 601-582-7655 or message us at www.arthritisassociates.com.

Drug Safety Monitoring: Many of our patients are using medications that require drug safety monitoring. We will no longer accept monitoring labs done outside our office as lab results and the way they are reported vary greatly from lab to lab, and our ability to follow trends in your lab work is very important to your care. For your safety, patients who have not had monitoring labs drawn in our office will not receive refills of their medication until the lab has been drawn. You may also be subject to a urine drug test, Mississippi State Board of Medical Licensure Code 2640 Guidelines for prescribing Opioids.

Medication Refill Requests: Every effort will be made to provide medication refills at the time of your visit with Dr. Weiss. However, if you need a refill between appointments, we require 24 hours notice to provide the refill. Please do not go to the pharmacy prior to requesting a refill from Dr. Weiss and being notified by the nurse that your refill has been processed. When requiring a refill of control medication you must be present in the office for a visit. No phone refills for control medications. We will no longer be able to provide an instant refill.

Patient Telephone Calls: We will make every effort to return your telephone call the day you call. However, we see patients all throughout the day and may be unable to answer your call immediately. All return calls will be made at the close of morning or afternoon clinic. If you call in after lunch, your call may not be returned until the following morning. When you call, please provide the receptionist with a detailed message to assist the nurses in answering your questions as quickly as possible.

Prior Authorization (PA) Requests: More and more insurance companies are now requiring prior authorizations for physicians to prescribe certain medications. If you need a PA number, we require a minimum of 72 hours to submit the first request.

Primary Care: It is imperative that you continue to see your primary care provider for all non-rheumatologic care. Please be sure we know who you are seeing so that we can keep them informed about your care.

After-Hours Calls: Effective February 1, 2008, we will no long have an answering service to receive your after-hours calls. Our regular office hours are Monday through Thursday, 8:00 a.m. - 5:00 p.m and Friday 8:00 am - noon. We are closed on Saturday and Sunday. **If you have a medical emergency after regular clinic hours, call 911, go directly to the Emergency Room, or contact your primary care provider. Do not leave a message on the voice mail service for emergency calls. No one will be available to answer your call.**

Signature: _____ **Date:** _____