



RCNJ RHEUMATOLOGY
CENTER
OF NEW JERSEY

Ahmed Abdel-Megid, M.D.
Amanda Borham, M.D.
Jennifer Sidiropoulos, PA-C
Lauren Silverstein, PA-C
Manjula Chava, PA-C

PATIENT INFORMATION

Name: _____ Date of Birth: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Cell Ph: _____ Home Ph: _____ Work Ph: _____
Email (Required): _____
SSN: _____ Marital Status: S M D W DP Sex: ☐ M ☐ F
Emergency Contact Name: _____ Relationship: _____
Cell Ph: _____ Home Ph: _____ Work Ph: _____
Primary Care Physician: _____ Phone: _____
Pharmacy Name: _____ Phone: _____

ACCOUNT INFORMATION

Responsible Party: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Guarantor (if other than self): _____ Relationship: _____
Address (if different from above): _____
Cell Ph: _____ Home Ph: _____ Work Ph: _____

INSURANCE INFORMATION

Insurance Company: _____
Subscriber: _____ Subscriber Date of Birth: _____
Relationship: _____ SSN: _____ Sex: ☐ M ☐ F
Subscriber Address: _____
Subscriber Phone Number: _____

ADDITIONAL INFORMATION

Preferred Language: _____ Ethnicity: _____ Race: _____
Ethnicity Options: Hispanic/Latino, Non-Hispanic/Non-Latino, Other, Not Reported, Declined
Race Options: White, Black or African-American, American Indian/Alaskan Native, Asian, Native Hawaiian/Pacific Islander, Other, Multiple Races, Not Reported, Declined to Specify

ASSIGNMENT OF BENEFIT AND RELEASE OF INFORMATION

I certify that the information provided herein is correct and accurate and hereby authorize the Rheumatology Center of New Jersey to submit claims to Medicare, Medigap, and commercial payers on my behalf. I assign any payment and/or benefit from these payers for these services to the Rheumatology Center of New Jersey. I fully authorize the release of any medical records necessary for the adjudication and payment of these claims or any authorizations for services or procedures rendered or to be rendered. I understand balances for deductibles, co-insurance, co-payments, and non-covered services are my financial responsibility. If any balances become delinquent and are referred for further collection activity, I may be liable for any cost of collection including collection fees, court fees, and legal fees.

Signature

Date

56 Union Avenue | Somerville, New Jersey 08876
11 Centre Drive | Monroe, New Jersey 08831
148 State Route 31 Suite 201 | Flemington, New Jersey 08822

Phone (908) 722-5380
Fax (908) 685-7501

REASON FOR TODAY'S VISIT:					
PRESENT MEDICATIONS:					
PAST MEDICAL HISTORY: (Briefly list unusual CHILDHOOD diseases, MAJOR SURGERY, and MAJOR ILLNESS, other than your current complaints)					
FAMILY HISTORY: (Indicate any major medical conditions that run in your family, especially a history of gout or psoriasis)			SOCIAL HISTORY: Occupation: _____ Number of Children: _____ Do you smoke? _____ How long/often: _____ Do you drink? _____ How much/often: _____		
MEDICATION ALLERGIES:					
CONDITION	Y	N	CONDITION	Y	N
SKIN RASH OR PSORIASIS			RECURRENT CHEST PAIN		
PITTING OR INFECTION OF NAILS			PLEURISY		
HARDENING OR TIGHTENING OF SKIN			ASTHMA OR BRONCHITIS		
RECENT UNEXPLAINED HAIR LOSS			RECURRENT COUGH OR VOMITING OF BLOOD		
RECURRENT SORES ON/IN PENIS OR VAGINA			RECENT NAUSEA OR VOMITING		
FREQUENT OR RECURRING MOUTH SORES			STOMACH ULCER OR INTESTINAL TROUBLE		
RECURRENT CONJUNCTIVITIS OR PINK EYE			STOMACH PAIN OR HEARTBURN		
IRITIS, UVEITIS OR RED EYE			HEMORRHOIDS OR COLITIS		
ANEMIA OR BLOOD DISEASE			FREQUENT LOOSE BOWEL MOVEMENTS		
SEVERE BLEEDING PROBLEMS			HEPATITIS, LIVER TROUBLE, OR JAUNDICE		
FREQUENT HEADACHE			KIDNEY OR BLADDER DISORDER		
NEW EXCESSIVE FATIGUE			PSYCHIATRIC OR PSYCHOLOGICAL TREATMENT		
EMOTIONAL OR NERVOUS PROBLEMS			EPILEPSY, FITS, OR CONVULSIONS		
DEPRESSION			HISTORY OF RECURRENT CANCER OR TUMORS		
RECENT PROGRESS OR RECURRENT BACK PAIN OTHER THAN THE OCCASIONAL LOWER BACK ACHE					
INABILITY TO PRODUCE NORMAL AMOUNTS OF SALIVA					
DIFFICULTY IN MAKING TEARS, EYE DRYNESS, OR GRITTY FEELING IN THE EYES ON AWAKENING					
INFLAMMATION OF VEINS OR BLOOD CLOTS					
RAYNAUD'S SYNDROME (HANDS TURN BLUE ON EXPOSURE TO THE COLD)					
ON EXPOSURE TO SUNLIGHT, DO YOU BECOME ILL, DEVELOP ACHING JOINTS, OR SEVERE SKIN RASH?					
HAVE YOU EVER EXPERIENCED A MISCARRIAGE? IF SO, HOW MANY?					
HAVE YOU BEEN BITTEN BY OR REMOVED ANY TICKS?					
IS THERE ANY COMPENSATION CLAIM PENDING BECAUSE OF AN INJURY OR ACCIDENT?					
HAVE YOU RECENTLY BEEN OUTSIDE OF THE UNITED STATES?					
HAVE YOU BEEN SEEN BY A RHEUMATOLOGIST BEFORE?					
IF SO, NAME:			PHONE:		

Patient Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____



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OFFICE POLICIES

Initials

_____ I understand that if I fail to cancel my appointment within 24 hours of my scheduled time, I will be charged a \$50.00 fee. I understand that Medicare and other commercial insurance companies will not reimburse me for this fee. By signing, I am agreeing to these terms.

_____ I understand that if my check is returned, there will be a \$35 charge in addition to the money owed.

_____ I understand that it is my responsibility to pay any co-pays, co-insurance, and deductibles at the time of service.

_____ I understand that it is my responsibility, if required by my insurance, to bring a valid referral with me at time of service. If I do not, I understand that the insurance company may not pay RCNJ and therefore I will be fully responsible for the cost of my visit. By signing, I am agreeing to these terms.

_____ I understand that RCNJ will make every effort to explain the cost of visits, medication, and procedures, but it is my responsibility to be aware of my insurance company's reimbursement policies and guidelines. I understand and acknowledge that I am fully responsible for anything they do not cover. By signing, I am agreeing to these terms.

_____ I give permission to leave detailed messages regarding appointments, payments, etc. on the phone number on file.

_____ I give permission to leave detailed messages regarding test results, treatment, and labs on the phone number on file.

_____ I understand all test results must be reviewed by a physician during an office visit before copies of results are given.

_____ If another doctor requires copies of results or records, I will have them call RCNJ directly to make the request.

I authorize the release of information including diagnosis and/or records including examinations rendered to me and claim information. This information may be released to the following people:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

☐ Do not release my information to anyone.

(This release of information will remain in effect until terminated by me in writing)

Patient Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

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PATIENT ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's Notice of Privacy Practices explaining:

- ☐ How this office will use and disclose my Protected Health Information.
- ☐ My privacy rights in regard to my Protected Health Information.
- ☐ This office's obligation concerning the use and disclosure of my Protected Health Information.

I understand that this Notice of Privacy Practices may be revised that that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request.

I also understand that if I have any concerns, I may contact:

Rheumatology Center of New Jersey
56 Union Avenue
Somerville, NJ 08876

Phone Number (908) 722-5380

For additional information, I may visit <https://www.hhs.gov/hipaa/index.html>

Patient Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

OFFICE USE ONLY:

We made a good faith effort to obtain an acknowledgment of _____'s receipt of our Notice of Privacy Practices. In spite of our efforts, we were unable to obtain a signed acknowledgment for the following reason:

- ☐ Patient refused to sign (date of refusal) ____/____/____
- ☐ Communication barriers prevented obtaining acknowledgment.
- ☐ An emergency situation prevented us from obtaining acknowledgment.
- ☐ Other: _____

Attempt made by: _____ Date: _____

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BONE HEALTH (OSTEOPOROSIS/OSTEOPENIA) SCREENING QUESTIONNAIRE

Today's Date: _____

Patient Name: _____

Date of Birth: _____ Age: _____ Gender: _____

RISK FACTORS:

Have you ever fractured/broken a bone? Y / N

Has a parent ever fractured/broken a bone? Y / N

Do you smoke or use tobacco products? Y / N

Do you drink three or more alcoholic drinks a day? Y / N

Are you on steroids/ immunosuppressants? Y / N

Do you have rheumatoid arthritis? Y / N

Have you ever had a bone density test (DEXA) to check for Osteoporosis/Osteopenia? Y / N

If you had a bone density test,

Test Location: _____ Date of Test: _____

Do you know the results?

☐ Normal

☐ Osteopenia

☐ Osteoarthritis

FOR STAFF USE ONLY

No Risk Factors

F Age 50-64 / M Age 50-69 NO DEXA REQUIRED

With Risk Factors from Above

F Age 50-64 / M Age 50-69 PROCEED TO ORDER DEXA

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PATIENT RESPONSIBILITY FOR FOLLOW-UP CARE PLEDGE

I _____, hereby acknowledge and understand that even with the best
(Print Name)

training, skill, and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand that it is important that any and all recommendations by my medical care providers are followed completely in order to increase the likelihood of a positive and healthy treatment outcome. I acknowledge and understand that if any medical care provider at this office prescribes medication to me that the proper taking of any such medication shall be my sole responsibility (or my guardian who has attended this consultation.) I agree to adhere to the prescribed dosage and frequency of all medications as recommended by my medical care provider.

I understand that if a medical care provider at this office refers me to see another physician or receive additional testing including, but not limited to blood testing, an MRI, or CT scan, this timely recommendation is important and essential to the ultimate success of my treatment outcome. I understand that it is not possible for any person in this office to constantly follow up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see a recommended physician or obtain the test for which I was referred immediately, I may risk my current health or increase future health risks.

I understand that it is solely my responsibility to follow any of the medical advice given by any medical care provider in this office and any negative health outcome from my failure to follow the recommendations and advice of my medical care providers should be expected.

Patient Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____



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MEDICATION REFILL POLICY

Prescription refills require close monitoring by your provider to ensure their safety and effectiveness. Your provider will prescribe the appropriate number of prescription refills to last until your next scheduled appointment. Generally, when you are down to zero refills, it is time to schedule a follow up appointment. We prefer you to request any refills of your medications at the beginning of your office visit.

It is your responsibility to notify the office in a timely manner when refills are necessary. **Approval of your refill may take up to three business days** so please be courteous and do not wait to call. If you use a mail order pharmacy, please contact us **fourteen (14) days** before your medication is due to run out. Your pharmacy may participate in automatic refill renewal requests which are sent to us via fax. We will not fill any medication refill requests submitted by a pharmacy. Refills must be requested by the patient or patient's representative.

MEDICATION REFILL TIMEFRAMES

Medication refills will only be addressed during regular office hours as listed below:

Monday-Thursday

Requests must be received between the hours of 9:00AM and 4:00PM.

Requests made after 4:00PM will be processed the following business day.

Friday

All requests must be received prior to 12:00PM

Any request received after 12:00PM will be processed the following Monday, or the next business day if that Monday is a holiday.

All requests received over the weekend will be processed the following Monday, or the next business day if that Monday is a holiday.

To effectively process your prescription refill request, we will need the following information:

- Date that the request is made
- Spell your first and last name
- Your date of birth
- Spell the name of the medication, dosage, and how you are currently taking the medication
- Date that the current prescription will run out
- Name and location of your pharmacy
- Contact information for follow up on the request

REFILL REQUESTS AFTER A MISSED APPOINTMENT

Patients who miss a follow-up appointment will only receive enough of a particular medication, that is identified as needed in the applicable prescription, to cover the patient until their next scheduled appointment. Repeated no shows or cancellations will result in a denial of refills. **You must have an appointment scheduled on your medical provider's calendar for refills to be processed. All prescriptions require a follow-up appointment every 3 to 6 months.**

Please be aware that there may be charges, co-pays, or other out-of-pocket costs from your insurance and or Pharmacy you must pay as a result of not receiving a full supply of medication

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**CONTROLLED MEDICATIONS AND MEDICATIONS PRESCRIBED BY OTHER PHYSICIANS**

Refills for controlled medications will only be processed during follow-up appointments.

Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers.

NEW SYMPTOMS, QUESTIONS, AND REQUESTING CHANGES TO MEDICATION

If you have any questions regarding your medication, please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed, please contact us immediately to schedule a follow-up visit with your provider.

New symptoms or events require a clinic appointment. Your provider will not diagnose or treat over the phone.

PRIOR AUTHORIZATION FOR MEDICATION

Some medications require prior authorization. Depending on your insurance this process may involve several steps for both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.

By signing below, I understand, agree and accept the policy listed above. Failure to comply may result in termination of prescriptive medications.

Patient Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____