STERLING GROUP
RHEUMATOLOGY

SEDRICK BRADLEY, M.D.

Please complete this paperwork and return it to our office for review. All questions must be answered accurately. Incomplete paperwork will not be accepted. Please write your name at the top of each page. After it has been reviewed we will contact you to schedule your New Patient appointment. Please arrive 15 minutes early for your New Patient appointment, if you this time we will need to scan a copy of your insurance card(s), a picture ID, and your co-pay or payment. Thank you.

Fax: (229) 890-7053

Name :_____

Address:_____ Apt #:_____

City:_____ State:_____ Zip:_____

Home Phone Number:_____ Cell Phone Number: _____

Work Phone Number : _____ E-Mail Address: _____

Birth Date:_____ SSN:_____

Sex:_____ Marital Status:_____ Referred By:_____

Race: _____ Ethnicity: _____ Language used most: _____

Patient Employee Information

Employer:_____ Occupation:_____

Address:_____ Phone:_____

City:_____ State:_____ Zip:_____

Emergency Contact

Name:_____ Relationship:_____

Address:_____ Home Phone:_____

City:_____ State:_____ Zip:_____ Work Phone:_____

Primary Insurance Information **(You MUST present your Insurance card(s) and a State issued picture ID at visit)**

Insurance Company:_____

Group Name/Number:_____ ID #:_____

Insured Name:_____ Relationship:_____ Birthdate:_____

Guarantors Name: _____ SSN: _____ Birthdate: _____

For a Minor, please list parent's name _____ Parent's Social Security # _____

Secondary Insurance Information Parent's DOB: _____

Insurance Company:_____

Group Name/Number:_____ ID #:_____

Insured Name:_____ Relationship:_____ Birthdate:_____

Patient Medical History

Please list **any allergies** and type of reaction:_____
_____

Do you take daily medications including non-prescription medicine? □Yes □ No If you checked yes, please list all medications on the last page of this paperwork.

Preferred Pharmacy: _____

Do you use tobacco or smokeless tobacco products? □Yes □ No If Yes, # of packs per day ____ # of years _____

Are you a former smoker? Yes □ No If Yes, # of packs per day ____ # of years _____

Do you drink alcoholic beverages? □Yes □ No What type of alcohol: (CIRCLE)

Beer How many _____ per day _____ per week
Wine How many _____ per day _____ per week
Hard liquor How many _____ per day _____ per week

Do you use controlled substances? □Yes □ No Drug(s) used: _____
How often: _____ per day _____ per week _____ per month
How long have you been using controlled substances? (CIRCLE) #_____ of Days / Weeks / Months / Years

If you have a past history of substance abuse,
How long have you been sober? (CIRCLE) #_____ of Days / Weeks / Months / Years
Have you ever participated in an Inpatient or Outpatient treatment program? When? _____

Past Medical History

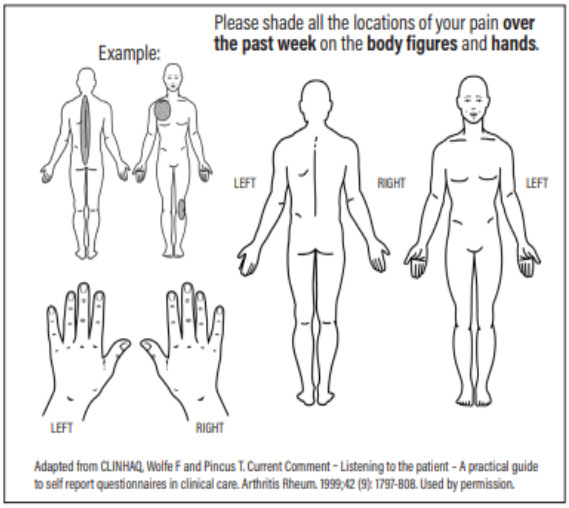
Do you have or have you had any of the following?

High Blood Pressure	□Yes □ No	Cancer	□Yes □ No
Heart Attack	□Yes □ No	Arthritis	□Yes □ No
Rheumatic Fever	□Yes □ No	Joint Replacement or Implant	□Yes □ No
Swollen Ankles	□Yes □ No	Hepatitis/Jaundice	□Yes □ No
Fainting /Seizures	□Yes □ No	Sexually Transmitted Disease	□Yes □ No
Asthma	□Yes □ No	Stomach Troubles/Ulcers	□Yes □ No
Low Blood Pressure	□Yes □ No	Epilepsy/Convulsions	□ Yes □ No
Easily Winded	□Yes □ No	Anxiety / Depression	□Yes □ No
Leukemia	□Yes □ No	Stroke	□Yes □ No
Diabetes	□Yes □ No	Hay Fever/Allergies	□Yes □ No
Kidney Diseases	□Yes □ No	Tuberculosis	□Yes □ No
AIDS/HIV	□Yes □ No	Radiation Therapy	□Yes □ No
Thyroid Problem	□Yes □ No	Glaucoma	□Yes □ No
Heart Disease	□Yes □ No	Recent Weight Loss	□Yes □ No
Cardiac Pacemaker	□Yes □ No	Liver Disease	□Yes □ No
Heart Murmur	□Yes □ No	Heart Trouble	□Yes □ No
Angina	□Yes □ No	Respiratory Problems	□Yes □ No
Frequently Tired	□Yes □ No	Mitral Valve Prolapse	□Yes □ No
Anemia	□Yes □ No	Emphysema	□ Yes □ No
Elevated Cholesterol or Triglycerides	Yes No	Other_____	□Yes □ No

Briefly describe your present symptoms: _____
_____
_____
_____
_____
_____

Date Symptoms began *(approximate)*:_____
Diagnosis:_____
_____

Previous treatment for this problem *(include physical therapy, surgery and injections; medications to be listed later)*:
_____
_____
_____
_____
_____



Rheumatologic (Arthritis) History

At any time have your or a blood relative had any of the following? (check if "yes")

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood Arthritis			Osteoporosis	

Other arthritis conditions:_____

Activities of Daily Living

Do you have stairs to climb? Yes No *If yes, how many?*_____
How many people in household?_____Relationship and age of each_____
Who does most of the house work?_____Who does most of the shopping?_____
Who does most of the yard work?_____

Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects?			
Walking?			
Climbing?			
Descending stairs?			
Sitting Down?			
Getting up from chair?			
Dressing yourself?			
Going to sleep?			
Staying asleep due to pain?			
Obtaining restful sleep?			
Bathing?			
Eating?			
Working?			
Getting along with family members?			
Engaging in leisure time activities?			
With morning stiffness?			
Do you use a cane, crutches, walker, or wheelchair? *(circle one)*			

Please list any persons and relationships that test results or appointments can be discussed with: If you do not list anyone, our office will not be able to discuss or release medical information to anyone other than you or the minor patient's parent/guardian: Emergency contact's names needs to be written in this area or medical information will not be released.

_____
_____

Where may we leave appointment reminders? **(CIRCLE all that applies)** Home number / Answering Machine/ Work number / Cell Phone / Voicemail / Text Message / other Mobile devices / E-Mail / U.S Mail - Message will state the patient's name, the doctor's name, the appointment date time and our office number.

Family Medical History

	Living/Deceased	Medical problem(s)
Mother	_____	_____
Father	_____	_____
Maternal Grandmother	_____	_____
Maternal Grandfather	_____	_____
Paternal Grandmother	_____	_____
Paternal Grandfather	_____	_____
Siblings # _____	_____	_____
Children # _____	_____	_____

_____

Past Surgical History

Year of Surgery	Description of Procedure
_____	_____
_____	_____
_____	_____
_____	_____

Authorization and Release

I certify that I have accurately answered the above questions to the best of my knowledge. I authorize the physician to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the physician any monies due. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my minor child's behalf if my account is self pay or if the insurance company has reported that I am responsible for the full amount or a portion of the charged amount.

_____ _____

Signature of Patient Date

Payment Arrangements

I understand that if I do not pay my account balance in full or make payment arrangements within 90 days after the original date of service, I will be turned over to the account management agency used by Sterling Group Rheumatology. I understand that I must complete a Payment Arrangement Form at Sterling Group Rheumatology prior to the 90 days and continue to make the monthly payments I have agreed to pay on time each month to prevent being turned over to the account management agency. I also understand that I may contact the office if I have questions regarding my account.

_____ _____

Signature of Patient Date

Updating Information

I understand that it is my responsibility to inform the office of changes or additions to my information. This includes but is not limited to my contact information, insurance information, emergency contact(s), person's we may release health information to, where our staff may leave appointment reminders, allergies, hospitalizations, surgeries, specialist visits, medical information, family history, pharmacy you are using and any other changes or additions that may affect my medical care.

_____ _____

Signature of Patient Date

Canceling and No Showing Scheduled Appointments

I understand that reminder phone calls are done as a courtesy by the clinic staff and that it is my responsibility to remember my future scheduled appointments. I also understand that it is Sterling Group Rheumatology's Policy that I am responsible to call more than 24 hours in advance of my scheduled appointment to cancel or reschedule my appointment. I also understand that if I cancel three or more appointments or no show two or more appointments that it is up to my provider whether or not they will continue to see me as a patient or dismiss me from the clinic. *And lastly I understand that if I am 15 minutes late for my appointment that I will be required to reschedule for a later date.*

_____ _____

Signature of Patient Date

Notice and Acknowledgement of Privacy Practices - HIPPA

The Office for Civil Rights enforces the HIPAA Privacy Rule, which protects the privacy of individually identifiable health information; the HIPAA Security Rule, which sets national standards for the security of electronic protected health information; and the confidentiality provisions of the Patient Safety Rule, which protect identifiable information being used to analyze patient safety events and improve patient safety.

A copy of Sterling Group Rheumatology Notice of Privacy Practices is located in the front lobby and you may ask the receptionist for a copy prior to signing the acknowledgement statement.

Acknowledgement:

I acknowledge that I have read the Notice of Privacy Practices.

_____ _____

Patient or Personal Representative Signature Date

If Personal Representative's Signature appears above, please describe the Personal Representative's relationship to the patient.

_____

Have you completed a Release of Medical Information Form so we will be able to request a copy of your medical information from your medical provider? □Yes □ No

If your answer to the previous question was no, we will have you complete a Release of Medical Information Form at your first appointment. Having a copy of all of your medical information will help our providers to better care for you and your medical needs.

NOTICE TO PATIENT ABOUT PAIN MEDICATIONS

Our physician's do not routinely prescribe pain medications or narcotics. If your medical conditions require long term pain medications our physician's may find it necessary to refer you to a physician or Pain Management Clinic that will help develop a care plan for you and to manage and monitor your pain medications. If a provider chooses to provide a patient with a controlled medication a medication contract will be required. Patient's prescribed controlled substances will be required to submit to urine drug screening when requested by the physician/provider.

Signature of Patient:_____ Date: _____

NOTICE TO PATIENT ABOUT MEDICATION SAMPLES

Our office does not accept medication samples for patient distribution. Our office does accept discount vouchers from medicine companies. When available our physician's will give our patient's a medicine voucher. These vouchers are not available for all medications and may have certain criteria set forth by the medication company. Our office is not responsible if there are problems experienced at the pharmacy with the use of these vouchers. Please contact your pharmacy if you have questions about vouchers.

Signature of Patient:_____ Date: _____

AUTHORIZATION TO TREAT PATIENT

I, _____, hereby authorize that the doctors and staff at Sterling Group Rheumatology, LLC have my permission to treat me or my minor child.

Signature of Patient:_____ Date: _____

Medication List:

You must fill this out if you take any medications. This list needs to include all prescription medicines and over-the-counter medications and vitamin supplements. Please bring your medications with you to your appointment. Thank you.

(Examples of over-the-counter medications: Advil, Tylenol, Multi-Vitamins, Iron, St. John's Wort, etc.)

Name of Medication:	Dosage / Strength	How many times do you take this medicine each day?

Point of Service Collection Policy

Updated: March 2013

Participating Provider Plans

- Our billing department will file your insurance for services rendered.
- The patient is responsible for presenting all current available insurance cards at the time of service.
- The patient is responsible for all co-pays, deductibles, co-insurance at the time of service. Our office utilizes an insurance program with up to the minute insurance information for most insurance companies; this program is referred to daily to confirm patient co-pays, deductibles, and co-insurance amounts which are due.
- The patient is responsible for knowing their policy, coverage, deductible, co-insurance, etc.
- The patient is responsible for contacting their insurance carrier with eligibility changes and will be responsible for informing our clinic of changes and terminations of coverage.
- If the patient (new patient or established patient) is unable to pay prior to services being rendered and they are not being seen for an urgent or sick visit the patient will be asked to reschedule.
- At our clinic we are aware that at times a patient may be unable to pay the full amount of their visit. Minimal requirements for a new patient are $100.00 prior to services being rendered and $50 for an established patient prior to services being rendered. The remainder of the charges for that date of service will be billed to the patient and should be paid by the due date on their billing statement.

Non-Participating Provider Plans

- The patient is responsible for contacting their insurance carrier to verify that our clinic physician is in their insurance plans network.
- If our clinic is not within the patient's insurance network and the patient chooses to use our clinic, the patient will be responsible for their full balance at the time services are rendered unless other payment arrangements have been made.
- Our billing office will file the patient's insurance as a courtesy. If the insurance company sends payment to the clinic rather than to the patient, a refund will be issued.
- If the patient (new patient or established patient) is unable to pay prior to services being rendered and they are not being seen for an urgent or sick visit the patient will be asked to reschedule.
- At our clinic we are aware that at times a patient may be unable to pay the full amount of their visit. Minimal requirements for a new patient are $100.00 prior to services being rendered and $50 for an established patient prior to services being rendered. The remainder of the charges for that date of service will be billed to the patient and should be paid by the due date on their billing statement.

Self-Pay Patients

- Patients with no insurance coverage or inactive coverage will be considered self-pay.

- Self-pay patients will sign this form indicating that they have NO health insurance coverage.
- Self-pay patients are responsible for the full balance at the time services are rendered unless other arrangements have been made.
- Self-pay patients may apply for the clinics discount program. This program is a sliding scale discount program based on the households size and total income and requires an application be completed and financial documentation be provided for the application to be considered. Please ask our clinic staff for an application.
- Patients approved for the clinics discount program are required to pay their percentage prior to services being rendered.
- If the patient (new patient or established patient) is unable to pay prior to services being rendered and they are not being seen for an urgent or sick visit the patient will be asked to reschedule.
- At our clinic we are aware that at times a patient may be unable to pay the full amount of their visit. Minimal requirements for a new patient are $100.00 prior to services being rendered and $50 for an established patient prior to services being rendered. The remainder of the charges for that date of service will be billed to the patient and should be paid by the due date on their billing statement.

Collections

- Patients with an account balance will receive a monthly statement and will need to pay the amount indicated by the due date unless other payment arrangements have been made with our clinic.
- All patients with an account balance will be required to complete a monthly payment agreement form and commit to pay on their account each month. The monthly amount will be figured by dividing the account balance by 12 to resolve the patient's outstanding balance within 12 months. Example: Account balance is $120.00 ÷ 12 = $10.00 per month. Patients are encouraged to pay a higher amount each month to satisfy this debt in the shortest amount of time.
- Accounts that do not receive a payment within 90 days of the date of service will receive a collection notice.
- All unpaid balances may be sent to an outside collection agency. This may result in a negative credit rating and constitute dismissal from the clinic.

If you have questions regarding this policy, please ask to speak to one of our front office staff members who will be glad to help answer your questions.

Point of Service Collection Policy

I have received a copy of the Point of Service Collection Policy for Sterling Group Rheumatology, LLC and agree to abide by this policy. I understand that if I have any questions I may call the front office staff at the clinic or stop by and speak to a Certified Patient Account Representative or a billing professional.

☐ I do not have health insurance coverage

☐ I have health insurance coverage with _____

(Insurance company name)

_____ _____

Signature of Patient, Parent/Guardian Date

Updated: 07/18/2018