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: 10/7/2021

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

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. 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

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.

PLEASE DO NOT MAIL THIS PAPERWORK BACK TO US.
YOU MAY BRING IT IN AT THE TIME OF YOUR APPOINTMENT. THANK YOU!

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:_____

PATIENTS WITH MEDICARE, PLEASE SIGN MEDICARE AUTHORIZATION ON BACK SIDE

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: _____

Mobile Number: _____

Signature of Patient: _____
Or
Legal Guardian: _____Date: _____

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

Name	Relationship
Name	Relationship
Name	Relationship

For the convenience of our patients, AAOC offers online bill pay. With this consent, I authorize AAOC to contact me by email, text, or phone (including an automatic dialing system or artificial/prerecorded voice) at the mobile number listed for notification of patient balances due. I understand I am not required to sign or agree to this as a condition of treatment.

Signature: _____

Please Complete All 7 Pages
Front and Back

Patient Information Date: _____

Name: _____

Address: _____
_____

Age: _____ Race: _____

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:
_____

Other Physicians you CURRENTLY see:
_____
_____
_____
_____
_____

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 (Prevnar, Pneumococcal) Date(s) Administered: _____
Flu Vaccine Date Administered: _____
Shingles Vaccine (Zostavax or Shingrix) Date(s) Administered: _____
Date of last T.B. Test Date Administered: _____
Result of T.B. Test (please circle one) T.B. Test was: Negative Positive
COVID-19 Vaccine (which one): _____ Date(s) Administered: _____
Other_____ Date Administered: _____

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

NAME OF MEDICINE	DOSE (mg, ml, cc, etc.)	HOW MANY TIMES A DAY
Example: Zinc	*50mg*	*1 tab twice a day*

Pharmacies: Please list your pharmacies. Review your insurance card for pharmacy coverage:

_____
_____
_____

Your Medical History: please circle all that have been diagnosed, now or in the past.

Fibromyalgia	Eye Disease	High Cholesterol
High Blood Pressure/Hypertension	Osteoporosis/Osteopenia	Stroke
Heart Disease	Diabetes	Anxiety requiring medication
Gout or Pseudogout	Stomach Ulcers	Depression requiring medication
Kidney Stones	GERD	Seizure Disorder
Skin Disease (type)	Kidney Disease	Neurologic Disorder
Blood Clots requiring medication	Lung Disease	Thyroid Disease
Cancer (type)	Positive TB test	Obesity
Sleep Apnea	Liver Disease/Fatty Liver	Osteoarthritis
Hearing Impaired	Shingles	Neuropathy
Miscarriage, how many?	Anemia	Sjogrens
Loss of Balance	Vertigo	Fainting when having blood drawn

Any other medical problems that have been diagnosed? _____

_____

_____

_____

_____

List any broken bones you have had and at what age: _____

_____

List the last time you had a steroid injection or took oral prednisone or other steroid?

_____

_____

Allergies to medications, medical products or any other intolerances or sensitivities (please list):

NAME OF MEDCINE/MEDICAL PRODUCT/INTOLERENCE/SENSITIVITY	TYPE OF REACTION

Surgical History:

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

_____
_____
_____
_____

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

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

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?

_____
_____
_____
_____

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 living:_____Deceased:_____
Sisters living: _____Deceased:_____

Are your siblings healthy? _____

How many children do you have? Sons living:_____Deceased:_____
Daughters living:_____Deceased:_____

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 (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)				
Cancers (type)				
Other Disease Processes				

Social History

Do you currently use tobacco, electronic cigarettes – vaping, smokeless tobacco? _____
What type?_____How many packs/cans a day? _____
Or have you used these in the past?_____If so, year or age when you quit: _____

Have you ever used illicit drugs? _____ If yes, what did you use?_____
When did you use last? _____

Have you had a drink containing alcohol within the past year? _____
If so, what kind (beer/wine/liquor)? _____
On average how many drinks per week: _____

Do you drink any caffeine?_____If yes, how often? _____
If yes, list what kind (coffee, tea, sodas, energy drinks): _____

Do you exercise?_____If yes, how much exercise do you do in a typical week? _____
What kind of exercise? _____
How many minutes/hours per day? _____

Who lives with you? _____
Number of adults:_____children:_____in household.

Marital Status: (please circle one) Married Divorced Separated Single
Widowed Partnered

Occupation:_____(please circle) full/part time.
Highest level of education: _____

Have you traveled outside of the United States in the past year? _____
If yes, where have you traveled? _____

If you are a student: what school do you go to? _____
What grade are you in?_____Estimated date of graduation: _____
What is your major? _____

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

Symptom	Yes	No	Explanation if needed
Chills			
Significant change in appetite			More or Less?
Decreased energy level			
Recent fever			
Night sweats			
Recent infections			What type?
Significant change in weight (unintentional)			Up or Down?
Environmental Allergies			
Eye dryness			
Eye pain			Which eye?
Recent vision changes			
Eye redness			Which eye?
Frequent nose bleeds			
Mouth dryness			
Ulcers in your mouth, nose			
Headaches or recent change in headaches			Migraines?
Pain in temples or jaw			
Coughing			
Shortness of breath			
Chest pain			
Increased swelling in lower legs			When?
Stomach pain			
Blood in stool			
Diarrhea or constipation			Which one?
Difficulty swallowing			
Blood clot requiring medication			
Swollen lymph nodes			
Blood in your urine			
Painful urination			
Genital Ulcers			
History of Fracture			
Patchy hair loss			
Fingers and toes that get cold and turn blue, white or red			
Rash			
Skin rash caused by sunlight			
Muscle weakness, numbness and /or tingling			Which one?
Seizures			
Symptoms of depression			
Problems going to sleep or staying asleep			Which one?