Specialists in Arthritis and Osteoporosis

www.eastpenn-rheumatology.com

Charles L. Ludivico, M.D., F.A.C.P.

Nancy McFadden, MSN, C.R.N.P

Dear: ______________________________________

WELCOME TO OUR PRACTICE - Our medical staff and office personnel want you to know that we are dedicated to providing quality healthcare and professional service. This letter will acquaint you with our office policies. We will do all that we can to make your visit as pleasant as possible.

YOUR APPOINTMENT IS SCHEDULED FOR: ___________________________

*****YOU MUST SEND YOUR COMPLETED NEW PATIENT PACKET BACK ONE WEEK BEFORE APPOINTMENT BY FAXING 610-882-1133, EMAIL contactus@eastpenn-rheumatology.com OR USING ENCLOSED ENVELOPE*******

YOU WILL RECEIVE A REMINDER CALL FROM THE OFFICE **<u>** We require you to call to CONFIRM your appointment with the office within 48 hours of receiving the reminder call to avoid cancellation**</u>** Rheumatologists in this area have long wait times for new patients and we want to accommodate everyone as soon as possible. There is a **NO SHOW fee of $50.00** that you will be billed.

- * Bring your insurance cards, a form of photo ID and referral form (if applicable) with you. **<u>Unfortunately, the providers will NOT be able to see you without a referral form if this is a requirement from your insurance company.</u>**
- * The **<u>COMPLETED</u>** enclosed medical history and the enclosed financial statement signed.
- * Bring with you copies of any recent lab results, any written x-ray reports and x-ray films you have and a list of all prescription and nonprescription medication you are currently taking.

<u>WHAT TO EXPECT AT YOUR FIRST VISIT-PLEASE ALLOW 2 HOURS FOR FIRST VISIT</u>

Please complete the enclosed forms prior to your visit and return to office 1 week prior to your scheduled appointment on ___________________________. Failure to complete these forms prior to your arrival may delay your visit. ***Please allow approximately two hours for your first visit.*** You may be examined by the Nurse Practitioner. They will obtain outside diagnostic information and discuss their findings with the rheumatologist who will confirm the history and physical exam. The rheumatologist will discuss his diagnosis and treatment plan consider additional testing; such as auto immune labs, x ray and DXA testing and also send a letter to your primary care physician. Please feel free to ask any questions.

<u>OFFICE POLICIES</u>

OFFICE FEES – We make every effort to keep the cost of your medical care to a minimum. Payment at the time of your visit is expected. We accept cash, checks, Visa, MasterCard and Discover Cards. It is the responsibility of the patient to verify that our office participates with your insurance and it is the responsibility of the patient to have the proper insurance referrals (if applicable). Please assist us by bringing your referrals and co-payments at the time of your visit.

PRESCRIPTION REFILLS/REFERRALS/PRIOR AUTHORIZATIONS – Please provide the practice with 48/72 (depending on prescription) hour notice to complete your prescription refills, referrals and prior authorizations. NO exceptions.

FORM FEES: There is a $25.00 form fee for all forms except for a handicap placard which is a $10.00 fee. Some forms may require a form visit.

EMERGENCIES – Our doctor is available for emergencies 24 hours a day, 7 days a week. After normal office hours, our answering service operator will relay your name, phone number and problem to us immediately. The doctor will quickly respond and appropriately take care of your problem. *** Note for routine questions, please allow up to 36 hours***

*Directions are printed on the reverse side of this letter

701 Ostrum Street, Suite 302, Bethlehem, PA 18015 · 610-868-1336 · FAX 610-882-1133

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DIRECTIONS

Doctor's Pavilion, 701 Ostrum Street, Suite 302, Bethlehem, PA 18015

Next to St. Luke's, Bethlehem

From North: Route 33 S, Route 22W, Route 378 S. At the end of the expressway proceed over bridge. Stay in the right lane. At second traffic light, turn right onto Delaware Avenue, proceed to the next traffic light, and turn right onto St. Luke's Place. Go one block – you are facing St. Luke's Hospital. Doctor's Pavilion is to the right.

From South: Route 309N to Route 378N. Proceed down Wyandotte Hill to Five Points intersection. Continue straight on 378N to second traffic light (there is a church on your right). Turn left onto Delaware Avenue, proceed to the next traffic light, and turn right onto St. Luke's Place. Go one block – you are facing St. Luke's Hospital. Doctor's Pavilion is to the right.

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DATE:	TIME:	LOCATION: 701 OSTRUM STREET, SUITE 402, BETHLEHEM, PA 18015

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize East Penn Rheumatology Associates, its medical practices and providers including physicians, technicians, nurses, and other qualified personnel to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner(s). I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations or procedures.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized medical benefits is made on my behalf directly to East Penn Rheumatology. I authorize East Penn Rheumatology to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to East Penn Rheumatology. I hereby authorize that photocopies of this form to be valid as the original.

PAYMENT GUARANTEE: I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through East Penn Rheumatology medical practice and providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of an East Penn Rheumatology billing statement whether it is an interim or final bill. In the event that I fail to make full payment or fail to comply with other payment arrangements made with East Penn Rheumatology's approval, I understand that appropriate collection measures may be initiated. I understand that my insurance card is not a substitute for payment and should my account become delinquent, I understand that I will be responsible for 28% collection fees, attorney fees, court costs, administrative fees and/or interest of 1.5% per month or 18% per annum.

Myself or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand it contents, and I hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested.

____ ______________________________________

Signature of Patient or Parent/Legal Guardian/Authorized Representative Relationship to Patient if Applicable

____ ______________________________________

Witness to Signature Date of Signing

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EAST PENN RHEUMATOLOGY COMMUNICATION PREFERENCES

It is the office policy of East Penn Rheumatology Associates, P.C. and staff not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail and cell phone. Whenever returning telephone calls and the answering machine picks up, **we do not leave a message** if the name or telephone number is not on the recorded message to identify the residence. Also, information will not be left with an unauthorized person who may answer the telephone.

I authorize East Penn Rheumatology Associates, P.C. and/or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

METHOD	YES	NO	AREA CODE #, EXT,EMAIL
Home Telephone	☐	☐	
Answering Machine	☐	☐	
Work Phone	☐	☐	
Cell Phone	☐	☐	
Email – appointment reminders	☐	☐	
Email – newsletters	☐	☐	
Pager	☐	☐	

Without specific **permission,** we will **NOT** release any medical information to anyone other than you. In some cases you may wish for another person to have access to your medical information. Please identify those individual and their relationship to you (i.e. spouse, parent, son, daughter, partner, etc.)

☐ Do NOT release my medical information to anyone other than myself.

☐ I give permission to release my medical information pertaining to me to the individuals listed below:

NAME	RELATIONSHIP	AREA CODE, PHONE #, EXT.

COMMENTS:

I assume the responsibility to inform the practice of changes in my phone numbers or my preferences or to revoke this specific medical information authorization at any time.

____________________________________ ____________________________________

Signature Date Signed

Charles L. Ludivico, M.D., F.A.C.P.
Nancy McFadden, MSN, C.R.N.P

PATIENT INFORMATION

LAST NAME______________________________ FIRST NAME _________________________________ MI_____

ADDRESS____

CITY____ STATE_____________________ ZIP______________

HOME PHONE___________________________ CELL________________________ MALE______ FEMALE_____

DATE OF BIRTH________________ SS#______________________ MARITAL STATUS____________________

EMPLOYER INFORMATION

PATIENT EMPLOYER_____________________________________OCCUPATION__________________________

EMPLOYER ADDRESS____PHONE#_______________________

REFERRING DOCTOR INFORMATION

FAMILY DOCTOR____PHONE#________________________

REFERRING DOCTOR____PHONE#________________________

PHARMACY INFORMATION:

LOCAL PHARMACY NAME:____________________________________ PHONE#____________________________

____

MAIL AWAY PHARMACY NAME:________________________________ PHONE#____________________________

SPOUSE INFORMATION

LAST NAME_______________________________ FIRST NAME_____________________________________MI____

DATE OF BIRTH______________________ SS#_________________________ WORK PHONE__________________

EMPLOYER______________________________ EMPLOYER ADDRESS_____________________________________

EMERGERNCY CONTACT

NAME____ PHONE#_____________________

RELATIONSHIP_____________________________________ NEXT OF KIN_______________________________

IF PATIENT IS A MINOR

MOTHER'S NAME _______________________________ SS#______________________ DOB____________________

FATHER'S NAME ________________________________ SS#______________________ DOB____________________

INSURANCE **PRIMARY** **SECONDARY**

NAME ________________________________ ______________________________

ID ________________________________ ______________________________

GROUP# ________________________________ ______________________________

SUBSCRIBER/DOB ________________________________ ______________________________

EFFECTIVE DATE ________________________________ ______________________________

RHEUMATOLOGY QUESTIONNAIRE (for patient to complete and bring to appointment)

Patient Name:_______________________________________ Age:________ Date:______________________

The name of the physician providing your primary medical care____

Reason for your visit____

____

When did you first notice this problem? Month ________ Year ________

Have you had x-rays, CT, MRI for this problem? ☐Yes ☐No If yes, where did you go for them? __________________

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

____

Please list any previous treatments (such as physical therapy, medications) for this problem:_______________________

____

Please list all of the DRUGS or MEDICATIONS you are taking (including aspirin, any drug you purchased without a prescription or birth control pills)

	Name of Medication	Dose	How many a day		Name of Medication	Dose	How many a day
1				7			
2				8			
3				9			
4				10			
5				11			
6				12			

Are you allergic to any medications? ☐ Yes ☐ No If Yes, please list which ones: ________________________________

List any vitamins or herbal remedies you are using:____

Please list all of your previous hospitalizations and surgeries below:

	Condition of Procedure	Year		Condition of Procedure	Year
1			6		
2			7		
3			8		
4			9		
5			10		

Please **CHECK BOX** if you have ever been diagnosed with or had any of the following conditions:

Cataract		Stomach/duodenal ulcer		Meningitis	
Glaucoma		Liver cirrhosis		Stroke/paralysis	
Uveitis or Iritis		Hepatitis		Seizures/epilepsy	
Migraine Headaches		Gallstones		Depression	
Sinus Infections		Pancreatic Disease		Nervous Breakdown	
		Intestinal polyp			
Rheumatic Fever		Esophageal reflux		Anemia	
Heart Attack/myocardial infarct		Other esophageal disease		Blood Transfusion	
Heart failure		Colitis		If yes, what year?	
Arrhythmia		Diverticulitis		Tattoos	
High Blood Pressure		Irritable bowel syndrome		Blood clot in leg	
Heart Murmur					
		Kidney stones		Cancer	
Asthma		Nephritis		Type	
Pneumonia		Kidney Infection		Alcoholism	
Pleurisy		Syphilis		Drug Abuse	
Blood clot in the lung		Gonorrhea		HIV testing	
Tuberculosis		Chlamydia		OTHER CONDITIONS	
Positive TB skin test					
Emphysema		Rheumatoid arthritis		WOMEN ONLY	
Chronic Bronchitis		Gout		Pregnancies	
		Lupus		If yes, how many?	
Skin ulcers lower leg		Serious joint injury		Miscarriages	
Psoriasis		Broken bones		If yes, how many?	
Other skin conditions		Disabling back pain		Contraception	
		Degenerative arthritis		Last menstrual period Date	
Thyroid disease		Osteoporosis		Age at menopause	
Diabetes		Raynaud's		Estrogen use	

Have you noticed any of the following symptoms in the past 6 months? **CHECK ALL THAT APPLY**

CONSTITUTIONAL		**MUSCULOSKELETAL**		**GASTROINTESTINAL**	
Weight loss		Joint Pain		Difficulty swallowing	
Poor appetite		Joint swelling		Heartburn	
Fevers/chills/sweats		Stiff muscles		Nausea/vomiting	
Fatigue		Painful muscles		Abdominal pain	
NEUROLOGICAL		Back Pain		Constipation	
Headaches		**EYE/EARS/NOSE/THROAT**		Diarrhea	
Numbness		Eye pain		Rectal bleeding	
Weak muscles		Vision loss		Black bowel movements	
Fainting/dizzy spells		Very dry eyes		**GENITOURINARY**	
RESPIRATORY		Redness in eyes		Problems passing urine	
Chronic cough		Ringing in ears		Burning on urination	
Coughing up blood		Hearing loss		Discharge from penis	
Shortness of breath		Nasal congestion		Discharge from vagina	
Wheezing		Dry mouth		Genital sores or rash	
Loud snoring		Mouth sores/ulcers		Blood in urine	
CARDIOVASCULAR		Recent dental work		Possible pregnancy	
Heart palpitations		Hoarseness			
Angina		Sore throat		Breast lump	
Chest pain		**HEMATOLOGIC**		**PSYCHIATRIC**	
Fingers change color in cold		Swollen glands		Anxiety	
INTEGUMENT		New lump or growth		Depressed mood	
Hair loss		Bleeding tendency		Difficulty falling asleep	
Rashes				Difficulty staying asleep	
Bumps on skin					
Skin thickening					
Rash in the sun					

Patient Name _____________________________ Date of Visit________________

FAMILY HISTORY:

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

	How many living?	Any medical conditions	Any who died?	List ages each died and causes
Brothers				
Sisters				
Children				

Does anyone in your family have;

Rheumatoid arthritis ☐Yes ☐No Ankylosing spondylitis ☐Yes ☐No Colitis ☐Yes ☐No

Lupus ☐Yes ☐No Psoriasis ☐Yes ☐No

Muscle Disease ☐Yes ☐No Thyroid Disease ☐Yes ☐No

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Your occupation:________________________________

Are you currently working? ☐Yes ☐No

If not, are you ☐retired ☐disabled ☐sick leave?

Do you receive disability or SSI? ☐Yes ☐No

If yes, for what disability?

____

What date did this disability begin?

____

Your marital status:☐single ☐married☐separated

☐divorced ☐widowed

Do you smoke cigarettes? ☐Yes ☐No ☐In Past

If yes, how many packs a day? _______________

How many years have you smoked?__________

Do you smoke cigars or a pipe? ☐ Yes ☐No

If yes, how many per day? _____________

Do you drink alcohol? ☐Yes ☐No

If yes, number of drinks/glasses per week? ___________

Do you drink caffeinated beverages? ☐Yes ☐No

Cups/glasses per day? _______________

Do you exercise regularly? ☐Yes ☐No

Type & frequency: ________________________________

____

Have you ever used illegal or recreational drugs?

☐Yes ☐No

If yes, please list type______________________________

How many hours do you sleep at night?______________

Do you wake feeling rested? ☐Yes ☐No

Have you traveled anywhere In the past 12 months?

☐Yes ☐No If yes, where? __________________________

____

Try to complete as much as you can yourself, but if you need help, please ask. **There is no right or wrong answers! Please answer exactly how you think or feel.**

1. Please check ✔ the best answer for your abilities at this time:

OVER THE LAST WEEK, were you able to:	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE To DO
Dress yourself, including tying shoelaces and doing buttons?				
Get in and out of bed?				
Lift a full cup or glass to your mouth?				
Walk outdoors on flat ground?				
Wash and dry your entire Body?				
Bend down to pick up clothing from the floor?				
Turn regular faucets on and off?				
Get in and out of a car,bus, train, or airplane?				
Walk two miles, if you wish?				
Participate in recreational activities and sports as you would like, if you wish?				
Get a good night's sleep?				
Deal with feelings of anxiety or being nervous?				
Deal with feelings of depression of feeling blue?				

2. How much pain have you had because of your condition OVER THE PAST WEEK?

Please indicate below how severe your pain has been:

No 0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10 Pain as BAD

Pain AS IT COULD BE

3. Considering all the ways in which illness and health conditions may affect you at this time, please

Indicate below how you are doing:

VERY 0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10 VERY

WELL POORLY

4. Please ✔ check if you have experienced any of the following over the last month:

___ Fever ___ Dry Eyes ___ Constipation ___ Weight Gain (>10Lbs) ___ Problems Hearing

___ Diarrhea ___ Weight Loss (>10lbs) ___Sores in Mouth ___Dark/bloody Stools ___ Feeling Sickly

___ Dry Mouth ___ Problems Urinating ___ Headaches ___ Cough ___ Dizziness ___Unusual Fatigue

___ Shortness of Breath ___Muscle Pain,aches,cramps ___Swollen Glands ___Pain in Chest

___ Muscle Weakness ___Loss of appetite ___Trouble swallowing ___ Back pain ___Skin rash/hives

___Heartburn/Gas ___Depression ___Unusual Bruising/Bleeding ___Stomach pain ___Anxiety/Nervous

___Skin problems ___Nausea ___Problems with Memory ___Loss of Hair ___Vomiting

___Problems with sleeping

Patient's Name ____ Date:____________________________________