INSTITUTE *for* SPECIALIZED MEDICINE
State-of-the-Art Integrative Care for Arthritis and Autoimmune Diseases

Welcome to the Institute for Specialized Medicine (IFSMED). We are pleased to have you as a patient and we are committed to providing you with exceptional medical care. We are a unique practice, utilizing state-of-the-art diagnostic and treatment protocols as well as a broad spectrum of additional services. In order to best serve you, we want you to be fully informed of our financial policies prior to your first visit. Please read and initial each section below, indicating your understanding and agreement with each statement.

_____ I understand that a co-pay does not cover all expenses incurred during an office visit and that I am responsible for all co-payments, deductibles, and co-insurances. I am also responsible for all charges for services/supplies that are non-covered or deemed experimental, investigational, or not medically necessary. Any services rendered or tests performed may or may not be a covered benefit of my insurance plan and it is my responsibility to verify coverage.

_____ I understand that diagnostic ultrasound is recommended for all new patient appointments and is a procedure that is billed separately from the office visit co-pay, resulting in additional charges. Each joint or body part that is viewed through ultrasound is billed as a separate, additional charge. In understand that in-office diagnostic ultrasound may or may not be a covered benefit on my insurance plan and it is my responsibility to verify coverage.

_____ I understand that IFSMED processes outside lab tests through LabCorp who will bill me separately for their lab services. It is my responsibility to verify if LabCorp is contracted or in-network with my insurance policy. If they are not, I will notify IFSMED if I want my lab work completed at an alternate lab.

_____ I understand that appointments at IFSMED are in high demand. Please contact us 48 hours in advance if you must cancel your appointment. Your first missed appointment will be charged a $25 no call/no show fee if you choose not to arrive on time or keep your appointment without notification. Two consecutive missed appointments without notification will incur a $50 fee and three consecutive missed appointments without notification will result in removal from the practice.

_____ I understand that any self pay, fee-based services or products require full payment at the time of service. This includes, but is not limited to, alternative therapies, supplements, and non-covered products and services. This also includes all services rendered to Private Pay patients who do not have insurance.

_____ I understand that if I have not yet met my deductible AND out-of-pocket, IFSMED will collect a deposit of $600 (in addition to my co-pay) prior to being seen for an initial visit. This deposit will be applied to my account for coinsurance and other charges incurred. In the event that there are funds remaining on my account at the end of the calendar year, IFSMED will provide me a full refund of the remaining balance. I may also request to have that balance carried on to the following year.

_____ I understand that if I have not yet met my deductible, IFSMED will collect a deposit of $100 (in addition to my co-pay) for any follow up appointment prior to being seen for my visit. This deposit will be applied to my account for coinsurance and other charges incurred. In the event that there are funds remaining on my account at the end of the calendar year, IFSMED will provide me a full refund of the remaining balance. I may also request to have that balance carried on to the following year.

Signed: _____ Date: _____
(patient or responsible party if patient is a minor)

Print name: _____

AMERICAN COLLEGE OF RHEUMATOLOGY
EDUCATION • TREATMENT • RESEARCH

Patient History Form

Date of first appointment: _____ Date of birth:_____ Age:_____ Sex:_____ SSN:_____

Name:_____
LAST FIRST MIDDLE INITIAL MAIDEN

Address:_____

City:_____ State:_____ Zip:_____

Telephone:Home:_____ Cell:_____

Email:_____
Needed to create online patient portal for secure access to your health information and secure communication with the practice.

Language Preference: _____
❑Refused

Race: ❑White ❑White Hispanic or Latino
❑Black or African American ❑American Indian
❑Black Hispanic or Latino ❑Alaska Native
❑Native Hawaiian ❑Filipino ❑Chinese
❑Japanese ❑Korean ❑Other Asian
❑Guamanian ❑Samoan ❑Tongan
❑Other Pacific Islander ❑Vietnamese ❑Refused

Ethnicity: ❑Hispanic or Latino
❑Not Hispanic or Latino ❑Refused

Emergency contact and relationship to you: _____

Emergency contact phone number: _____

Marital status (circle one): Never married Married Divorced Separated Widowed

Education (circle highest level attended): Grade school 7 8 9 10 11 12 College 1 2 3 4 Grad school

Occupation: _____ Number of hours worked/average per week: _____

Who referred you: _____

Who is your primary care physician: _____

Date symptoms began (approximate):_____

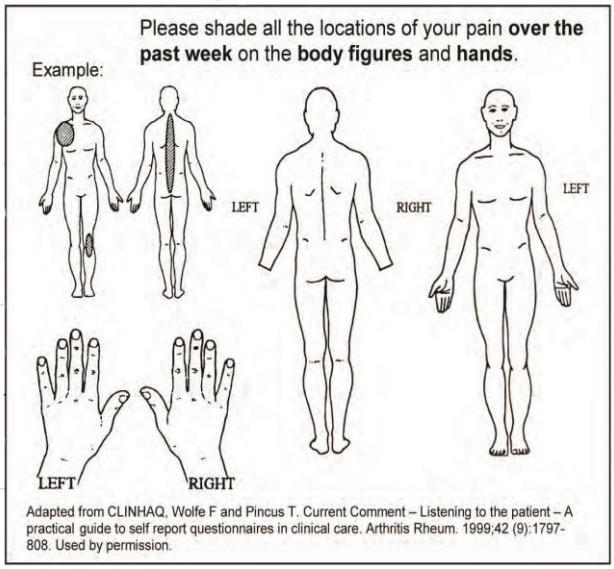
Diagnosis: _____

Please list the names of other practitioners you have seen for this problem: _____

_____

Briefly describe your present symptoms:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Previous treatments for this problem (include physical therapy, surgery and injections; medications will be listed later):_____
_____
_____
_____
_____



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

Date of last mammogram: _____ Date of last eye exam: _____ Date of last chest x-ray: _____

Date of last Tuberculosis test: _____ Date of last bone densitometry: _____

As you review the following list, please check any problem which as significantly affected you

Constitutional
- ☐ Recent weight gain Amount: _____
- ☐ Recent weight loss Amount: _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever

Eyes
- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye
- ☐ Itching eyes

Ear-Nose-Mouth-Throat
- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Dryness in nose
- ☐ Runny nose
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness of mouth
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing

Cardiovascular
- ☐ Pain in chest
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat
- ☐ High blood pressure
- ☐ Heart murmurs

Respiratory
- ☐ Shortness of breath
- ☐ Difficulty in breathing at night
- ☐ Swollen legs or feet
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing (asthma)

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting of blood or coffee ground material
- ☐ Stomach pain relieved by food or milk
- ☐ Jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools
- ☐ Heartburn

Genitourinary
- ☐ Difficult urination
- ☐ Pain or burning on urination
- ☐ Blood in urine
- ☐ Cloudy, “smoky” urine
- ☐ Pus in urine
- ☐ Discharge from penis/vagina
- ☐ Getting up at night to pass urine
- ☐ Vaginal dryness
- ☐ Rash/ulcers
- ☐ Sexual difficulties
- ☐ Prostate trouble

For women only:
Age when period began:_____
Periods regular? ____yes_____no
How many days apart? _____
Date of last period:_____
Date of last pap:_____
Bleeding after menopause:
____yes _____no
Number of pregnancies?_____
Number of miscarriages?_____

Musculoskeletal
- ☐ Morning stiffness. Lasting how long? _____
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint swelling: list joints affected in the last 6 months
  _____
  _____
  _____
  _____

Integumentary (skin and/or breast)
- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive (sun allergy)
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet in the cold

Neurological System
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle spasm
- ☐ Loss of consciousness
- ☐ Sensitivity or pain of hands and/or feet
- ☐ Memory loss
- ☐ Night sweats

Psychiatric
- ☐ Excessive worries
- ☐ Anxiety
- ☐ Easily losing temper
- ☐ Depression
- ☐ Agitation
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

Endocrine
- ☐ Excessive thirst

Hematologic/Lymphatic
- ☐ Swollen glands
- ☐ Tender glands
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Transfusion/when_____

Allergic/Immunologic
- ☐ Frequent sneezing
- ☐ Increased susceptibility to infection

Any previous fractures?_____
_____
Any other serious injuries?_____
_____
_____
_____

Previous operations: Year:_____ Year:_____

Year:_____ Year:_____

Social History

Do you drink caffeinated beverages? _____
Cups/glasses per day? _____

Do you smoke? ___yes ___no ___
past: how long ago? _____

Do you drink alcohol? ___ yes ___ no how many per week? _____
Has anyone ever told you to cut down on your drinking?
___ yes ___ no

Do you use drugs for reasons that are not medical?
___ yes ___ no If yes, please list:_____
_____

Do you exercise regularly? ___ yes ___ no
Type:_____
Amount per week:_____

How many hours of sleep do you get at night? _____
Do you get enough sleep at night? ___ yes ___ no
Do you wake up feeling rested? ___ yes ___ no

Past Medical History

Do you now or have you ever had: (check if yes)

☐ Cancer	☐ Heart problems	☐ Asthma
☐ Goiter	☐ Leukemia	☐ Stroke
☐ Cataracts	☐ Diabetes	☐ Epilepsy
☐ Nervous breakdown	☐ Stomach ulcers	☐ Rheumatic fever
☐ Bad headaches	☐ Jaundice	☐ Colitis
☐ Kidney disease	☐ Pneumonia	☐ Psoriasis
☐ Anemia	☐ HIV/AIDS	☐ High blood pressure
☐ Emphysema	☐ Glaucoma	☐ Tuberculosis

Other significant illness (please list): _____
_____
_____

Natural or alternative therapies (chiropractic, magnets, massage, over-the-counter preparations etc..):
_____
_____
_____

Family History

If Living	Age	Health	**If Deceased**	Age at Death	Cause
Father					
Mother					

Number of siblings _____ Number living _____ Number deceased _____
Number of children _____ Number living _____ Number deceased _____ List ages of each _____
Health of children: _____

Do you know any blood relative who has or had: (check and give relationship)

☐ Cancer	☐ Heart disease	☐ Rheumatic fever	☐ Tuberculosis
☐ Leukemia	☐ High blood pressure	☐ Epilepsy	☐ Diabetes
☐ Stroke	☐ Bleeding tendency	☐ Asthma	☐ Goiter
☐ Colitis	☐ Alcoholism	☐ Psoriasis	

Rheumatologic (Arthritis) History

At any time have you or a blood relative had any of the following? (check if yes)

Yourself		Relative/Relationship	Yourself		Relative/Relationship
	Arthritis (unknown) type			Rheumatoid Arthritis	
	Osteoarthritis			Lupus or “SLE”	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	
Other arthritis conditions:					

Immunization History (If unsure of the dates, please contact your primary doctor and provide to us at a later date.)

Vaccine	**Dates**	**Vaccine**	**Dates**
Haemophilus influenza type b (Hib)		Pneumococcal 13 (PCV13)	
Hepatitis A		Pneumococcal polysaccharide (PPSV23)	

Hepatitis B		Varicella	
Influenza		Zoster	

Activities of Daily Living

Do you have stairs to climb? ___ yes ___ no If yes, how many?_____

How many people in household? _____

Relationship and age of each: _____

Who does most of the housework? _____

Who does most of the shopping? _____

Who does most of the yardwork? _____

On the scale below, circle a number which best describes your situation. *Most of the time I function*….

1	2	3	4	5
VERY POORLY	POORLY	OK	WELL	VERY WELL

Because of health problems, do you have difficulty: (Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil etc.)			
Walking?			
Climbing stairs?			
Descending stairs?			
Sitting down?			
Getting up from chair?			
Touching your feet while seated?			
Reaching behind your back?			
Reaching behind your head?			
Dressing yourself?			
Going to sleep?			
Staying asleep due to pain?			
Obtaining restful sleep?			
Bathing?			
Eating?			
Working?			
Getting along with family members?			
In your sexual relationship?			
Engaging in leisure time activities?			
With morning stiffness?			
Do you use a cane, crutches as a walker or wheelchair? (circle one)			

What is the hardest thing for you to do? _____

Are you receiving disability? ___ yes ___ no

Are you applying for disability? ___ yes ___ no

Do you have a medically related lawsuit pending? ___ yes ___ no

PATIENT MEDICATION LIST

Patient name: _____ Date of birth: _____

MEDICATION NAME	DOSE/STRENGTH	FREQUENCY	PRESCRIBING PHYSICIAN

PLEASE LIST ANY MEDICATIONS YOU ARE ALLERGIC TO:

_____

_____

_____

_____

_____

PATIENT SUPPLEMENT LIST

Patient name: _____ Date of birth: _____

SUPPLEMENT NAME	DOSE/STRENGTH	FREQUENCY	PRESCRIBING PHYSICIAN

HIPAA AND PRIVACY PRACTICES

Please take time to review our **notice of privacy practices** on our website at www.ifsmed.com/about-hipaa

I hearby acknowledge that I have reviewed the **notice of privacy practices** made available to be my Institute for Specialized Medicine.

Signed: _____
(patient or responsible party if patient is a minor)

Print name: _____

Date: _____

INSURANCE INFORMATION

Please provide your insurance card or cards so we may keep a copy on file. Any time there is a change to your insurance, or new cards are issued, it is your responsibility to provide the updated cards to our office.

Patient name:_____

Primary insurance company: _____ Effective date:_____

Policy holder name: _____ Date of birth:_____

Relationship to patient: SELF SPOUSE CHILD OTHER _____

Secondary insurance company: _____ Effective date: _____

Policy holder name: _____ Date of birth: _____

Relationship to patient: SELF SPOUSE CHILD OTHER _____

If you are **not** the Policy Holder on either of your insurance plans, please complete the following:

I hereby authorize IFSMED to release and discuss my healthcare and/or financial information with the Policy Holder of my insurance plan, named here: _____

Signed: _____

Print name: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS AND CERTIFICATION OF ACCURATE INFORMATION

I hereby authorize Institute for Specialized Medicine to release information which is normally required in the course of my treatment for the sole purpose of processing any insurance claim(s) submitted.

I hereby authorize my insurance company to send payment directly to Institute of Specialized Medicine for any insurance benefits for services rendered. I understand that I am financially responsible for any unmet deductible, co-pays and for any charges of services not covered by my insurance.

I have reviewed the preceding information and I certify that this information is correct. I further understand that I am responsible for any financial loss due to inaccurate or incomplete information provided by me.

Signed: _____
(Patient or responsible party, if patient is a minor)

Print name: _____Date: _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient name: _____ Date of birth: _____

Previous name: _____ Social Security Number:_____

I authorize Institute for Specialized Medicine to release healthcare information and discuss my treatment with the following people:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

This authorization applies to:

☐ Healthcare information

☐ Billing information

☐ Other:_____

Signed: _____

(Patient or responsible party, if patient is a minor)

Print name: _____Date: _____