

Due to the public health pandemic that will last for the near future, we are strongly encouraging our patients to have televisits for follow up visits when possible. The following information will help us determine if you have the technology that would allow a video call with your physician.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Account #: \_\_\_\_\_ Date: \_\_\_\_\_

Physician: \_\_\_\_\_

**Yes or NO**

\_\_\_\_\_ I have a smart phone with camera such as Apple iPhone, Android phone or Google phone and would like to use this method.

\_\_\_\_\_ I have an Apple iPad that can receive email or that can be called through Apple FaceTime and would like to use this method.

\_\_\_\_\_ I have a computer or laptop that can receive email that also have a camera, microphone and speaker and would like to use this method.

\_\_\_\_\_ I have access to high speed internet at home or through my smart phone's cellular data service

\_\_\_\_\_ If there is a problem connecting for a video call televisit I am OK with having an audio only visit over the telephone.

\_\_\_\_\_ I am not comfortable with televisits or I would need help to setup a televisit

Your email address: \_\_\_\_\_

Your cell phone number: \_\_\_\_\_

# Asheville Arthritis and Osteoporosis Center, P.A.

## Notice of Privacy Practices

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.**

**If you have questions about this Notice, please contact the Privacy Officer at (828) 258-9533 or by mail at 4 Vanderbilt Park Dr, Suite 200 Asheville, N.C. 28803**

**Effective Date: April 14, 2003**

**Revised: September 17, 2013  
April 27, 2020**

We are committed to protect the privacy of your protected health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website at [www.ashevillearthritis.com](http://www.ashevillearthritis.com)

### **Uses and Disclosures of Protected Health Information**

#### **We may use or disclose (share) your PHI to provide health care treatment for you.**

Your PHI 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.

**EXAMPLE:** Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

#### **We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.**

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

#### **We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.**

**EXAMPLES:**

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

#### **We may use and disclose your PHI in other situations without your permission:**

- **If required by law:** The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.
- **Public health activities:** The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- **Health oversight agencies:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- **Legal proceedings:** To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- **Police or other law enforcement purposes:** The release of PHI will meet all applicable legal requirements for release.
- **Special government purposes:** Information may be shared for national security purposes, or if you are a member of a military, to the military under limited circumstances.
- **Correctional institutions:** Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.

#### **Other uses and disclosures of your health information.**

- **Business Associates:** Some services are provided through the use of contracted entities called "Business Associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information.
- **Health Information Exchange:** We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.
- **Treatment alternatives:** We may provide you notice of treatment options or other health related services that may improve your overall health.
- **Appointment Reminders:** We may contact you as a reminder about upcoming appointments or treatment.

**We may use or disclose your PHI in the following situations UNLESS you object.**

- We may share your information with family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

AAOC participates in the North Carolina Health Information Exchange Network, called NC HealthConnex, which is operated by the NC Health Information Exchange Authority (NC HIEA). We will share your protected health information, or PHI, with the NC HIEA and may use NC HealthConnex to access your PHI to assist us in providing health care to you. We are required by law to submit clinical and demographic data pertaining to services paid for with funds from NC programs like Medicaid and State Health Plan. We may also share other patient data with NC HealthConnex not paid for with State funds. If you do not want NC HealthConnex to share your PHI with other health care providers who are participating in NC HealthConnex, you must opt out by submitting a form directly to the NC HIEA. Forms and brochures about NC HealthConnex are available in our office and online at [NCHealthConnex.gov](http://NCHealthConnex.gov). You may also contact our Privacy Office at (828)210-8758. Again, even if you opt out of NC HealthConnex, we still will submit your PHI if your healthcare services are funded by State programs. Your patient data may also be exchanged or used by the NC HIEA for public health or research purposes as permitted or required by law. For more information on NC HealthConnex, please visit [NCHealthConnex.gov/patients](http://NCHealthConnex.gov/patients)

**The following uses and disclosures of PHI require your written authorization:**

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclose will occur.

**Your Privacy Rights**

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. Request should be addressed to the Practice Administrator at Asheville Arthritis & Osteoporosis Center, 4 Vanderbilt Park Dr., Suite 200, Asheville, N.C. 28803.

**You have the right to see and obtain a copy of your protected health information.**

This means you have the right to review or obtain a copy of your protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

**You have the right to request a restriction of your protected health information.**

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

**Here is one exception:** we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

**You have the right to request for us to communicate in different ways or in different locations.**

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

**You may have the right to request an amendment of your health information.**

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

**You have the right to a list of people or organizations who have received your health information from us.**

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

**Additional Privacy Rights**

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

**Complaints**

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Asheville Arthritis & Osteoporosis Center  
Attn: Practice Administrator  
4 Vanderbilt Park Dr., Suite 200  
Asheville, N.C. 28803

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on September 17, 2013.



ASHEVILLE ARTHRITIS  
Asheville Arthritis & Osteoporosis Center

4 Vanderbilt Park Drive • Suite 200 • Asheville, NC 28803  
Tel. 828-258-9533 • Fax 828-253-4434 • www.ashevillearthritis.com

### New Patient Registration Form

(Please Print)

#### PATIENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender at time of birth:  M  F Social Security Number: \_\_\_\_\_  
 Employer Name: \_\_\_\_\_ Employer Phone: \_\_\_\_\_  
 Marital Status:  Single  Married  Divorced  Widowed  Other Email: \_\_\_\_\_  
 Spouse Last Name: \_\_\_\_\_ Spouse First Name: \_\_\_\_\_  
 Spouse Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Spouse Social Security Number: \_\_\_\_\_

#### IN CASE OF EMERGENCY

Name of Emergency Contact Person: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

#### RESPONSIBLE PARTY (GUARANTOR)

The guarantor is the person responsible for the patient's bill. If the patient is responsible for his/her own bill, please skip this section. If the patient is a minor (under the age of 18), the parent or guardian bringing the patient to the visit is usually the guarantor for the patient.

Guarantor's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
(if guarantor's address is different from patient's address)  
 Guarantor's Phone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Guarantor's Social Security Number: \_\_\_\_\_

#### INSURANCE INFORMATION

(INSURANCE CARDS ARE REQUIRED AT EACH VISIT)

Primary Insurance Company: \_\_\_\_\_ Policy Subscriber's Name: \_\_\_\_\_  
(if other than patient)  
 Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Policy Subscriber's Employer: \_\_\_\_\_  
 Policy Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient's Relationship to Subscriber:  Self  Spouse  Child  Other: \_\_\_\_\_  
(please specify)  
 Secondary Insurance Company: \_\_\_\_\_ Policy Subscriber's Name: \_\_\_\_\_  
(if other than patient)  
 Policy Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient's Relationship to Subscriber:  Self  Spouse  Child  Other: \_\_\_\_\_  
(please specify)  
 Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Policy Subscriber's Employer: \_\_\_\_\_

#### OTHER INFORMATION

Primary Care Physician: \_\_\_\_\_ Address: \_\_\_\_\_  
 Referring Physician: \_\_\_\_\_ Address: \_\_\_\_\_  
 Pharmacy Name: \_\_\_\_\_ Pharmacy Location: \_\_\_\_\_  
 Pharmacy Phone Number: \_\_\_\_\_ Pharmacy Card Number: \_\_\_\_\_

#### INSURANCE AUTHORIZATION AND ASSIGNMENT

\*I hereby authorize Asheville Arthritis & Osteoporosis Center, P.A. to furnish information to Insurance Carriers concerning my illness and treatments and I hereby assign to Asheville Arthritis & Osteoporosis Center, P.A. all payments for medical services rendered to myself or my dependents, if not paid in full at the time of service. I understand that I am responsible for any amount not covered by insurance on assigned claims.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

# Signature on File

Name of Patient: \_\_\_\_\_

Health Insurance Claim Number: \_\_\_\_\_

I request that payment of authorized Medicare benefits be made either to me on my behalf or to **Asheville Arthritis & Osteoporosis Center, P.A.** for any services provided to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCF A 1500 claim form is completed, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ASHEVILLE ARTHRITIS  
AND  
OSTEOPOROSIS CENTER**

**PATIENT INFORMATION CONSENT FORM**

I have received a copy of Asheville Arthritis and Osteoporosis Center's (AAOC) Notice of Privacy Practices. AAOC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment (TPO). With this consent, AAOC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care. AAOC may also mail to my home or other alternative location any items that assist the practice in carrying out TPO. I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations. AAOC will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

With this consent, I grant AAOC permission to obtain information from external sources (Pharmacy) regarding medications that have been prescribed to me.

I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature of Patient : \_\_\_\_\_

Or

Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

**Please list any other persons that you authorize to have access to your medical records.**

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|      |              |
|------|--------------|
| Name | Relationship |
|------|--------------|

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| Name | Relationship |
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|      |              |
|------|--------------|
| Name | Relationship |
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ASHEVILLE ARTHRITIS  
Asheville Arthritis & Osteoporosis Center

Please Complete All 7 Pages

**Patient Information**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Age: \_\_\_\_\_ Race: \_\_\_\_\_ Gender: \_\_\_\_\_

Do you currently reside in a skilled nursing facility?  Yes  No

Does your office visit require an interpreter?  Yes  No

Do you reside in another state part of the year? If so which state and what dates are you here locally? \_\_\_\_\_

Primary Care Physician:

\_\_\_\_\_

Specialists:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate who referred you here: \_\_\_\_\_

Please give a brief reason for your visit here: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you have any family members who are presently patients being treated at Asheville Arthritis?  Yes  No





**Please circle or list vaccinations that you may have had and record the date the vaccination was given next to it if possible:**

|  |  |
|--|--|
| Pneumonia Vaccine (Pevnar, Pneumococcal) | Date Administered: _____               |
| Flu Vaccine                              | Date Administered: _____               |
| Shingles Vaccine (Zostavax)              | Date Administered: _____               |
| Date of last T.B. Test                   | Date Administered: _____               |
| Result of T.B. Test (please circle one)  | T.B. Test was:    Negative    Positive |
| Other _____                              | Date Administered: _____               |

**Current Medications:** Please review your current daily medication bottles before filling this out. Please List all medications you are currently taking (please include over the counter medications such as Tylenol, Advil, Aleve, BC, Goody Powders, vitamins, supplements, etc...)

| <b>NAME OF MEDICINE</b> | <b>DOSE (mg, ml, cc, etc.)</b> | <b>HOW MANY TIMES A DAY</b> |
|-------------------------|--------------------------------|-----------------------------|
|                         |                                |                             |
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**Pharmacies:** Please list your pharmacies. Review your insurance card for pharmacy coverage:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Surgical History:**

List any orthopedic surgeries. Include dates, who performed them, what hospital and what state:

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Circle any surgical procedures you have had, please give dates and who performed them, what hospital and what state:

- |  |                             |
|--|-----------------------------|
| Appendectomy                                 | Stomach Surgery             |
| Breast Surgery                               | Heart Surgery               |
| Gall Bladder Removed                         | Tubal Ligation (tubes tied) |
| Hysterectomy                                 | Ovaries removed             |
| Kidney Surgery                               | Prostate Surgery            |
| Parathyroid Surgery                          | Vasectomy                   |
| Thyroid Surgery                              | Recent Oral Surgery         |
| Cataract Surgery                             | Weight Loss Surgery         |
| Implant Surgery- ie. Pacemaker/Defibrillator |                             |

Any other surgeries, please list: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you been hospitalized in the past year? If yes, please include dates and reason for hospitalization: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Circle any that you have had: physical therapy, water therapy, chiropractor, acupuncture

Have you had any falls inside or outside of you home in the last year? If so did you require medical care?

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**Family History**

Mother: Living Deceased \_\_\_\_\_  
 Age or age when deceased: \_\_\_\_\_

Father: Living Deceased \_\_\_\_\_  
 Age or age when deceased: \_\_\_\_\_

How many siblings do you have? \_\_\_\_\_ Brothers \_\_\_\_\_ Sisters

Are your siblings healthy? \_\_\_\_\_

How many children do you have? \_\_\_\_\_ Sons \_\_\_\_\_ Daughters

Are your children healthy? \_\_\_\_\_

Please place letters in appropriate box below, if any family members have had any of the following:

- M**-Mother                                      **F**- Father                                      **MM**- Maternal Grandmother
- MF**- Maternal Grandfather              **PM**- Paternal Grandmother              **PF**- Paternal Grandfather
- B**- Brother                                      **S**- Sister                                      **S**- Son                                      **D**- Daughter

| Disease  | Parents | Grandparents | Siblings | Children |
|--|---------|--------------|----------|----------|
| General Osteoarthritis                                     |         |              |          |          |
| Rheumatoid Arthritis                                       |         |              |          |          |
| Connective Tissue Disease<br>(Lupus, Scleroderma or other) |         |              |          |          |
| Gout   |         |              |          |          |
| Stroke   |         |              |          |          |
| Breast Cancer  |         |              |          |          |
| Heart Disease  |         |              |          |          |
| High Blood Pressure  |         |              |          |          |
| Diabetes   |         |              |          |          |
| Crohn's or Ulcerative Colitis                              |         |              |          |          |
| Osteoporosis (thin bones)                                  |         |              |          |          |
| Psoriasis, Eczema (type of rash)                           |         |              |          |          |
| Other Cancers & Diseases Processes                         |         |              |          |          |



**Check the appropriate box and add additional explanation needed for symptoms you are CURRENTLY having:**

| Symptom  | Yes | No | Explanation if needed |
|--|-----|----|-----------------------|
| Decreased energy level                                     |     |    |                       |
| Significant change in appetite                             |     |    | More or Less?         |
| Significant change in weight (unintentional)               |     |    | Up or Down?           |
| Recent fever   |     |    |                       |
| Recent infections  |     |    |                       |
| Recent vision changes                                      |     |    |                       |
| Eye pain   |     |    |                       |
| Eye dryness  |     |    |                       |
| Eye redness  |     |    |                       |
| Headaches or recent change in headaches                    |     |    | Migraines?            |
| Pain in temples or jaw                                     |     |    |                       |
| Ulcers in your mouth, nose                                 |     |    |                       |
| Mouth dryness  |     |    |                       |
| Shortness of breath  |     |    | When?                 |
| Coughing   |     |    |                       |
| Pain with breathing  |     |    |                       |
| Chest pain   |     |    |                       |
| Increased swelling in lower legs                           |     |    |                       |
| Stomach pain   |     |    |                       |
| Diarrhea or constipation                                   |     |    | Which one?            |
| Nausea   |     |    |                       |
| Difficulty swallowing                                      |     |    |                       |
| Painful urination  |     |    |                       |
| Blood in your urine  |     |    |                       |
| Muscle weakness, numbness and /or tingling                 |     |    | Which one?            |
| Loss of consciousness                                      |     |    |                       |
| Seizures   |     |    |                       |
| Patchy hair loss   |     |    |                       |
| Rash   |     |    |                       |
| Fingers and toes that get cold and turn blue, white or red |     |    |                       |
| Skin rash caused by sunlight                               |     |    |                       |
| Symptoms of depression                                     |     |    |                       |
| Problems going to sleep or staying asleep                  |     |    | Which one?            |
| Excessive thirst or urination                              |     |    |                       |
| Excessive bleeding after surgery                           |     |    |                       |
| Blood clots requiring medication                           |     |    |                       |
| Swollen lymph nodes  |     |    |                       |
| Hay Fever  |     |    |                       |
| Environmental allergies                                    |     |    |                       |
| Do you feel rested in the morning                          |     |    |                       |
| Have you had a miscarriage?                                |     |    |                       |