HOUSTON RHEUMATOLOGY & ARTHRITIS SPECIALISTS

PATIENT REGISTRATION FORM

DEMOGRAPHICS

◯ **No change in address, phone number**

Name: (Last)______________________(First)______________________(Middle)______________

DOB: ______________________________ Sex: ◯ Male ◯ Female ◯ Other

Address: ____

City:________________________State:______ Zip_______ Country:____________________

Phone: (Home): ________________(Cell):____________________ (Work):______________
Fax:______________________________ Email: _____________________

Contact by: Phone /E-mail/ Fax (circle preference)

Status: ◯Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated ◯Other

Race: Black/ Hispanic/ Native American/ Asian/ White/ Chinese/ Filipino/ Native Hawaiian/ Multiracial /Pacific Islander/ Japanese / Other

Languages spoken and preferred:____

Employment Status: Full-time/ Part-time/ Self-employed/ Retired/ Student /Unemployed/ Disability

INSURANCE INFORMATION:

◯ **No change in insurance information since last visit**

Primary Insurance: ____
Member ID: ________________________________ Group number: ____________________
Number on back of card for providers: ____

Responsible Party (Party Responsible for payment): ◯ Self ◯ Spouse ◯ Parent ◯ Other

Responsible party Name: (Last)________________(First)____________________(Middle)________

Address: ____

City:________________________State:______ Zip_______ Phone:____________________

Secondary Insurance:____
Member ID: ________________________________ Group number: ____________________
Number on back of card for providers: ____

Responsible Party (Party Responsible for payment): ◯ Self ◯ Spouse ◯ Parent ◯ Other

Responsible party Name: (Last)________________(First)____________________(Middle)________

Address: ____

City:________________________State:______ Zip_______ Phone:____________________

Rheumatology New Patient Intake Form

Primary reason for your visit today?

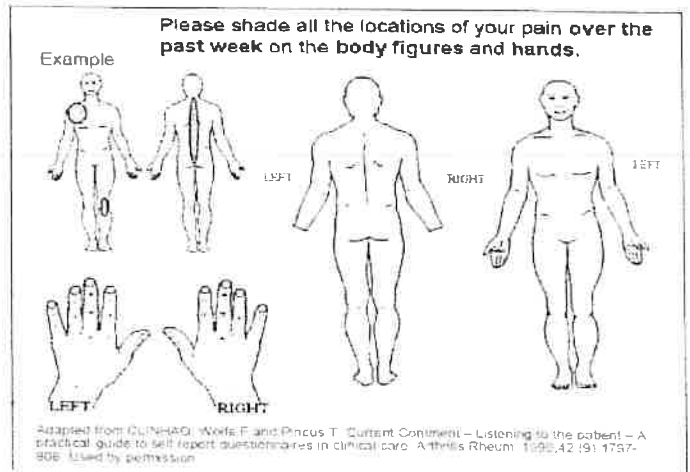
____

Describe briefly your *present* symptoms:

____

____

____



Adapted from CLINHAQ: Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum [illegible];42(9):1797-808. Used by permission.

Date symptoms began (approximate): ______________

Diagnosis: ______________________________

Previous treatment for this problem (include physical therapy, surgery, and injections.

____

____

Please list the other practioners you have seen for this problem:

____

____

Primary Doctor's Name: ______________________________________

Preferred Pharmacy: ______________________________________

How did you hear about us/Who referred you? ______________________

Allergies: ____

What medications do you take (prescription and over-the-counter)?

1. ______________________ 7. ______________________

2. ______________________ 8. ______________________

3. ______________________ 9. ______________________

4. ______________________ 10. ______________________

5. ______________________ 11. ______________________

6. ______________________ 12. ______________________

Do you currently have or *have you ever had* the following: (circle if "yes")

High blood pressure	Epilepsy(seizure)	Osteoporosis or osteopenia	Crohns disease/ulcersative colitis
High cholesterol	Liver disease	Diabetes	Kidney disease
Heart attack or heart failure	Stomach ulcers	Thyroid problem	H.Pylori infection
Stroke FRACTURES	Cancer	Tuberculosis	cataracts
			Psoriasis

Other medical diagnoses/problems

____

____

Surgery or procedures Year Reason

____

____

____

For women:

How many times have you been pregnant? ________ How many miscarriages or abortions? ______________

What type of contraception (birth control) do you use currently?

Date of last menstrual cycle: ______________ Current or past use of female hormones? Y N

Have **you or anyone in your family** ever been diagnosed with any of the following? (Check if "yes.")

	Self	Family (What relation?)		Self	Family (What relation?)
Arthritis (unknown type)			Lupus (SLE)		
Rheumatoid arthritis			Ankylosing spondylitis		
Osteoarthritis			Psoriatic arthritis		
Gout			Childhood arthritis		
Vasculitis			Scleroderma		
Dermatomyositis or polymyositis			Uveitis (inflammatory eye disease)		

Past Exams/Evaluations: Date of last eye exam: __ /____/____ Date of last chest x-ray: ____/____/____

Date of last bone density: ____/____/____ Date of last Tuberculosis Test: ____/____/____

Do you smoke or use smokeless tobacco products (eg, "chew")? Yes No Past (When did you quit?) ________

Do you drink alcohol? Yes No Past (When did you quit?) ________

If yes, how often? Daily Weekly Monthly or less

Have you ever used "street" drugs, including by injection? Yes No Past (Ever) [When did you quit?] ________

Do you exercise?: Yes No (If yes, what type and how often?) ______________________________

With whom do you currently live? ____

Occupation: ________________________

Have you had any of these symptoms

General	
☐	Fevers
☐	Weight gain or loss: How much?
☐	Swollen lymph nodes: Where?
☐	Fatigue
HEENT	
☐	Double or blurry vision
☐	Dry eyes or mouth
☐	Snoring
☐	Mouth or nose ulcers/sores
☐	Dry cough
☐	Sore throats
☐	Nasal congestion
Cardiac	
☐	Chest pain
☐	Racing heart beat or palpitations
☐	Foot/leg swelling
Pulmonary	
☐	Shortness of breath
☐	Coughing up blood
☐	Coughing up phlegm
Gastrointestinal	
☐	Abdominal pain
☐	Nausea and/or vomiting
☐	Diarrhea
☐	Bloody stool
☐	Hemorrhoids
☐	Dark black stool
Genitourinary	
☐	Buring with urination
☐	Blood in urine
☐	Foamy urine
☐	Kidney stones

Musculoskeletal			
☐	Finger/toe color changes		
☐	Fingertip ulcers		
☐	Shoulder	☐ pain	☐swelling
☐	Elbow	☐ pain	☐swelling
☐	Wrist/hand	☐ pain	☐swelling
☐	Hip	☐ pain	☐swelling
☐	Knee	☐ pain	☐swelling
☐	Ankle/foot	☐ pain	☐swelling
☐	Neck/back pain		
☐	Muscle aches		
☐	Morning stiffness: How long?		
Neurologic			
☐	Headache		
	Numbness or tingles: Where?		
☐	Burning pain: Where?		
☐	Weakness: What body part?		
☐	Passing out		
Dermatologic			
☐	Rash		
☐	Sun sensitivity		
☐	Hair falling out		
☐	Mouth/nose ulcers		
☐	Nail pits/dents		
☐	Eczema		
☐	Dandruff		
Hematologic			
☐	Anemia		
☐	Low platelets		
☐	Easy bruising		
Psychologic			
☐	Excessive worry/anxiety		
☐	Depressed mood		
☐	Difficulty falling/staying asleep		

PLEASE CIRCLE ANY MEDICATION(S) YOU HAVE TAKEN IN THE PAST OR CURRENTLY.

Pain medications

Ibuprofen (Motrin, Advil)
Naproxen (Naprosyn, Aleve)
Meloxicam (Mobic)
Diclofenac (Voltaren, Athrotec)
Celecoxib (Celebrex)
Acetaminophen (Tylenol)
Hydrocodone (Lortab, Norco)
Tramadol (Ultram)
Piroxicam (Feldene)
Rofecoxib (Vioxx)
Aspirin (full strength)
Sulindac (Clinoril)
Indomethacin (Indocin)
Codeine (Vicodin, Tylenol #3 or #4)
Oxycodone (Oxycontin, Roxicodone)

Oral immunosupressants (ie. pills)

Gold pills or shots
Methotrexate (Rheumatrex)
Azathioprine (Imuran)
Apremilast (Otezla)
Steroids (prednisone, methylprednisolone, dexamethasone, Rayos, "dose pack")
Olumiant (baricitinib)
Hydroxychloroquine (Plaquenil)
Sulfasalazine (Azulfidine)
Tofacitinib (Xeljanz)
Cyclophosphamide (Cytoxan)
Mycophenylate mofetil (CellCept)

Injectable or infusion immunosuppressants

Cyclophosphamide (Cytoxan)
Adalimumab (Humira)
Certolizumab (Cimzia)
Abatacept (Orencia)
Ustekinumab (Stelara)
Canakinumab (Ilaris)
Rituximab (Rituxan)
Etanercept (Enbrel)
Infliximab (Remicade)
Golimumab (Simponi)
Toculizumab (Actemra)
Kinaret (Anakinra)
Corticotropin (Acthar)
Others (please name)

Gout medication

Colchicine (Colchrys)
Probenacid (Benemid)
Pegloticase (Krystexxa)
Allopurinol (Zyloprim, Lopurin)
Febuxostat (Uloric)
Rasburicase (Elitek)

Osteoporosis medication

Alendronate (Fosamax)
Risedronate (Actonel)
Teriparatide (Forteo)
Calcitonin (Calcimar, Miacalcin)
Ibandronate (Boniva)
Zolendronate (Reclast)
Denosumab (Prolia)
Estrogen (Premarin, Vivelle)

Fibromyalgia or chronic pain medications

Amitriptyline (Elavil)
Pregabalin (Lyrica)
Milnacipran (Savella)
Carisoprodol (Soma)
Gabapentin (Neurontin)
Duloxetine (Cymbalta)
Cyclobenzaprine (Flexeril)
Methocarbamol (Robaxin)

Tara J Rizvi MD PLLC
23920 KATY FWY STE 240
KATY TX 774940881
Ph: 346-257-4300 Fax:877-745-2756

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: ______ **Date:** ______

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "x" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling down, depressed, or hopeless	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired or having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself-or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8) Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9) Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

Total Score: ______

Interpretation

☐ Minimal Depression

☐ Mild Depression

☐ Moderate Depression

☐ Moderately severe depression

☐ Severe Depression

Interpretation of Total Score for Depression Severity

- 1-4 Minimal depression
- 5-9 Mild depression
- 10-14 Moderate depression
- 15-19 Moderately severe depression
- 20-27 Severe depression

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Houston Rheumatology & Arthritis Specialists

Patient Consent for Use of Email Communication

To better serve our patients, out office has established an email address for some forms of communication. For routine matters that do not require immediate responsc, plcasc feel free to contact us at *info@myhras.com* Please remember however, that this form of communication is not appropriate for use in an emergency. **The turnaround time for routine patient communications is 3 business days.** The service provider may delay message delivery. Should you require urgent or immediate attention, this medium is not appropriate.
When sending email, please put the subject of your message in the subject line so we can process it more efficiently. Also, be sure to put your name, date of birth, and return telephone number in the body of the message. We also ask that you acknowledge receipt of emails coming from this office by using the auto reply feature.
Communications relating to diagnosis and treatment will be filed in your medical record. This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to your physician, staff and covering physician would have access to this information.
I understand that this office will not be responsible for information loss or delay, or breaches in confidentiality that are due to technical factors beyond this office's control.

I understand and agree to the above email policy.
By signing below, you are agreeing that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

____________________________ Patient signature

____________________________ Witness (optional)

____________________________ Date

Houston Rheumatology & Arthritis Specialists
Tara Rizvi, M.D.

DISCLOSURES AND WAIVERS

FINANCIAL POLICY

In order to provide a reasonable quality of healthcare it is very important for a practice to stay financially viable. Payment is due at the time of service unless arrangements have been made in advance. We accept cash, Visa, MasterCard, Discover and American Express. We reserve the right to accept checks for our established patients.

Upon your arrival, your benefits will be explained to you, to the best of our understanding and you will be asked to authorize a credit card on file to authorize payments, above and beyond your co-pay to cover the remaining deductible or co-insurance amount you may owe. We will securely store your credit card information per PCI guidelines. We will always try to work with you and your insurance. We will not charge anything to your card until we have an exact balance returned to us from your insurance company.

_______ Initials - I authorize Houston Rheumatology & Arthritis Specialists to store my credit card in a secure electronic format that is PCI-DSS compliant.
I understand an email with a statement will be sent to the email provided. The credit card will be charged WITHIN A WEEK of the email; if no email address is provided, a paper statement will be mailed, and the credit card will be charged a week later.

_______ Initials - I understand the services rendered may not be covered by my health plan. If the insurance plan determines a service to be "not covered" I will be responsible for the complete charges. If it is later determined that my coverage was not active on the day of the service, I will be responsible for the charges.
I confirm the following is the correct email address:

____

Your health plan is a contract between you and your insurance company. Health plans vary widely as far as benefits are concerned and in some instances your responsibility may not be evident until we get a response from the insurance company. You will be responsible for co-pay, co-insurance, and deductible and uncovered charges, if they apply to you. If you are unable to pay, please call the office for setting up a payment plan or an alternate arrangement. No response after repeated attempts to contact you will result in your case being referred to a collection agency.

_______ Initials - A charge of $25 will apply for all returned checks. I understand and agree that such terms may be amended by the office from time to time.

- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after receipts if the initial statement.
- Payment is in full due upon receipt of the statement. Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Past due accounts may be referred to a professional collection agency for further collection activity. You will be responsible to pay all collection cost incurred, including attorney's fees and court cost if applicable.

- If you are unable to pay the balance due in full, you must contact our billing office to discuss a payment schedule. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney.
- In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $30.00 to your original balance. In addition, we may seek additional legal remedies provided to us under Texas law.

ASSIGNMENT OF BENEFITS:

I hereby assign all medical benefits payable for serviced provided by Tara J. Rizvi M.D PLLC., including Medicare, private insurance and any other health plans to Tara J. Rizvi, M.D. PLLC. I further authorize a release of any medical information necessary to process the claim and payment of benefits. A photocopy of this assignment is to be considered as valid as an original. This assignment remains in effect until I revoke in writing.

Signature: ________________________________ **Print Name** _________________________

APPOINTMENT POLICY

Our goal is to provide quality individualized medical care in a timely manner. "No shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.
Please note that the office attempts to call, text or email you to confirm your appointment with us one to two days prior to your visit.

No Show Policy
A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in the medical record as a "no-show". Emergency cancellations are accepted for major illness, illness of a family member or death in the family.
After three no show appointments, the office reserves the right to discharge a patient from the practice.

______
Initials - Missed appointment: There is a $25.00 charge for no shows for follow up office visits and $35.00 for a missed new patient appointment. The charge is not billable to insurance you will be responsible for payment out of pocket. If multiple no shows occur we reserve the right to provide you with another providers information and request you to seek you care at a different facility and your medical records to be sent to a provider of your choice.

Cancellation of an Appointment
In order to be respectful of the medical needs of other patients, please be courteous and call the office at 346-257-4300 promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of an appointment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.
Late Cancellations: A late cancellation is when a patient fails to cancel their scheduled appointment with a 24-hour advance notice. Late cancellations may be charged as no shows.

TO CANCEL APPOINTMENTS, PLEASE CALL 346-257-4300 BETWEEN 8AM – 5PM.

MEDICATION REFILL POLICY:

I understand that should I need any refills on my medications, they should be requested during my appointment with the doctor. I understand that if I make any requests outside of this time, I must allow 3-5 business days for my prescriptions to be filled. I take responsibility to call the office in the appropriate time frame for my medications to be refilled before I run out. If there is a change in my pharmacy information, I take responsibility to give the office updated information.

Opioids and controlled substances will not be filled outside of regular business hours and physician must have seen the physician in the past 3 months for refills on these medications. Additionally, I am aware that based on my insurance and prescription benefits, a 90-day supply of these medications may not be permitted. I am responsible to inquire and be aware of my insurance policy on this subject.

Signature: ______________________________ **Print Name** ______________________

Request for Medical Records and any Additional Paperwork

_____ Initials- I understand and agree to pay a $25 fee for requesting a hard copy of my medical records and for any other additional paperwork that I would like my doctor to fill out. I understand that it can take up to 72 hours for my medical records to be processed and up to 2 weeks for other forms to be filled out.

Acknowledgement of Review of Notice of Privacy Practices

_____ Initials - I have reviewed this office's notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ Initials - I authorize the following person/people full access to my medical records and allow them to receive medical phone messages from the clinic. I also allow the following individuals to speak with Dr. TARA RIZVI directly regarding all my medical information, testing results, and medical decision making:

____________________ ____________________ ____________________

(I realize that my not electing this, the doctor's office cannot leave a message with any one in my home regarding results or further care.)

DECLARATION

I have read and understand the above agreements and authorizations. The terms and consequences of this document have been fully explained to me and I have signed it freely and without inducement than the rendition of services. All of my questions have been fully answered.

______________________________ ______________________________

PATIENT SIGNATURE **Date**

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician and/or other individuals he or she deems appropriate to perform and/or order exams, test, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of a\my medical condition. This consent is valid for each visit I make to Houston Rheumatology &Arthritis Specialists unless revoked by me orally or in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), The viruses associated with aids, I THE FOLLOWING SITUATUON: 1) to screen blood products, organs or tissues to determine suitability for donation: 2) if another individual is accidentally exposed to a patient's blood or body fluids, such as through a needle stick (any such test shall be conducted pursuant to Houston Rheumatology &Arthritis Specialists infectious disease protocol); or 30 if a medical or surgical procedure is to be performed which expose health care workers to the patients' blood or body fluids. This disclosure is to inform you that you may be tested, at the expense of Houston Rheumatology &Arthritis Specialists. If any of those situations occurs during your treatment period.

______________________________________ ______________________

Patients Printed Name Date of Birth

______________________________________ ______________________

Patients/Legal Representative Signature Date

____

Relationship to Patient

______________________________________ ______________________

Witness Date

HOUSTON RHEUMATOLOGY & ARTHRITIS SPECIALISTS

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

I authorize the transfer of my healthcare information

From:

Dr. ______________________________

Clinic/
Hospital: ______________________________

Address: ______________________________

____

Phone: ______________________________

Fax: ______________________________

To: Dr. Tara J Rizvi, MD.

23920 Katy Fwy, Suite 240

Katy, Texas 77494

Phone: 346-257-4300

Fax: 346-202-0088

Health Information Requested:

- ○ Complete Medical Records
- ○ Last Consultation Reports
- ○ Discharge Summary
- ○ IMMUNIZATION RECORD
- ○ Hospital Records
- ○ Imaging Reports
- ○ Laboratory Reports
- ○ Other (specify) ______________________________

Reason for Disclosure: ☐ Continuing patient care ☐ Treatment ☐ Other: ______________________________

Limit Records to: ______________________________

I understand that the specific information to be released may include but is not limited to management of drug or alcohol abuse, mental/psychiatric illness or communicable disease. I understand this consent may be revoked at anytime in writing.

THIS CONSENT WILL EXPIRE 180 DAYS AFTER DATE OF SIGNATURE

→

Last Name **First Name** **Middle Initial** **Date of Birth**

Previous Names

→

Signature **Date**

Signature of Patient Representative | Relationship to patient | Date

Telemedicine means real-time evaluation, diagnosis, consultation on, and treatment of a health condition using advanced telecommunications technology, which may include the use of interactive audio, video, or other electronic media. As such, telemedicine allows the provider to see and communicate with the patient in real-time.

I. **Consent for Treatment.** I voluntarily request Houston Rheumatology and arthritis associates to participate in my medical care through the use of telemedicine.

I understand that Providers (i) may practice in a different location than where I present for medical care, (ii) may not have the opportunity to perform an in-person physical examination, and (iii) rely on information provided by me. I acknowledge that Telemedicine Providers' advice, recommendations, and/or decision may be based on factors not within their control, such as incomplete or innacurate data provided by me or distortions of diagnostic images or specimens that may result from electronic transmissions. I acknowledge that it is my responsibility to provide information about my medical history, condition and care that is complete and accurate to the best of my ability. I understand that the practice of medicine is not an exact science and that no warranties or guarantees are made to me as to result or cure.

If Telemedicine Providers determine that the telemedicine services do not adequately address my medical needs, they may require an in-person medical evaluation. In the event the telemedicine session is interrupted due to a technological problem or equipment failure, alternative means of communication may be implemented or an in-person medical evaluation may be necessary. If I experience an urgent matter, such as a bad reaction to any treatment after a telemedicine session, I should alert my treating physician and, in the case of emergencies dial 911, or go to the nearest hospital emergency department.

II. **Release of Information.** To facilitate the provision of care and/or treatment through telemedicine, I voluntarily request and authorize the disclosure of all and any part of my medical record (including oral information) to my Telemedicine Providers. I understand and agree that the information I am authorizing to be released may include: 1) AIDS/HIV test results, diagnosis, treatment, and related information: 2) drug screen results and information about drug and alcohol use and treatment; 3) mental health information; and 4) genetic information.

I understand that the disclosure of my medical information to Telemedicine Providers, including the audio and/or video, will be by electronic transmission. Although precautions are taken to protect the confidentiality of this information by preventing unauthorized review, I understand that electronic transmission of data, video images, and audio is new and developing technology and that confidentiality may be compromised by failures of security safeguards or illegal and improper tampering.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents.

Signature of Patient/Responsible Party (Relationship to Patient) ______ Time ______ Date ______

Signature of Interpreter/Provider Using Telephone Translation Services ______ Time ______ Date ______