Midtown Office
1918 Randolph Road
Suite 600
Charlotte, NC 28207

Arthritis & Osteoporosis
Consultants of the Carolinas

Phone: 704.342.0252 • Fax: 980.533.7801
www.AOCC.MD

Ballantyne Office
7810 Ballantyne Commons Parkway
Suite 300
Charlotte, NC 28277

Dear ________________,

WELCOME!

Thank you for entrusting us with your care.
You are scheduled for an appointment with the nurse at ______________ on ______________ for preparation of your consultation with ________________ at the

_______ Ballantyne location: 7810 Ballantyne Commons Parkway Suite 300 Charlotte, NC 28277

_______ Midtown location: 1918 Randolph Road Suite 600 Charlotte, NC 28207

If you called to schedule your own appointment please check with your referring physician to ensure all appropriate medical records (lab results, bone density tests and x-rays) have been forwarded. Records are critical for continuation of care.

We look forward to seeing you. You may have opted to complete the new patient paperwork online. If so, you will receive an email 5 days prior to your appointment date to complete the paperwork. This must be completed prior to your appointment date. If you chose to complete forms on paper, we have enclosed the new patient forms for you to complete prior to your appointment. Please give these forms to our front desk staff when you arrive for your appointment.

All patients must bring your insurance cards, copay, photo ID and a current list of your medications to your appointment.

Please notify us at least 48 hours in advance if you cannot keep your appointment. It will be your responsibility to pay an $100.00 late cancellation fee if this is not done.

If you have any questions, please call 704-342-0252, extension 1701 or 1702.

Arthritis & Osteoporosis
Consultants of the Carolinas

To maintain organization throughout the office and to guarantee that your needs are met, please review our

Office Policies

Confirmation & Cancelation of Appointments Protocol

- You will receive an appointment reminder 24-48 hours prior to your appointment date. If you need to cancel or reschedule your appointment, you MUST CALL AT LEAST ***48 hours prior***.
- A $100 administrative fee will be charged for missed New Patient appointments. This fee is not covered by your medical insurance.
- You must arrive 30 minutes prior to your appointment time to allow for any paperwork and registration process.
- For our Randolph Road location, please allow extra time to navigate from the parking deck to our office.
- If you do not show for your new patient appointment or fail to cancel within 48 hours of your appointment, you may not be able to reschedule.
- Copays are due at the time of service.

Your cooperation with these guidelines will help our practice provide the best possible care. Thank you for your understanding and we look forward to serving your healthcare needs!

Midtown Office
1918 Randolph Road
Suite 600
Charlotte, NC 28207

Arthritis & Osteoporosis Consultants of the Carolinas

Ballantyne Office
7810 Ballantyne Commons Parkway
Suite 300
Charlotte, NC 28277

New Patient Form

Name______________________________ Date of Birth ____________
Name of referring physician ____________________ Primary Care Physician ________________
Gender at Birth ________________ Approximate Last Visit ________________
Current Gender Identity ______________

Reason for your visit today ____

Current medications: ____

Name of Practitioners seen in last 5 years (Names of doctors)

ALLERGIES (medication and reaction)______________________________

When did your symptoms begin- approximately ____________________

Please describe your Rheumatologic symptoms ____________________________

Prior Diagnosis of your symptoms ____________________

Previous Treatments for this problem (physical therapy, medications etc.)

Pharmacy Information

Past Medical History: (check if you have had)

☐ Alcoholism ☐ Cancer ☐ Hepatitis ☐ Diverticulitis ☐ Systemic lupus
☐ Anemia ☐ COPD ☐ High blood pressure ☐ Tuberculosis ☐ Rheumatoid Arthritis
☐ Arthritis ☐ Depression ☐ Heart attack ☐ Shingles ☐ Psoriasis
☐ Asthma ☐ Diabetes ☐ Osteoporosis ☐ Stomach Ulcer ☐ Gout
☐ Blood Clots ☐ Heartburn ☐ Thyroid trouble ☐ Fracture
☐ Other- Please list below

____

Past Surgical History:

Year	Hospitalization or Surgery	Year	Hospitalization or Surgery
______	______________________	_____	______________________
______	______________________	_____	______________________
______	______________________	_____	______________________

Obstetrical history: Age at first period _____Age of last period (menopause) ____Hysterectomy ☐ Yes ☐ No Ovaries Removed? ☐ Yes ☐ No
# of Pregnancies ________ # of abortions _____ # of miscarriages______ # of living children ____

Family History:

At any point has a blood relative had any of the following: (check those that apply)

	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Child
Alcoholism						
Arthritis						
Bleeding disorder						
Cancer						
Heart Attack						
Diabetes						
High Cholesterol						
High Blood pressure						
Stroke						
Osteoporosis						
Ankylosing Spondylitis						
Behcet's						
Crohn's Disease/ Ulcerative Colitis						
Lupus						
Psoriasis/ psoriatic arthritis						
Hip Fracture						
Other (list)						

Mother living ? ☐ Yes ☐ No Cause of death? ______________________
Father living ? ☐ Yes ☐ No Cause of death? ______________________

Social History:

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Occupation/ Prior jobs ____

Who lives at home with you? ____

Habits:
Have you ever smoked? ☐ Yes ☐ No How many packs/ day? ____ How many years? __ Quit? __ years
Have you ever used a vaping device? ☐ Yes ☐ No With Nicotine? ☐ Yes ☐ No

Any other tobacco use? ______________
Do you drink alcohol ☐ Yes ☐ No How often? _____ How much? _______
Do you exercise? ☐ Yes ☐ No How often? _____ How much? _____
Are you at risk of HIV infection? ☐ Yes ☐ No

Yes	No	Check each Item	Yes	No	Check each Item	Yes	No	Check Each Item	Yes	No	Check Each Item
		GENERAL			**HEART**			**METABOLIC**			**SKIN**
		Chills			Chest pain			Cold intolerance			Bruising
		Fatigue			Leg pain with walking			Hair loss			Discoid rash
		Fever			Lower extremity swelling			Heat intolerance			Hives
		Night Sweats			Fingers turning white, blue or red			Excess hair growth			Nail changes
		Weight gain			Fast heart rate			Hot flashes			Sensitivity to the sun
		Weight Loss			Varicose veins			Increased thirst			Psoriasis
		Eyes, Ears and mouth			**GASTROINTESTINAL**			**NEUROLOGIC**			Rash
		Vision changes			Abdominal pain			Confusion/ disorientation			Scalp tenderness
		Vision loss			Bloating			Dizziness			**Musculoskeletal**
		Dental cavities			Blood in stools			Extremity numbness			Back pain
		Double vision			Constipation			Extremity weakness			Height loss
		Dry mouth			Diarrhea			Changes in gait			Joint pain
		Dry eyes			Difficulty swallowing			Headache			Joint swelling
		Nose bleeds			Heartburn			Memory loss			Joint tenderness
		Hearing loss			Loss of appetite			Seizures			Low back pain
		Hoarseness			Nausea			Fainting			Morning stiffness
		Jaw pain			Vomiting			Tingling			Muscle cramping
		Nose sores			**GENITOURINARY**			Tremors			Muscle weakness
		Mouth sores			Genital ulcers			**PSYCHIATRIC**			Muscle pain
		Red eye			Blood in urine			Anxiety			Neck pain
		Sinus infections			Kidney stones			Depression			Neck stiffness
		RESPIRATORY			Urination at night			Worry			**BLOOD**
		Sleep apnea			Pelvic pain			Insomnia			Easy bruising
		Cough			Scrotum or testicular pain			**IMMUNOLOGIC**			Easy bleeding
		Frequent respiratory infections			Urinary frequency			Allergic Rhinitis			Enlarged lymph nodes
		Coughing up blood			Urinary incontinence			Frequent infections			
		Chest pain with deep breaths						Food allergies			
		Shortness of breath									

Please check any symptoms that you have had in the past (outside of an acute infection)

Other (Please list) ____

____

Arthritis & Osteoporosis Consultants of the Carolinas

HIPAA Authorization for Release of Information

Name of Patient____________________ Date of Birth__________

Arthritis and Osteoporosis Consultants of the Carolinas is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/xrays ☐ Other
☐ Other Person (s) (provide name and phone number)(i.e. Spouse, Friend, Family etc.) ☐ __________ ☐ __________ ☐ __________	☐ Financial ☐ Medical as follow(s)__________
☐ Email Communication - Provide email address* __________ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical as follow(s)__________ ☐ Appointment reminders ☐ Breach notification
☐ Text communication - Provide cell number* __________ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder Other:__________

☐ **For email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately, I still elect to receive email and/or text communication as selected.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

____________________ Date__________

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

____

PATIENT INFORMATION / CONSENT TO TREAT

Date		Referring Dr	PCP
Patient Name		Date of Birth	Social Security #
Address		Gender (please circle) **M F**	Marital Status
City/State/Zip		Home Phone	Work Phone
Emergency Contact	Phone #	Relationship to Patient	
Responsible Party	Phone #	Relationship to Patient	
Responsible Party Address		Date of Birth	
		Email:	

PRIMARY INSURANCE

Insurance______________ Subscriber Name______________ Subscriber SSN______________

Subscriber Date of Birth ______________ Subscriber ID # ______________ Patient Relationship to Subscriber ______________

Subscriber Group # ______________ Subscriber Employer/Group Name______________

SECONDARY INSURANCE

Insurance______________ Subscriber Name______________ Subscriber SSN______________

Subscriber Date of Birth ______________ Subscriber ID # ______________ Patient Relationship to Subscriber ______________

Subscriber Group # ______________ Subscriber Employer/Group Name______________

TO BE COMPLETED IN OFFICE

FINANCIAL RESPONSIBILITY

- I understand that it is my responsibility to verify my benefits in regard to AOCC with my insurance company.
- I understand it is my responsibility to obtain the necessary approval(s), authorization(s), and/or referral(s) from my insurance company.
- I acknowledge that if my insurance or HMO/PPO network does not participate or contract with AOCC I am responsible for the balance of services rendered.
- I understand that I am financially responsible for any non-covered services and/or if my insurance does not pay.
- I understand that filing of insurance is a courtesy only, not a guarantee of payment; I am responsible for my bill.
- If covered by Medicare or Medicaid, I certify that the information I provide for payment under Titles V, XVII, and/or the Social Security Act is correct.

CONSENT TO TREAT

I am asking for care and I agree to be offered all necessary diagnostic tests, examinations, surgical, and medical treatments prescribed by the treating physician(s). No one has given me a guarantee of how these examinations and treatments will affect me. or my condition.

Signature of Patient / Responsible Party: ______________________________ Date: ______________

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

I acknowledge that a copy of the NPP has been made available to me. I understand this NPP is subject to change at any time. I may obtain a revised copy of the NPP by request.

Signature of Patient / Responsible Party: ______________________________ Date: ______________

FOR STAFF USE ONLY

Patient declined to sign after NPP was made available.

Staff Signature: ______________________________ Date: ______________

ARTHRITIS AND OSTEOPOROSIS CONSULTANTS OF THE CAROLINAS

OUR FINANCIAL POLICY

Thank you for choosing AOCC as your health care provider. We are committed to providing quality medical care, including doing everything we can to ease your financial and insurance worries so that you can concentrate on getting better. Please understand that payment of your bill is considered part of your care plan. We ask that you read and sign this Financial Policy prior to receiving any treatment or recommendations for care and let us know if you have any questions.

- We will verify your insurance coverage at every visit. It is your responsibility to supply all current insurance cards so that we can accurately determine your insurance coverage. Failure to provide accurate insurance information in a timely manner may result in claim denials and higher out of pocket costs.
- A No Show Fee of $25.00 will be charged to your account for not cancelling a follow up appointment at least 24 hours in advance.
- Consult and New Patient appointments must be cancelled at least two business days prior to the appointment. Failure to do so will result in your account being charged a $100 No Show/Late Cancellation fee that will need to be paid prior to rescheduling your appointment.
- Full payment, including deductibles, coinsurance and copays are due at the time of service.
- We offer self pay rate discounts for all bills paid on the date the services are rendered. Failure to pay the full balance due on the date services are rendered will result in being charged full price for those services.
- We offer a variety of payment plan options for those patients who cannot afford to pay at the time of service. *Please note that payment plans have a minimal monthly requirement and must be set up by automatic draft.
- We accept cash, checks, and all major credit and debit cards. A $25.00 fee will be assessed for all returned checks.
- It is your responsibility to know and understand the terms of your insurance policy and your coverage limitations including network participation, deductibles, coinsurance and copays.
- When labs, x-rays, or other tests are ordered by AOCC, you are responsible for knowing where your insurance carrier authorizes you to receive these services. AOCC will not be responsible for any bill you receive for services performed by an out of network provider.

AOCC will submit claims to your insurance carrier(s) on your behalf. Please be aware that insurance plans vary considerably so we cannot guarantee what part of our services will or will not be covered by your particular insurance plan. If you are unsure if certain services will be covered by your insurance carrier, please contact the insurance company directly for clarification of coverage prior to having services rendered.

I hereby authorize AOCC to release any medical information to my insurance carrier required for claims processing and to issue any insurance payments directly to AOCC for all services rendered. I recognize and accept financial responsibility for services rendered regardless of insurance coverage. This financial responsibility includes, but is not limited to, coinsurance, copays, deductible and any noncovered services.

I________________________________ have read, understand, and agree to the Financial Policy as outlined above.
(Please Print)

____ ____________________

Signature of Patient or Responsible Party Date

ARTHRITIS AND OSTEOPOROSIS CONSULTANTS OF THE CAROLINAS
NOTICE OF NONDISCRIMINATION

Arthritis and Osteoporosis Consultants of the Carolinas ("AOCC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AOCC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

AOCC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages
- If you need these services, contact Tracy Capers

If you believe that AOCC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Tracy Capers, AOCC Civil Rights Coordinator, 1918 Randolph Rd. Suite 600, Charlotte NC 28207, 704-342-0252 , civilrights@aocc.md. You can file a grievance in person or by mail, or email. If you need help filing a grievance, Tracy Capers, AOCC Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Signature: ______________________________

Name (Print): ______________________________

Date: ________________