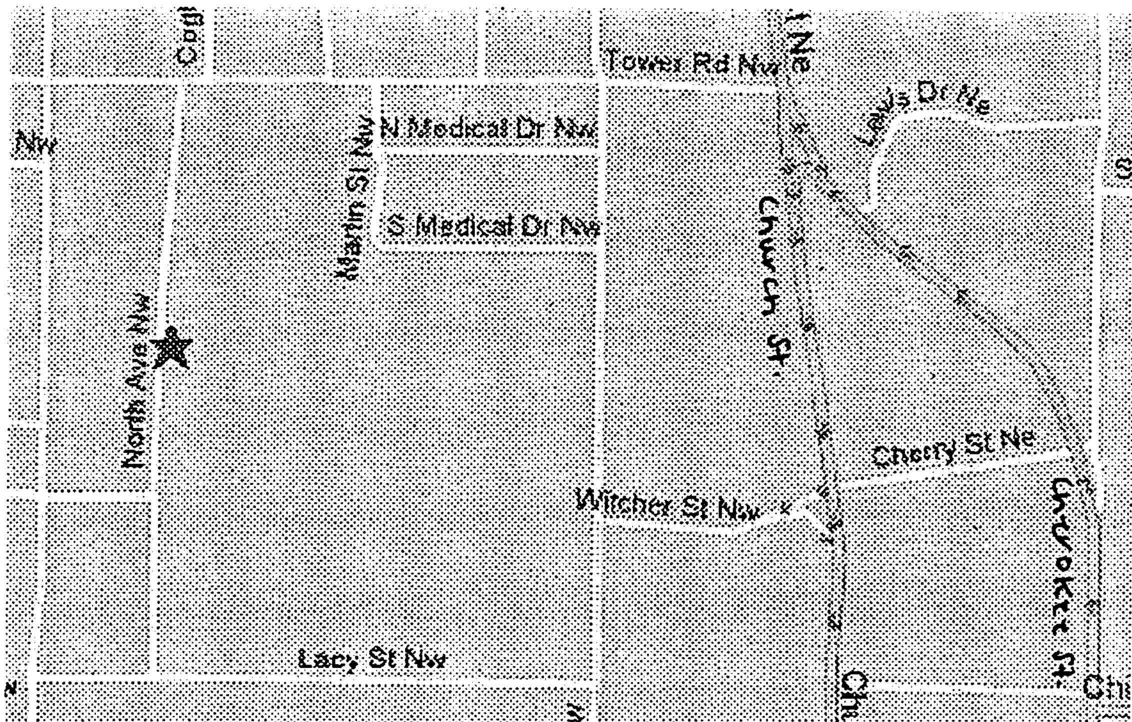
Map for Marietta Rheumatology Associates, P.C.

670 North Avenue
Suite A
Marietta, GA 30060
(770)590-8328



Driving Directions:	I-75 N/S:	Exit 267 B. Merge into traffic. Go to the second traffic light and turn **Right** onto Tower Rd. Then go to the second stop sign and turn **Left** onto North Avenue. Go approximately 1 block and we will be a three story brick building on the left hand side.
Driving Directions:	Marietta Square:	Turn onto Cherokee Street. Go to the third traffic light and turn **Left** onto Tower Rd. Go to the second stop sign and turn **Left** onto North Avenue. Go approximately 1 block and we will be a three story brick building on the left hand side.

Your appointment has been scheduled for:

Date: ______________________________ Time: __________________

Marietta Rheumatology Associates, P.C.
670 North Avenue Suite A
Marietta, GA 30060
(770) 590-8328

REGISTRATION INFORMATION

Name: ______________________________ Date: ______________________________

Address: ____________________________ SSN: ______________________________

____________________________ Marital Status: ________________________

Phone: ______________________________ Cell Phone: ________________________

Date of Birth: _________________________ Age: ______________________________

Place of Employment: ____________________ Work Phone: ________________________

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Primary Insurance

Ins Company: ________________________

Name of Cardholder: ____________________

DOB of Insured: ______________________

Relationship to Cardholder:________________

Employer of Cardholder: __________________

Secondary Insurance

Ins. Company: ________________________

Name of Cardholder: ____________________

DOB of Insured: ______________________

Relationship to Cardholder: ________________

Employer of Cardholder: __________________

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How did you hear about us? ____

Have you had any blood work or x-rays done recently? ______________________________________

If yes, by what Physician? ________________________Physician's Phone #: ____________________

I hereby authorize Marietta Rheumatology Associates, P.C. to release to my insurance company any insurance information required in the course of my examination or treatment I also authorize any physician, clinic or hospital to release details of my medical history to Marietta Rheumatology Associates, P.C.

Signature: ____________________________________**Date:** ______________________________

I hereby assign payment directly to Marietta Rheumatology Associates, P.C. for medical benefits payable for these services. I understand that I am responsible for paymentof all services regardless of insurance coverage I further understand that any and all collection cost necessary to secure payment will be added to the outstanding balance and that I will be responsible for the total

Signature: ____________________________________**Date:** ______________________________

Marietta Rheumatology Associates P.C.
Office Policies - year 2001

PAYMENT

- **Payment is expected at time of service.**
- We will file insurance with only those plans we participate in. Deductibles, co-pays and patient percentages are the patient's responsibility. All balances must be paid off within 60 days.
- Unpaid balances will be referred to a collection agency. The cost of collection will be added to the outstanding balance.
- There will be a twenty-five dollar ($25.00) service charge for any returned checks. **This charge is not payable by your insurance plan.**
- Once a check is returned, further payment will be accepted only in cash.

VISITS

- Patients will be billed - and payment will be expected - for the whole amount of the visit (not the discounted amount contracted with the plan) for office visits scheduled but not kept. If you cannot come to a visit, please cancel more than 24 hours in advance and this charge will not apply. Exceptions will be made for extraordinary circumstances such as hospitalizations. This charge is not payable by your insurance plan.
- Three (3) unkept appointments represents a statement on your part that you intend to sever our physician-patient relationship. The said relationship shall be considered terminated effective the day of the last unkept appointment. This means that after three unkept appointments, this practice has no additional obligation towards you. Again, exceptions will be made for extraordinary circumstances such as hospitalizations.

REFERRALS

- Many insurance companies require a referral or other such document in order to pay the visit. **It is the patient's responsibility to obtain then documents - after all it *is your* insurance plan. *THERE WILL BE A $50.00 SERVICE CHARGE FOR EVERY VISIT CANCELLED THE DAY OF THE VISIT BECAUSE YOU HAVE NOT OBTAINED A REFERRAL DOCUMENT.* This charge is not payable by your insurance plan.**

DOCUMENTS

- There will be a $20.00 charge for forms filled for disability, medication prior authorizations, and other such needs. **This charge is not payable by your insurance plan.**
- Medical records shall not be released without a written, signed consent. It's the law, anyway.
- There is a $25.00 charge for copying and mailing records. **This charge is not payable by your insurance plan. Please note that while the information on the records is your property, the paper and ink that information is printed on is ours. Original medical records are never released, only copies are released.**
- Your consent is hereby obtained to leave appointment and other messages in your answering machine or voicemail.

MEDICATIONS

- There will be no prescriptions refilled over the telephone unless the patient has been seen within the last six (6) months for non-controlled medications and within the last three (3) months for controlled substances AND the medication is deemed safe enough to not warrant more frequent visits. Patients who are on a yearly visit are the exception.

MISCELLANEOUS

- In the unlikely event of a legal dispute between you and Marietta Rheumatology Associates, P.C., the matter shall be settled in binding arbitration by the rides of the American Arbitration Association.
- This practice is not designed to administer psychological counseling. Should this be necessary, we will refer you to a trusted counselor, psychologist, psychiatrist or other appropriate.
- This practice employs a certified nurse practitioner - a professional with post-graduate training in health care. This professional works in conjunction with the physician. All health care delivered by the nurse practitioner is done under the supervision of the physician.

Please indicate your understanding of these policies with your signature and today's date.

NAME ____________________ DATE ____________________

MARIETTA RHEUMATOLOGY
ASSOCIATES, P.C.

670 North Avenue, Suite A
Marietta, GA 30060

Telephone (770)590-8328
Fax (770)590-8231

Mohammed Y. Abubaker, M.D. **Roel N. Querubin, M.D.**

Patient Name: ____________________ Date: ________________

MEDICAL HISTORY FORM

Reason for visit ______________________ Duration of Symptoms ______________

Name of Referring Physician ______________ Telephone __________ Fax no. __________

Name of previous Rheumatologist ______________ Last office visit (mo/year)______________

Current Medications (**include Dose, how often**) 1. 2.

3. 4. 5. 6.

7. 8. 9. 10.

Rheumatologic Diagnosis ______________________ Date of diagnosis (mo/year) ______________

List all other previous Medical Conditions/Diagnosis (ex: Diabetes, hypertension, etc.) ______________

____

____

Allergies (list medication and reaction) ________________________________

Previous Surgeries/Hospitalizations (include date)________________________________

Family History of Rheumatologic Conditions ________________________________

Family History of other Medical Conditions ________________________________

Social History: Marital Status__________ Employment ____________ Number of children ______________

Previous Alcohol use? __________ Current Alcohol Use? ______ List amount weekly ______________

Any History of Smoking? __________ How many years? _________ Number of Packs per week ____________

IV/Recreational drug use? _________ Sexually Transmitted disease? ___ Type ________________

Tested for HIV? ______ Date _______ Result __________ Previous Transfusion? _____ Date_______

Please place a mark (✓) on each line below to indicate your level of symptoms recently

Joint pain on an Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Joint swelling on an Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Joint warmth on an Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Joint redness on an Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Joint tenderness on an Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Joint stiffness when I awake in the mornings lasts how long on an **average** day?
None 0----|----|----|----|----|----|----|----|----|---- 60 Minutes or
None 0----|----|----|----|----|----|----|----|----|---- 12 Hours or
All day

Back/Neck pain on an Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Back/Neck tenderness on Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Back/Neck stiffness when I awake in the mornings lasts how long on an **average** day?
None 0----|----|----|----|----|----|----|----|----|---- 60 Minutes or
None 0----|----|----|----|----|----|----|----|----|---- 12 Hours or
All day

Difficulty Dressing, Bathing: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Difficulty with Housework: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe or Not Performed

Difficulty with Yardwork: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe or Not Performed

Difficulty with Job responsibilities: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe or Not Working

Difficulty Falling Asleep: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Difficulty Staying Asleep: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Sleep Average # of Hours per night: (Include the time falling asleep through the time getting out of bed the next day)
None 0----|----|----|----|----|----|----|----|----|----10 Hours

Fatigue on Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Depressed Mood on Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Circle/Complete the most appropriate response

Exercise performed: None, circuit training, exercise bike, jogging, pilates, swimming, walking, water therapy, weights, yoga. Other ______________________________

Average number of days per week? 0 1 2 3 4 5 6 7 Days

How long on average day of exercise? 0 5 10 15 20 30 45 60 minutes

Currently Working: No Part Time Full Time

Circle all that apply: Have you experienced any of the following recently? **Describe**

Fever. Chills. ___

Skin rash. Nail changes. Hair loss. Bald patches on scalp. ___

Headache. Loss of consciousness. Numbness. Muscle weakness. ___

Eye Dryness. Eye Redness. Eye tearing. Visual changes / Loss of vision. ___

Shortness of Breath. Cough. Wheeze. ___

Blue/white/Purple Color changes of the fingers or Color changes of the toes. ___

Dry mouth . Sores in mouth. ___

Pain in chest. Difficulty in breathing at night while lying flat. Swollen legs or feet. ___

Nausea. Vomiting. Diarrhea. Abdominal pain. Blood in stools. ___

Previous medications mark (✓)

	Tried	Couldn't tolerate		Tried	Couldn't tolerate		Tried	Couldn't tolerate
Prednisone	☐	☐	Cortisone	☐	☐	Anaprox	☐	☐
Ansaid	☐	☐	Aspirin	☐	☐	Cataflam/voltaren	☐	☐
Clinoril/Sulindac	☐	☐	Daypro	☐	☐	Disalcid/salsalate	☐	☐
Feldene/pyroxicam	☐	☐	Ibuprofen/motrin	☐	☐	Indocin/indomethacin	☐	☐
Lodine	☐	☐	Meclomen/meclofen	☐	☐	Mobic / Meloxicam	☐	☐
Naproxen/naprosyn	☐	☐	Orudis / ketoprofen	☐	☐	Oruvail	☐	☐
Relafen	☐	☐	Tolectin/ tolmetin	☐	☐	Toradol	☐	☐
Bextra	☐	☐	Celebrex	☐	☐	Vioxx	☐	☐
Arava	☐	☐	Cytoxan	☐	☐	Enbrel	☐	☐
Humira	☐	☐	Imuran	☐	☐	Methotrexate	☐	☐
Orencia	☐	☐	Plaquenil	☐	☐	Remicade	☐	☐
Remicade	☐	☐	Rituxan	☐	☐	Sulfasalazine	☐	☐

List all other **Previous** Medications used for Rheumatologic symptoms

a. Muscle medications, Narcotic Pain medications ___

b. Antidepressants, Sleep medications ___

HIPAA Notice of Privacy Practices

Marietta Rheumatology Associates, P.C.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

MARIETTA
Rheumatology
ASSOCIATES P.C.

Mohammed Abubaker, M.D.
American Board of Internal Medicine
Subspecialty Board of Rheumatology
Janie Brier, R.N., M.S.N., C.F.N.P.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGMENT FORM.

I, ______________________________, have received a copy of Marietta Rheumatology's Notice of Privacy Practices.

_________________________________ ____________________

Signature of Patient Date

114 Cherry St. Suite E Marietta, GA 30060 Tel (770) 590-8328 Fax (770) 590-8231

PATIENT AUTHORIZATION

PATIENT NAME: ______________________________ DOB: ______________

MEDICAL INFORMATION AND/OR TEST RESULTS CAN BE GIVEN TO:

______ NO ONE EXCEPT MYSELF
______ THE FOLLOWING PERSON (S) ______________________________
____

RESTRICTIONS ☐ NO ☐ YES SPECIFY ______________________________

LEAVE TELEPHONE MESSAGE ON RECORDER? ☐ YES ☐ NO REGARDING:

______ PRESCRIPTIONS ______ RESULTS ______ APPOINTMENTS

____
SIGNATURE DATE