NEW PATIENT REGISTRATION FORM (PLEASE PRINT LEGIBLY)

PLEASE COMPLETE ALL FIELDS OF REGISTRATION FORM

Patient Last Name	First Name	Middle Name	Maiden Name

Address (Street or Box)	City	State	Zip

Home Phone #	Work Phone #	Cell Phone #

Sex (check one) □ Male □ Female	Date of Birth	Age	Social Security #	Drivers License #

Marital Status □ Single □ Married □ Divorced □ Widowed	Spouse's Name (If Applicable)

Employer Name	Employer Address	Occupation

Primary Care Physician	Phone #	Referring Physician	Phone #

Who may we thank for referring you?

In Case of an emergency who should be notified?	Relationship	Phone #

Race

□ American Indian or Alaska Native □ Black or African American □ Asian (includes Pakistan or Indian Origins)

□ White □ Multiracial □ Hispanic □ Decline

Language

□ English □ Spanish □ Chinese □Vietnamese □ Italian □ Sign Language □ Other □ Decline

Insurance Company (Primary)	Policy ID Number	Group Number	Eff Date

Subscriber Name (policy holder if different from pt)	Date of Birth	Social Security#	Relationship

Subscriber Employer	Employer Phone #	Employer Address

Insurance Company (Secondary)	Policy ID Number	Group Number	Eff Date

Subscriber Name (policy holder if different from pt)	Date of Birth	Social Security#	Relationship

Subscriber Employer	Employer Phone #	Employer Address

I, the undersigned certify that I (or my dependant) have insurance coverage with, ______________________, and assign directly to **SHAIKH ARIF ALI, MD. NORTHWEST HOUSTON ARTHRITIS CENTER, PA.** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessery to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Name **(PLEASE PRINT)**	Responsible Party Signature	Date

Northwest Houston Arthritis Center, P.A.

Arif Ali, M.D.

HEALTH HISTORY

Date:________ Patient Name:______________________________ Date of Birth:________

Age:_____ Allergies:____

FAMILY HISTORY:

□ Diabetes □ High Blood Pressure □ Stroke □ Heart Disease □ Arthritis

□ Cancer (If yes list types and family member):______________________________

____

SOCIAL HISTORY

Patient Occupation:______________________________________

Do you smoke? □ Yes □ No If so, how many per day?____________________

Do you consume alcohol? □ Yes □ No If so, how much per day?______________

Have you used social drugs in the past? (marijuana, etc.) □ Yes □ No

Are you currently using social drugs? If so, which ones?____________________

____

Please list current medications (or provide an updated list to our office) **PLEASE PRINT**

____

____

____

PAST MEDICAL HISTORY:

□ Measles	□ Chicken Pox	□ Mumps	□ Skin
□ Glaucoma	□ Cataracts	□ Hypertension	□ Rheumatic Fever
□ Asthma	□ Heart Attack	□ TB/STD	□ Depression
□ Hepatitis	□ PVD/Gallstones	□ CVA/Stroke	□ Kidney Disease
□ Cancer	□ Seizures/Epilepsy	□ Thyroid Disease	□ Diabetes

□ Rheumatoid Arthritis/Gout □ Degenerative Joint Disease □ Migranes

Please list all surgeries and years:______________________________________

____

____

Any recent hospitilizations: □ Yes □ No

Recent Lab test / x-rays? □ Yes □ No

Northwest Houston Arthritis Center, P.A.

Arif Ali, M.D.

REVIEW OF SYMPTOMS

- ☐ Fever
- ☐ Excessive Wt Loss
- ☐ Excessive Wt Gain
- ☐ Headaches
- ☐ Migranes
- ☐ Double Vision
- ☐ Sinus Trouble
- ☐ Hay Fever/Allergies
- ☐ Chest Pain
- ☐ Swelling in the Chest
- ☐ Palpitations
- ☐ Hypertension
- ☐ Dizziness
- ☐ Fainting Spells
- ☐ Swelling of Ankles/Legs
- ☐ Chronic Cough /Hempptysis
- ☐ Wheezing /SOB / PND
- ☐ Sensitive to Sun
- ☐ Back Pain
- ☐ Weakness
- ☐ Dryness/Redness of the Eyes
- ☐ Alopecia
- ☐ Tender Points in Muscles
- ☐ Heart Burn / Abdomincal Pain
- ☐ Nausea
- ☐ Vomitting
- ☐ Mouth Ulcers
- ☐ Gastric Ulcers
- ☐ Constipation
- ☐ Diarrhea
- ☐ Frequent or Difficult Urination
- ☐ Excessive Thirst
- ☐ Blood in Urine
- ☐ Depression / Anxiety
- ☐ Easy Bruising
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Hives
- ☐ Skin Rash / Sores
- ☐ Numbness
- ☐ Excessive Fatique
- ☐ Muscle Weakness
- Insomia

Please list any other health issues that you may be experiencing that is NOT listed on the above list:

____

____

Patient Name (Print) ________________ Date ________

Patient Name (Signature) ________________

RHEUMATOLOGIST MEDICATION WORKSHEET

COX 2	GI Bleeding, Renal Problems, High Blood Presssure, MI, Edema, CAD
NSAIDS	GI Ulceration and Bleeding, HTN, CAD
SULFASALAZINE	Decreased Blood Counts, Increased LFT's, Allergic Reaction
METHOTREXATE	Decreased Blood Counts, Hepatic Fibrosis, Cirrhosis, Pulmonary Infiltrate or Fibrosis, Infections
PLAQUENIL	Retinal Deposit
AZATHIOPRINE	Decreased Blood Counts, Infections, Increased LFT's
CYCLOPHOSPHAMIDE	Decreased Blood Counts, Malignacy, Infections, Myeloproliferative Disorders Hemorrhagic Cystitis, Infertility
CYCLOSPORIN A	Renal Insufficiency, Anemia, Hypertension, Infections
CORTICOSTERIODS	Hypertension, High Blood Sugar, Weight Gain, Infections, AVN, Cataracts
ARAVA	Diarrhea, Increased LFT's, Weight Loss, Infections
REMICAID	Infections, TB, Lymphoma, Lupus, Anaphylaxis, Vasculitis
ENBREL	Infections, TB, Lymphoma, Lupus, Anaphylaxis, Vasculitis
HUMIRA	Infections, TB, Lymphoma, Lupus, Anaphylaxis, Vasculitis
PAIN MEDS (NARCOTICS)	Addiction, Drowsiness, Patients advised not to drive while taking these medications, No Alcohol or Other Social Drugs
SLEEP MEDS	Addiction, Drowsiness, Patients advised not to drive while taking these medications, No Alcohol or Other Social Drugs

All of these above side effects have been explained to me, and I fully understand all of the listed information. I agree to report ALL reactions, and/or possible side effects that may be related to the ingestion of any of the referenced medications directly to Dr. Ali

Patient Name (please print) ______________________

Patient Signature ______________________

Date ______________________

Witness ______________________

NORTHWEST HOUSTON ARTHRITIS CENTER, P.A.

Arif Ali, M.D.
Rheumatology

**ACKNOWLEDGEMENT OF THE RECEIPT OF
NORTHWEST HOUSTON ARTHRITIS CENTER, PA
NOTICE OF HEALTH INFORMATION PRACTICES**

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your rights and of how your medical information can be used by our staff in providing and arranging your medical care.

Northwest Houston Arthritis Center, PA is furnishing you with the attached notice, which provides information about how Northwest Houston Arthritis Center, PA and it's physicians may use and/or disclose protected health information about you for treatment, payment, health care operation and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of the Northwest Houston Arthritis Center, PA's Notice of Health Information Practices (or had the opportunity to read if I chose).

____
Patient Name (Please Print)

______________________________ ____________________
Patient Signature, or Legal Guardian Date

455 School Street, Suite 27 • Tomball, Texas 77375 • (281) 357-0666 • Fax: (281) 255-2740

NORTHWEST HOUSTON ARTHRITIS CENTER, P.A.

Arif Ali, M.D.
Rheumatology

CONSENT TO TREAT

I hereby authorize employees and agents of Northwest Houston Arthritis Center, PA, (including physician assistants and nurse practitioners and other employees and staff members) to render medical evaluations and care to the patient indicated below. I also allow Northwest Houston Arthritis Center to provide other medical professionals, diagnostic facilities, hospital (in or out patient) and any other medical source with my personal demographics for the purpose of referring me for continued medical treatment. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

____
Patient Name (Please Print)

______________________________ __________________
Signature of Patient, or Legal Guardian Date

FINANCIAL RESPONSIBILTY

I hereby authorize payment of medical benefits directly to Northwest Houston Arthritis Center, Shaikh Arif Ali, M.D. Authorization is herby granted to release information contained in the patient's medical record to the patient's medical insurance company (or it's employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome (AIDS) and Human Immune Deficiency Virus (HIV). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to Northwest Houston Arthritis Center, Shaikh Arif Ali, M.D.. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of Northwest Houston Arthritis Center, Shaikh Arif Ali, M.D., if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

____
Patient Name (Please Print)

______________________________ __________________
Signature of Patient, or Legal Guardian Date

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Rheumatology

PATIENT PREFERENCES REGARDING COMMUNICATION OF PHI (Patient Health Information)

APPROVED HIPAA CONTACTS

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the **Patient** or **Legal Guardian**.

If you would like to add addition contacts (other than the patient or legal guardian) that **Northwest Houston Arthritis Center** allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list.

Contact Name (Please Print)	Relationship to Patient	Contact Phone Number

□ **Billing Account Information** □ **Medical Condition Information** □ **Emergency Contact**

Contact Name (Please Print)	Relationship to Patient	Contact Phone Number

□ **Billing Account Information** □ **Medical Condition Information** □ **Emergency Contact**

My preferred method of communication regarding **my medical conditions** is indicated below **(check one)**

□ Home Phone □ Work Phone □ Cell Phone □ Mailed Letter □ Guardian

If the above method of communication is by phone, please check the appropriate box below **(check one)**

□ Leave a message with detailed information □ Leave a message with a call-back number only

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that request for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information.

Patient Name (Please Print)

Signature of Patient, or Legal Guardian Date

NORTHWEST HOUSTON ARTHRITIS CENTER, P.A.

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Rheumatology

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Patient Name (Please Print)

Signature of Patient, or Legal Guardian | Date

NORTHWEST HOUSTON ARTHRITIS CENTER, P.A.

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Rheumatology

ATTENTION ALL PATIENTS

If you are prescribed a narcotic pain medication, sleep aid, or muscle relaxer, it is to be used on a **AS NEEDED BASIS (PRN)**

EXAMPLE: Prescription says take every 8 hours **AS NEEDED**, this means you may take medication no earlier than 8 hours apart **IF NEEDED**. It does not mean take every 8 hours around the clock

If you need to take medication around the clock on a stady basis to control your pain, Dr. Ali may refer you to a pain management doctor for better control of your pain. If referred to pain management, Dr. Ali will still treat you for your diagnosis, but not for the control of the pain.

All narcotics, sleep aids, and muscle relaxers **MUST LAST 30 DAYS** with **NO EARLY FILL** and **NO EXCEPTIONS**. If medication due date falls on a Saturday or Sunday we will fill it the Friday before it is due. Also these medications **CANNOT** be filled with multiple pharmacies.

If you have any questions or concerns, please feel free to ask the nurse.

______________________________ ______________________________
Patient name (Please Print) **Patient Signature**

______________________________ ______________________________
Witness **Patient Date of Birth**

____
Date

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NORTHWEST HOUSTON ARTHRITIS CENTER, P.A.

Arif Ali, M.D.
Rheumatology

FINANCIAL POLICY

Thank you for choosing us as one of your healthcare providers. We are committed to your treatment being successful. 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 prior to any treatment. We ask that after you have completed reading each paragraph that you initial the blank line provided. Thank You.

_____ **FOR ALL NETWORK PLANS AND MEDICARE:** We accept assignment of insurance benefits; however if the insurance carrier has not made payment within 60 days from the date of service, you may be billed for the balance. If the insurance company does render payment, we will gladly refund the difference to you. Please be aware that not all services provided may be covered by your plan. It is **your responsibility** to know your benefit plan. **All co-pays and unpaid balances must be paid before the patient sees the physician.**

_____ **PATIENTS WITH HMO/POS PLANS REQUIRING REFERRAL FROM PCP:** It is the responsibility of the patient to obtain a written and/or verbal referral, whichever is required by the insurance carrier, prior to the visit to our clinic. Dr. Ali is a specialist and our office does not call to obtain referrals. If a patient presents to our office without a referral, the patient must reschedule an appointment for a later date.

_____ **RETURNED CHECKS:** There will be a $30 return check fee added to the balance owed on your account for any returned checks,

_____ **ADULT PATIENTS:** Adult patients are responsible for full payment at the time of service.

_____ **MINOR PATIENTS**: The adult accompanying a minor is responsible for full payment. For unaccompanied (by parent or guardian) minors, treatment will be denied.

_____ **MISSED APPOINTMENTS:** Please help us serve our patients better by adhering to the policy of canceling appointments 244 hours in advance. Unless cancelled at least 24 hours in advance, our policy is to change for missed appointment at the rate of a normal office visit.

_____ **DOCUMENTATION FEES:** A fee will be charged for all documentation that must be completed (e.g. letters of medical necessity, FMLA, disability, dictated letters, etc.). The amount charged will depend on the specific requirements of the request.

Please let us know if you have any questions or concerns.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE
WE ACCEPT CASH, CHECKS, AND MOST MAJOR CREDIT CARDS
Information and insurance forms must be completed and accompany this form.

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

_______________________________ _______________________________
Patient Name **(Please Print)** Patient Signature

____
Date

455 School Street, Suite 27 • Tomball, Texas 77375 • (281) 357-0666 • Fax: (281) 255-2740