NORTHWEST HOUSTON ARTHRITIS CENTER, PA
455 School St. Ste 27 17045 Saint Edwards Dr Ste. 110
Tomball, TX 77375 Houston, Tx 77090
Phone: 281-357-0666 Fax: 281-255-2740

S. Arif Ali, M.D.
Adnan Peer, M.D.
Iqtidar Hanif, M.D.

PATIENT DEMOGRAPHICS

Date: _____

LAST NAME: _____ **FIRST NAME:**_____ **MI:**_____

DATE OF BIRTH: ____/_____/_____ **GENDER:** ☐ **MALE** ☐ **FEMALE** **SOCIAL SECURITY:** _____

ADDRESS: _____**APT:** _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME: _____ **CELL:** _____ **OTHER:** _____

EMAIL ADDRESS: _____ **PREFERRED CONTACT:** ☐ **HOME** ☐ **CELL** ☐ **E-MAIL**

MARITIAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ OTHER SPOUSE NAME: _____

EMERGENCY CONTACT: FULL NAME: _____ PHONE: _____

☐ No Advance Directive ☐ Does Not Wish to Disclose ☐ Advance Directive In Place: NAME: _____

RACE: ☐ American Indian or Alaska Native ☐ African American ☐ Asian (includes Pakistan or Indian Origins)
☐ Caucasian ☐ Multiracial ☐ Hispanic ☐ Decline

PREFERRED LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ SIGN LANGUAGE ☐ OTHER ☐ DECLINE

PRIMARY INSURANCE: _____ **PHONE NUMBER:** _____

POLICY ID NUMBER: _____ **GROUP NUMBER:** _____

POLICY HOLDER INFORMATION: ☐ SAME AS PATIENT ☐ PARENT ☐ SPOUSE ☐ OTHER_____

LAST NAME: _____ FIRST NAME: _____ DATE OF BIRTH: _____

SECONDARY INSURANCE: _____**PHONE NUMBER:** _____

POLICY ID NUMBER; _____ **GROUP NUMBER:** _____

POLICY HOLDER INFORMATION: ☐ SAME AS PATIENT ☐ PARENT ☐ SPOUSE ☐ OTHER _____

LAST NAME: _____ FIRST NAME: _____ DATE OF BIRTH: _____

PRIMARY CARE PHYSICIAN: _____ **PHONE:** _____

REFERRING PHYSICIAN: _____ **PHONE:** _____

REASON FOR TODAYS VISIT: _____

_____

MEDICATION ALLERGIES: _____

PLEASE LIST ALL CURRENT MEDICATIONS OR PROVIDE A COPY TO THE OFFICE: _____

_____

_____

PHARMACY NAME: _____ **NUMBER:** _____

SOCIAL HISTORY: ☐ Retired ☐ Disabled ☐ Employed- Occupation: _____

DO YOU SMOKE: ___YES ___ NO (IF YES: PACKS/DAY: ____) DO YOU DRINK: _____ YES _____ NO (IF YES ____ DAY ___WEEK)

DO YOU USE SOCIAL DRUGS: ____ YES _____NO

PLEASE CHECK THE FOLLOWING SYMPTOMS THAT YOU MAY HAVE:

☐ Fever	☐ Excessive Weight Loss	☐ Excessive Weight Gain	☐ Headaches
☐ Migraines	☐ Double Vision	☐ Sinus Troubles	☐ Hay Fever/Allergies
☐ Chest Pain	☐ Swelling in the chest	☐ Palpitations	☐ High Blood Pressure
☐ Dizziness	☐ Fainting Spells	☐ Swelling of Ankles/Legs	☐ Chronic Cough
☐ Weakness	☐ Sensitive to Sun	☐ Wheezing/Shortness Of Breath	☐ Alopecia
☐ Nausea	☐ Frequent Urination	☐ Difficulty Urinating	☐ Tender Points in Muscles
☐ Insomnia	☐ Dryness/Redness of Eyes	☐ Heart Burn	☐ Abdominal Pain
☐ Vomiting	☐ Constipation	☐ Mouth Ulcers	☐ Gastric Ulcers
☐ Diarrhea	☐ Excessive Fatigue	☐ Excessive Thirst	☐ Dry Mouth
☐ Depression	☐ Anxiety	☐ Blood in Urine	☐ Easy Bruising
☐ Joint Pain	☐ Joint Swelling	☐ Joint Stiffness	☐ Hives
☐ Skin Rash	☐ Skin Sores	☐ Numbness	☐ Back Pain
☐ Knee Pain	☐ Muscle Weakness/ Spasms	☐ Hand/ Wrist Pain	☐ Hip Pain

YOUR CURRENT OR PAST MEDICAL CONDITIONS:

☐ Measles	☐ Glaucoma	☐ Asthma	☐ Hepatitis	☐ Cancer: _____
☐ Cataracts	☐ Mumps	☐ Hypertension	☐ Rheumatoid Arthritis	☐ Fibromyalgia
☐ Heart Attack	☐ Stroke	☐ Gout	☐ Thyroid Disease	☐ PVD/Gallstones
☐ Chicken Pox	☐ Tuberculosis	☐ Seizures	☐ Skin Rash/Sores	☐ Depression/Anxiety
☐ Diabetes	☐ Lupus	☐ Osteoporosis	☐ Osteoarthritis	☐ Kidney Disease
☐ Migraines	☐ HIV/STD	☐ Dementia	☐ Hyperlipidemia	☐ COPD/Emphysema

PLEASE LIST ALL SURGERIES AND YEAR:

_____

_____

ANY RECENT HOSPIALIZATIONS: _____ **RECENT LABS:** _____ **RECENT X-RAYS:** _____

FAMILY HISTORY/MEDICAL CONDITIONS:

☐ Diabetes	☐ High Blood Pressure	☐ Stroke	☐ Heart Disease	☐ Arthritis	☐ Lupus
☐ Gout	☐ Thyroid Disease	☐ Cancer – Please List Type _____			

RELEASE OF INFORMATION

I, _____**,** HEREBY AUTHORIZE THE OFFICE OF NORTHWEST HOUSTON ARTHRITIS CENTER, P.A., ADNAN PEER, M.D., IQTIDAR HANIF, M.D. TO RELEASE ALL MEDICAL INFORMATION, IN ADDITION TO THE PATIENT OR LEGAL GUARDIAN, TO:

1. NAME: _____ NUMBER: _____ RELATIONSHIP:_____
2. NAME: _____ NUMBER: _____ RELATIONSHIP:_____
3. NAME: _____ NUMBER: _____ RELATIONSHIP:_____

PATIENT SIGNATURE: _____ **DATE:** _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment of medical benefits directly to **Northwest Houston Arthritis Center, Shaikh Arif Ali, M.D. / Adnan Peer, M.D./ Iqtidar Hanif, M.D.** Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its 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**. / **Adnan Peer, M.D. / Iqtidar, Hanif, 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. / Adnan Peer, M.D. / Iqtidar Hanif, M.D.** if any.

I also understand that it is my responsibility to provide **Northwest Houston Arthritis Center, Shaikh Arif, Ali, M.D**. / **Adnan Peer, M.D./ Iqtidar Hanif, M.D.** with my most current and active insurance that is effective at the time of my visit. If I fail to provide my most current and active insurance at the time of my visit, and claims are denied and/or proper referrals or authorizations were not obtained, due to my failure to provide current insurance for my visit(s) at any time, that I am fully responsible for the charges incurred for services rendered to me by **Northwest Houston Arthritis Center, P.A., Shaikh Arif Ali, M.D. / Adnan Peer, M.D. / Iqtidar Hanif, M.D.**

I fully understand that I am fully responsible for obtaining the proper referrals/authorizations for my visits as required in my benefit package through my insurance.

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) **PATIENT SIGNATURE** **DATE**

PRESCRIPTIONS POLICY

Prior authorization (PA) is a management process used by insurance companies to determine if a prescribed medication will be covered by your plan. Your pharmacy will alert the office if a PA is required for medication prescribed. **Our clinic's time to process these requests can take up to 7-10 business days**. We appreciate your patience and understanding.

If you are prescribed a narcotic pain medication, sleep aid, or muscle relaxer, it is to be used on a **AS NEEDED BASIS (PRN).** All narcotics, sleep aids, and muscle relaxers **MUST LAST 30 DAYS** with **NO EARLY REFILL** 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 need to take medication around the clock on a steady basis to control your pain our office may refer you to a pain management doctor for better control of your pain. If referred to pain management, our office will still treat you for your diagnosis, but not for the control of the pain.

POSSIBLE SIDE AFFECTS:

COX 2	GI Bleeding, Renal Problems, High Blood Pressure, 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 Deposits
AZATHIOPRINE	Decreased Blood Counts, Infections, Increased LFT's
CYCLOPHOSPHAMID	Decreased Blood Counts, Malignancy, Infections, Myeloproliferative Disorders, Hemorrhagic Cystitis, Infertility
CYCLOSPORIN A	Renal Insufficiency, Anemia, Hypertension, Infections
CORTICOSTERIODS	Hypertension, High Blood Sugar, Weigh Loss, Infections
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	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.

I agree to report ALL reactions, and/or possible side effects that may be related to the ingestion of any referenced medications directly to our office.

_____ _____ _____

PATIENT NAME (Print) **PATIENT SIGNATURE** **DATE**

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.

_____ **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 authorization or written and/or verbal referral, whichever is required by the insurance carrier, prior to the visit to our clinic. Dr. Ali/Dr Peer are 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 $35 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 24 hours in advance. Unless cancelled at least 24 hours in advance, our policy is to charge 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.

_____ **NO PETS ALLOWED IN OFFICE:** I understand that my personal pets are not allowed in office unless a Certified Service Dog for disabilities.

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 outpatient) 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.

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 its 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 SIGNATURE:_____ **DATE:**_____

NORTHWEST HOUSTON ARTHRITIS CENTER, PA
455 School St. Ste 27 17045 Saint Edwards Dr Ste. 110
Tomball, TX 77375 Houston, Tx 77090
Phone: 281-357-0666 Fax: 281-255-2740

S. Arif Ali, M.D.
Adnan Peer, M.D.
Iqtidar Hanif, M.D.

MEDICAL RECORDS RELEASE FORM

MEDICAL RECORDS RELEASE FORM Medical Records Pertaining To:

Patients Name: _____ **Date of Birth:** _____

I AUTHORIZE SHAIKH A. ALI, M.D. / ADNAN PEER, M.D./ IQTIDAR HANIF, M.D. TO RECEIVE/RELEASE MY MEDICAL RECORDS FROM/TO THE FOLLOWING PHYSICIAN(S):

Name of Physician/Facility: _____

Address: _____

Phone #:_____ **Fax #:**_____

Information to be released/received:

_____ **History & Physical** _____ **Radiology Reports** _____ **Lab Results** _____ **Consultations**

_____ **Billing Records** _____ **All Record** **Other**_____

The release of my records is for continuation of care. This information has been disclosed to you from records whose confidentiality may be protected by federal law. I understand that if the recipient authorized to receive the information is no covered entity (insurance company or non-health provider) the released information may no longer be protected by federal and state privacy regulations.

_____ _____ _____

PARTIENT SIGNATURE DATE WITNESS

PLEASE FAX ALL RECORDS BACK TO : 281-255-2740