



Arthritis & Rheumatology
Clinic of Northern Colorado, LLC

Michael Thakor, M.D., F.A.C.R.

Patricia Mayer, M.D., F.A.C.R.

Board Certified in Rheumatology

IMPORTANT NOTIFICATION

Dear patients:

Due to a large number of late appointment cancellations and missed appointments, we are enacting the following policy:

Effective July 1, 2009, there will be a \$25.00 charge for any missed follow-up appointment or any follow-up appointment cancellation within 24 hours. For a new patient visit, the charge will be \$50.00. Please notify us at least 24 hours in advance to cancel an appointment to avoid this fee. This fee will need to be paid before any future appointments are scheduled.

Sincerely,

Michael S. Thakor, MD

I have reviewed the above policy and understand the above fees will be charged if I cancel an appointment within 24 hours of the appointment time or if I miss an appointment.

Patient Signature

Printed Name

Patient Information:

Date: _____

Name: _____ Date of Birth: _____

Social Security Number: _____ Sex: [] M [] F

Address: _____

City: _____ State: _____ Zip: _____ Email Address _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Spouse Information:

Name: _____ Date of Birth: _____

Social Security Number: _____

Employer: _____ Work Phone: _____

Emergency Contact:

Name: _____ Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Referring Physician:

Name: _____ Phone: _____

City: _____ State: _____

Primary Physician:

Name: _____ Phone: _____

City: _____ State: _____

Primary Insurance

Company: _____

ID #: _____

Group #: _____

Policy Holder: _____

Policy Holder Date of Birth: _____

Secondary Insurance (if any)

Company: _____

ID #: _____

Group #: _____

Policy Holder: _____

Policy Holder Date of Birth: _____

Arthritis and Rheumatology
Clinic of Northern Colorado, LLC
2121 E. Harmony Road, Suite 360
Ft. Collins, CO 80528
(970) 267-9799 fax (970) 267-9559

ASSIGNMENT OF BENEFITS

I hereby request and authorize my insurance company to pay directly to ARCNC all medical benefits due to me under the provisions of this policy. I authorize the release of any medical information necessary to process this claim or as required by my health plan. I understand that I am personally responsible for payments of any charges not covered by my health plan.

Signature: _____ Date: _____

Please remember that it is your responsibility to obtain any referrals required by your insurance company. If you do not obtain required referrals, your insurance company may refuse to cover your visit, and you will be responsible for the payment. Please educate yourself on your insurance company referral requirements.

PLEASE READ CAREFULLY

The rheumatologist you will be seeing specializes in rheumatic diseases and does not provide primary care medical treatment, including health maintenance screening, such as screening for malignancies of the breast or colon. You **MUST** have a primary care physician to provide primary health care, emergency care, and routine health maintenance screenings. If you are not able to reach the rheumatologist, you will need to call your primary care physician or the local emergency room.

Please understand that if you arrive more than 5 minutes late to your scheduled appointment time, you may be asked to reschedule.

If you are a new patient and need to reschedule, you **must** give us 24 hours notice. If you do not, we may not reschedule your appointment, and you will be charged a \$50 fee. If you do not make it to your first appointment and do not call to cancel, you will not be rescheduled, and we will ask you to establish care with another rheumatologist.

Please understand that these policies were put in place to provide all of our patients with the very best patient care possible. We do not "double book" patients and you can expect to be seen in a timely manner unless there is an extreme emergency.

I UNDERSTAND AND AGREE TO THE ABOVE STATEMENT:

Signature: _____ Date: _____

PLEASE READ BOTH SIDES, SIGN AND DATE

Arthritis and Rheumatology
Clinic of Northern Colorado, LLC

Financial Policy

The Arthritis and Rheumatology Clinic of Northern Colorado LLC, is committed to providing you with the best treatment available. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our **Financial Policy** that we require you to read and sign.

All new patients must complete and sign our Patient Registration form, Medical History form, and Financial Policy before seeing the physician.

All co-payments are due at the time of service.

If you have no insurance coverage, payment is due at the time of service unless prior arrangements have been made.

Payment plans are accepted upon prior approval.

For your convenience, we accept cash, check, Visa and MasterCard.

REGARDING INSURANCE: Your insurance policy is a contract between you and your insurance company. We will bill your insurance for you as long as you provide us with the correct information. It is your responsibility to notify us of any changes in your insurance coverage. Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered medically necessary under your health insurance plan. You, as the patient, ultimately are responsible for payment of all services provided by our facility. While payment is your responsibility, we will assist you in negotiating a settlement with your insurance company for any disputed claim. Please call the billing office if you have any questions or need assistance with your insurance company.

Regarding insurance plans where we are a participating or preferred provider, all co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not listed as a participating or preferred provider, refer to the above paragraph. Please be aware that as the patient, it is your responsibility to call your insurance company and find out if we are contracted providers for your specific insurance plan.

REFERRALS: Please be aware that it is the patient's responsibility to obtain referrals required by your insurance company. Also, please be aware that if we refer you to another doctor or send you for diagnostic testing, we will do our best to acquire a referral/authorization from your insurance company, but it is ultimately your responsibility to confirm that referrals/authorizations are in place before your appointment.

If you have a secondary insurance, we will bill it for you as a courtesy, as long as you have provided us with the appropriate information.

If you request to bill your insurance yourself, we require payment at the time services are rendered.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MEDICALLY AND NECESSARY CARE: We will only provide you with a service if we consider it medically necessary. Therefore, if your insurance determines that a service we have rendered to you is unnecessary, you are responsible for the bill.

CREDIT POLICY: Accounts are due and payable as of the date billed. Unpaid balances will be considered delinquent after 60 days.

We realize it may be necessary on occasion to arrange a payment agreement. If financial problems arise, please contact our billing department at (970) 267-9799. If an account becomes past due without valid reason, necessary action will be taken to recover the account balance due.

All returned checks will be assessed a \$20.00 returned fee for processing.

Thank you for reading our Financial Policy. Please let us know if you have any questions or concerns.

I have read, and fully understand and agree with this Financial Policy.

X _____ Date: _____
Signature of Patient or Responsible Party

Arthritis and Rheumatology Clinic of Northern Colorado, LLC

NOTICE OF PRIVACY PRACTICES

This summary describes how we use and share information about you.
This summary describes how you may see and get copies of this information.

WE MIGHT USE OR SHARE INFORMATION ABOUT YOU FOR:

Treatment. Such as when our physicians and nurses discuss your care.

Payment. Such as when we bill your insurance company for services provided to you.

Other Ways. Such as when we send disease reports to county and state health offices (this is required by law). When we provide information to funeral directors, organ donation groups and researchers. When we share information to protect the health and safety of others or you, or when we respond to court requests. We may also send you appointment reminders, greeting cards and newsletters.

HOW YOU MAY SEE AND GET COPIES OF THIS INFORMATION:

You have the right to:

- Ask for restrictions on the ways we use and give out your information. However, we are not required to do what you ask.
- Get and inspect a copy of your health record.
- Add information to your health record.
- Ask that your health information be sent to a different address or that we contact you at a different phone number.
- Change your mind if you told us we could use or share information for reasons other than those listed above.
- Get a list of the times we gave out your information. It will be a list of the times that the law requires us to keep a record of giving out your information.

OUR COMMITMENT TO RESPECT YOUR PRIVACY:

Arthritis and Rheumatology Clinic of Northern Colorado, LLC is required to:

- Keep your information private.
- Let you know if we cannot do what you have asked us to do with your information.
- Try to reach you at another location of phone number, if you ask us to do so.
- Use and/or give out your information as listed above and as the law permits, unless we have your permission to do more.

As we serve our patient we may change what we do with your information. If we make a change, we will give you a new notice the next time you visit us. You may call or write us to check if we have made any changes.

COMPLAINTS:

If you think your privacy rights have been violated, you may complain to Arthritis and Rheumatology Clinic of Northern Colorado, LLC. You will not be mistreated for filing a complaint.

Contact information:

Arthritis and Rheumatology Clinic of Northern Colorado, LLC
Michael Thakor, M.D., F.A.C.R.
Patricia Mayer, M.D., F.A.C.R.
2121 E. Harmony Road, Suite 360
Fort Collins, CO 80528
(970) 267-9799 Fax (970) 267-9559

Patient acknowledgment of receipt of this notice:

Patient Name: _____ Signature: _____

Date: _____

Arthritis & Rheumatology
Clinic of Northern Colorado, LLC
Michael Thakor, M.D., FACR - Patricia Mayer, M.D., FACR
970-267-9799

Name _____ Date of Birth _____ Age _____

Date of Visit _____ **Time** _____ **Check-in Time** _____

Referring Doctor _____ Primary Doctor _____

Previous Arthritis Doctors _____

Briefly describe your present symptoms: _____

Recently have you had any of the following symptoms:

- | | | |
|--|---|---|
| <input type="checkbox"/> Fever/chills | <input type="checkbox"/> Hands changing color after cold exposure | |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Pain on chewing | <input type="checkbox"/> Morning stiffness (duration?) _____ |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Joint swelling (which joints?) _____ |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Bruising |
| <input type="checkbox"/> Sensitivity to sun | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Excessive hair loss | <input type="checkbox"/> Cough | <input type="checkbox"/> Numbness/tingling |
| <input type="checkbox"/> Dry eyes/mouth | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Change in vision |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain on urination | |

To your knowledge have you ever had any of the following conditions:

- | | |
|---|--|
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Low blood counts of any kind |
| <input type="checkbox"/> Iritis/uveitis | <input type="checkbox"/> Blood clots in your legs or lungs |
| <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Blood or protein in the urine |
| <input type="checkbox"/> Ulcerative colitis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Miscarriages | |

Past medical history:

Illnesses/hospitalizations:

Surgeries:

Current medications (include dosages):

Medication Allergies (list and describe reaction):

Social history:

Marital status _____

Occupation _____

Current tobacco use (circle): no yes

Packs per day _____ Number of years _____

Previous tobacco use (circle): no yes

Packs per day _____ Number of years _____

Alcohol use (circle) no yes

Type of beverage _____ Frequency/amount _____

Recent travel _____

Family history:

To your knowledge have any of your family members had the following diseases: (Please list relative)

- Rheumatoid arthritis _____
- Diabetes _____
- Osteoarthritis _____
- Cancer (type) _____
- "Arthritis" _____
- Kidney disease _____
- Lupus _____
- Gout _____
- Osteoporosis _____
- Thyroid disease _____
- Heart disease _____
- Other significant diseases _____

Father's age/age at death _____

Mother's age/age at death _____

Siblings (ages/sexes): _____

Children (ages/sexes): _____

Have you taken any of the following medications? *If so please note any side effects and if medication was effective:*

- Ansaid (flurbiprofen) _____
- Arthrotec _____
- Celebrex _____
- Clinoril (sulindac) _____
- Daypro (oxaprozin) _____
- Disalcid (salsalate) _____
- Dolobid (diflunisal) _____
- Feldene (piroxicam) _____
- Indocin (Indomethacin) _____
- Lodine (etodolac) _____
- Mobic _____
- Motrin (ibuprofen) _____
- Naprosyn (naproxen) _____
- Oruvail (ketoprofen) _____
- Relafen (nabumetone) _____
- Tolectin (tolmetin) _____
- Vioxx _____
- Voltaren (diclofenac) _____
- Darvon _____
- Codeine _____
- Hydrocodone _____
- Boniva _____
- Humira _____
- Orencia _____

- Lortab _____
- Lorcet _____
- Tylox _____
- Arava _____
- Cytoxan _____
- Enbrel _____
- Imuran _____
- Methotrexate _____
- Penicillamine _____
- Gold (injections/pills) _____
- Plaquenil (hydroxychloroquine) _____
- Remicade _____
- Sulfasalazine _____
- Actonel _____
- Fosamax _____
- Miacalcin _____
- Evista _____
- Colchicine _____
- Probenecid _____
- Zyloprim (allopurinol) _____
- Vicodin _____
- Reclast _____
- Rituxan _____