Patient Name: _____ Date: _____

Multi-Dimensional Health Assessment Questionnaire (R791-NP2)

This questionnaire includes information not available from blood tests, X-rays, or any source other than you. Please try to answer each question, even if you do not think it is related to you at this time. Try to complete as much as you can yourself, but if you need help, please ask. **There are no right or wrong answers**. Please answer exactly as you think you feel. Thank you.

1. Please check the ONE 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
a. Dress yourself, including tying shoelaces and doing buttons?	0	1	2	3
b. Get in and out of bed?	0	1	2	3
c. Lift a full cup or glass to your mouth?	0	1	2	3
d. Walk outdoors on flat ground?	0	1	2	3
e. Wash and dry your entire body?	0	1	2	3
f. Bend down to pick up clothing from the floor?	0	1	2	3
g. Turn regular faucets on and off?	0	1	2	3
h. Get in and out of a car, bus, train, or airplane?	0	1	2	3
i. Walk two miles or three kilometers, if you wish?	0	1	2	3
j. Participate in recreational activities and sports as you would like, if you wish?	0	1	2	3
k. Get a good night's sleep?	0	1.1	2.2	3.3
l. Deal with feelings of anxiety or being nervous?	0	1.1	2.2	3.3
m. Deal with feelings of depression or feeling blue?	0	1.1	2.2	3.3

FOR OFFICE USE ONLY

1. FN (0-10)

1-0.3	16-5.3
2-0.7	17-5.7
3-1.0	18-6.0
4-1.3	19-6.3
5-1.7	20-6.7
6-2.0	21-7.0
7-2.3	22-7.3
8-2.7	23-7.7
9-3.0	24-8.0
10-3.3	25-8.3
11-3.7	26-8.7
12-4.0	27-9.0
13-4.3	28-9.3
14-4.7	29-9.7
15-5.0	30-10

2. PN (0-10)

3. PTGL (0-10)

RAPID 3(0-30)

2. How much pain have you had because of your condition OVER THE PAST WEEK? Please indicate below how severe you pain has been:

NO PAIN ○ PAIN AS BAD AS IT COULD BE

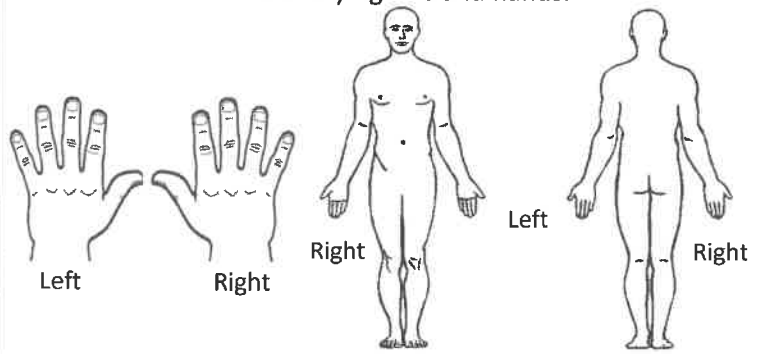
0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

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 WELL ○ VERY POORLY

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

Please **shade** all the locations of your pain over the past week on the body figures and hands.



What is your primary concern you wish to discuss with the physician today?

Please **circle** if you are experiencing the following:

Fevers	Night Sweats
Unexplained weight loss	Weight gain
Chest pain	Cough (chronic)
Mouth sores/ulcers	Breathing difficulty
Abdominal Pain	Diarrhea
Skin rash	Recent Infection

ARTHRITIS CONSULTANTS OF TIDEWATER

RHEUMATOLOGY · OSTEOPOROSIS & INFUSION CENTERS
PHONE (757) 491-7359 · FAX (757) 491-9359

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MICHAEL R. CANNON, M.D., F.A.C.R.
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JANICE SHERWOOD, M.D., F.A.C.R.
ROOPA ACHURI, PA-C

Patient Information

Name: Last _____ First _____ Middle _____

Date of Birth _____ Social Security No. (not required) _____

Mailing Street Address _____

City _____ State _____ Zip _____

Primary phone number (circle one): Home | Cell | Work

Home Phone _____ Cell Phone _____

Email _____

Employer _____ Work Phone _____

Emergency Contact Name _____ Relationship _____

Emergency Contact Phone _____

Gender (circle one): Male | Female | Other: _____

Which pronoun do you prefer: He | She | Other: _____

Marital Status (circle one): Single | Married | Divorced | Widow | Significant Other

Race (circle one): African American | Asian | Caucasian | Native American | Native Alaskan | Native Hawaiian | Pacific Islander

Ethnicity (circle one): Hispanic | Non-Hispanic

Primary Language (circle one): English | French | Spanish | Other: _____

Primary Care Physician _____ Phone # _____

Referring Physician _____ Phone # _____

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Insurance Information

Primary Insurance: _____

ID # _____ Group # _____

Subscriber's Name _____ DOB _____ SS# _____

Secondary Insurance: _____

ID # _____ Group # _____

Subscriber's Name _____ DOB _____ SS# _____

Third Insurance: _____

ID # _____ Group # _____

Subscriber's Name _____ DOB _____ SS# _____

Medicare Part D Prescription Insurance: _____

ID # _____ Group # _____

Subscriber's Name _____ DOB _____ SS# _____

Guarantor Information

Person responsible for the bill (if other than the patient) OR Parent if patient is a minor

Legal Guardian's relationship to patient (circle one): Parent | Step Parent | Other: _____

Last Name _____ First Name _____ Middle Name _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

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Payment of Medicare/Medicaid Benefits

I request that payment of authorized Medicare/Medicaid benefits be made either to me or on my behalf to Arthritis Consultants of Tidewater for services rendered. I authorize Arthritis Consultants of Tidewater to release the Health Care Financing Administration and its agents, any medical information needed to determine benefits or the benefits payable for related services.

Assignment of Insurance Benefits

I hereby authorize direct payment of medical benefits to Arthritis Consultants of Tidewater for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization for Release of Information

I consent to the use or disclosure of my protected health information by Arthritis Consultants of Tidewater and if needed information from other providers, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the healthcare operations of Arthritis Consultants of Tidewater. I understand that diagnosis or treatment of me by Arthritis Consultants of Tidewater may be conditioned upon my consent as evidenced by my signature on this document.

Acknowledge of Receipt of Privacy Notice

By signing below, I am acknowledging that I have been provided with a copy of Arthritis Consultants of Tidewater's Privacy Notice pursuant to the Federal regulations known as HIPAA Privacy Rule.

Cancellation Policy

If you are unable to make your appointment, please notify our office one day (24 hours) prior to the appointment. We reserve the right to charge a $25 fee for missed appointments. Three no shows or cancellations (24 hours prior to appt.) may result in discharge from the practice.

I have read and acknowledge that I understand the terms above.

Printed Name: _____

Patient's Signature: _____ Date: _____

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Patient Information Release

The Privacy Act of 1977 was designed to protect your privacy. It is to give you a feeling of security that when you visit our office, your medical affairs and financial affairs will not be discussed with anyone without your permission. This includes your spouse, family members, friends, and employer. In order for us to speak with anyone regarding your care, even in the event of an emergency, you must specify to whom we may speak.

If you wish for us to be able to release information regarding your care, please indicate below. Our staff cannot give out this information without your permission.

I give permission for the staff of Arthritis Consultants of Tidewater to discuss information indicated, regarding myself to:

Name	Relationship	Phone	Information to be released
_____	_____	_____	Medical / Financial
_____	_____	_____	Medical / Financial
_____	_____	_____	Medical / Financial
_____	_____	_____	Medical / Financial

Printed Name: _____

Patient Signature: _____ Date: _____

We ask that you update this information annually, or as circumstances change. Thank you.

Updated: _____ _____ _____ _____

Initials/Date Initials/Date Initials/Date Initials/Date

*****THIS FORM IS GOOD FOR 1 YEAR FROM THE DATE OF SIGNATURE*****

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Prescription Refill Policy

If in need of medication refills that have been prescribed by the doctor, please give your pharmacy 48-72 hours notice and they will contact our office.

We request refills to be handled during regular office hours, 8:30 am to 4:00 pm. Please plan on checking with your pharmacy before going to pick them up to be certain they have been filled. Some narcotic pain medications require a hand-written prescription so please be prepared to have someone pick up the prescriptions at our office. Identification may be required. The doctor cannot call these in on the weekend and need to be requested only during normal office hours.

If you are requesting a written prescription for mail order, please confirm with us if you want to pick it up or have it mailed to you.

Please note that our providers at Arthritis Consultants of Tidewater may request reports from the Virginia Prescription Drug Monitoring Program before refilling or prescribing controlled substances as an effort to comply with Virginia regulations regarding appropriate use of narcotic agents.

Pharmacy: _____ Phone #: _____

City: _____ State: _____

I have read and acknowledge that I understand the terms of the above policy.

Signature: _____ Date: _____

933 First Colonial Road, Suite 100, Virginia Beach VA 23454
680-C Kingsborough Square, Chesapeake VA 23320
22214 S Bayside Road, Cape Charles VA 23310

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Patient Portal

Our patient portal is a secure online website that gives you convenient 24-hour access to your personal health information and medical records—called an Electronic Health Record or EHR—from anywhere with an Internet connection. Please complete the information below to let us know if you would like access to your portal.

Patient Name _____ DOB _____ Date _____

Opt In:

☐ Email Address: _____

Opt Out:

☐ If you change your mind later, you can call the office at 757-491-7359 to join the portal.

ARTHRITIS CONSULTANTS OF TIDEWATER

PATIENT CONSENT TO THE USE OF TELEMEDICINE SERVICES

I have read and understand the information provided below regarding telemedicine, I have discussed it with my physician, or such assistants as may be designated, and all of my questions have been answered to my satisfaction.

I hereby give my informed consent for the use of telemedicine in my medical care. I hereby authorize for the providers at Arthritis Consultants of Tidewater (Drs Siegel, Sherwood, Cannon, Keck or NPs Sally Clark/Fredilynn Lansangan) to use telemedicine in the course of my diagnosis and treatment.

Patient Name (print): _____

Signature of Patient (or person authorized to sign for patient): _____

If authorized signer, relationship to patient: _____

Date: _____

Telemedicine involves the use of electronic communications to let health care providers communicate through a live two-way audio and video virtual visit with their patients at a different location e.g., home.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her home while having a virtual health visit with their physician/provider to obtain e.g., test results, medical consult etc.
- More efficient medical evaluation and management.

Possible Risks: As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s).
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My provider/provider's office has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

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PLEASE PROVIDE INFORMATION FOR PCP, PRIOR RHEUMATOLOGIST, OR ANY OTHER PROVIDER THAT MAY HAVE SEEN YOU FOR YOUR CURRENT CONDITION/SYMPTOMS.

Authorization to Release/Receive/Exchange Confidential Medical Information

I hereby authorize **Arthritis Consultants of Tidewater** to **RELEASE/RECEIVE/EXCHANGE (circle one)** my medical record including HIV/AIDS, psychiatric, drug abuse, and alcohol related information, if applicable **TO/FROM/WITH (circle one):**

	Provider/Facility Name	Phone Number	Fax Number	Type of Practice
1				
2				
3				
4				
5				

Specific type of information to be disclosed:

- ☐ All Medical Records
- ☐ Most recent imaging studies.
- ☐ Hospital Admission/Discharge Summary
- ☐ Other: _____
- ☐ Most recent visit notes & labs
- ☐ Medications
- ☐ Physical

Purpose or need for such disclosure:

- ☐ Continuity of Care
- ☐ Other: _____
- ☐ Discharge and/or follow up planning

I understand that I have the right to revoke this authorization at any time by giving written notice however, I understand that any information released prior to my revoking this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke the authorization prior to such time, this authorization will expire 365 days from this date unless otherwise specified _____.

Last name (printed) First Middle Date

Birthdate Patient Signature

933 First Colonial Road, Suite 100, Virginia Beach, VA 23454
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