Rheumatology & Dermatology
Associates, PC
8143 Walnut Grove Road
Cordova, TN 38018-7270

Phone: (901)753-0168
Fax: (901)754-4946

George R. Woodbury Jr., MD
Dermatology

Linda Myers, MD
Pediatric Rheumatology

Things you must bring to your appointment:

- Government issued photo ID
  - For minors: parent/legal guardian's photo ID required
- Insurance card
- New patient paperwork
- Copay, deductible, co-insurance payment (this will be collected up front)
- **You MUST have your insurance card with you at the time of service. In cases where the insurance company disputes the claim, patients are expected to pay their bills in a timely manner.**

For minors:

- All minors **must** be accompanied by their parent or legal guardian. If not the biological parent, we require a copy of legal guardianship papers.

Notice:

- We collect payment for all services up front.
- For check or credit/debit card payments, the account holder **must** be present to use his/her account.
- Patients who are not minors will be required to supply their social security numbers for billing purposes.
- **Effective June 1, 2012, there will be a $25.00 fee assessed to all patients who cancel or no show without 24 hours' notice.**

RHEUMATOLOGY & DERMATOLOGY Associates, PC

Patient Information

Legal Name: (First, Middle, Last)			Preferred Name:	
Address:	City:		State:	Zip:
Phone Number:	E-mail:		Would you like to receive our newsletter? ☐ Y ☐ N	
Date of Birth:	Social Security Number:		Marital Status: ☐ Married ☐ Single ☐ Other	Sex:

Employment/School Information

Employed: ☐ Full Time ☐ Part Time Student: ☐ Full Time ☐ Part Time	Employer/School:		Position:	
Employer/School Address:	City:	State:	Zip:	Phone Number:

Emergency Information

Person to Contact in Case of Emergency:			Relationship to Patient:	
Address:	City:	State:	Zip:	Phone Number:

Responsible Party for Minors

If Patient is a Minor, Responsible Party Name PRESENT WITH CHILD:			Relationship to Patient:	
Address:	City:	State:	Zip:	Phone Number:
Date of Birth:	Social Security Number:			

Referral Information

How were you referred?
☐ Our Website ☐ Family ☐ Friend ☐ Google ☐ Other (please list):

Primary Insurance

Policy Holder's Name: (As Appears on Card)	Patient's Relationship to Policy Holder:	Policy Holder's DOB:	Policy Holder's Sex:	
Policy Holder's Address:	City:	State:	Zip:	Phone Number:
Work Phone:	Employer's Name:	Policy Holder's SS#:	Individual ID Number:	Group Number:
Insurance Company Name & Address:				

Secondary Insurance (if Applicable)

Policy Holder's Name: (As Appears on Card)	Patient's Relationship to Policy Holder:	Policy Holder's DOB:	Policy Holder's Sex:	
Policy Holder's Address:	City:	State:	Zip:	Phone Number:
Work Phone:	Employer's Name:	Policy Holder's SS#:	Individual ID Number:	Group Number:
Insurance Company Name & Address:				

Signature

***By signing this, I agree that the information above is true to the best of my knowledge.**

Patient/Guardian Signature:	Date:

RHEUMATOLOGY & DERMATOLOGY Associates, PC

AUTHORIZATION TO DISCUSS MY CARE AND/OR ACCOUNT STATUS WITH ANOTHER PERSON

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits the office from discussing a patient's care and/or account information with any other person than the patient or the guardian of a minor and in some cases the legal guardian of an adult under such care. For this reason, your permission is needed if you want your medical and/or account information to be disclosed to another party. Once such permission is given, this permission will remain in effect until revoked in writing by the patient or by the guardian of a minor patient.

I give Rheumatology & Dermatology Associates, PC permission to discuss my medical care and/or account information with the following person(s):

Name	Relationship	Medical Info	Account Info
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No

OFFICE FEES DISCLOSURE

A fee of $25.00 will be charged by Rheumatology & Dermatology Associates for any physician appointment that is missed without notice and for physician appointments that are cancelled with less than 24 business hours' notice.

Payment is expected when services are rendered. You as the patient or guardian or guarantor are ultimately responsible for any charges, with or without insurance. By signing this agreement, you authorize the release of medical information to process any and all insurance claims and authorize all such payments to the physician for services rendered.

Should our office need to take any actions to collect an amount due, you agree to pay, in addition to the services, a collection fee of up to 33.3% of the outstanding balance and any incurred bank fees (such as return item fees charged on our office accounts), or $25.00, whichever is greater, which will be added to your account and shall become part of the Total Amount Due. In addition, you shall be responsible for any other reasonable collection fees, including, but not limited to, attorney fees and court and filing fees required to collect the outstanding amount. You also agree should there be any refunds due to you while an outstanding balance is owed to us by you, our office may take such amount and apply it to the outstanding balance.

You agree, that in order for us to service your account or to collect any amounts you may owe, we and any entity our office may use to collect such amount owed, may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We and our collection agencies or attorneys used to collect any amounts owed may also contact you via phone, text message, or e-mail, using any information you have provided. You agree to accept any service of process that may be available pursuant to applicable court rules. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I acknowledge that I have been informed of the Office Fees of Rheumatology & Dermatology Associates, P.C. disclosed above.

I acknowledge that I have had the opportunity to read Rheumatology & Dermatology Associate's Privacy Practices if I choose to do so.

Patient Name (Print): _____

Patient/Guardian Signature: _____

Date: _____

RHEUMATOLOGY & DERMATOLOGY Associates, PC

Name: _____ Date of Birth: _____

Occupation: _____ Did anyone come with you today? _____

Briefly describe why you are here today: _____

_____

When did symptoms begin? _____ Primary Physician: _____

What (if any) have you used to treat this before? _____

Cigarettes or tobacco? ☐ Yes ☐ No If yes, how much? _____ Would you like help quitting? ☐ Yes ☐ No

Drink alcohol? ☐ Yes ☐ No If yes, how much? _____ Children? ☐ Yes ☐ No Ages: _____

Are you or your partner: Pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Pregnancy prevention type: _____

Medications: *Please list all medications you currently take. Attach a list if you need more space.*

Medicine Name	Strength & How Often	When Started	Prescribing Doctor

Drug Allergies & Reactions:	Operations (with years):

What is your height? _____ Are you trying to lose weight? _____ gain weight? _____

When was your last: Pneumonia shot (pheumovax)? _____ Flu shot? _____

If applicable, when was your last PAP smear? _____ Mammogram? _____

Personal/Family History: *Please check if you or a family member (FM) have ever had any of the following:*

	You	FM		You	FM		You	FM		You	FM
Goiter			Anemia			SLE (Lupus)			Rheumatoid Arthritis		
Stroke			Diabetes			Leukemia			Stomach Ulcers		
TB/HIV			Epilepsy			Pneumonia			Rheumatic Fever		
Cancer			Psoriasis			Bad Headaches			Nervous Breakdown		
Asthma			Jaundice			Heart Problems			Scleroderma		
Gout			Cataracts			Kidney Disease					

Other significant illness(es): _____

Please circle below to indicate how severe your pain has been.
How much pain have you had due to your condition in the past week?

0 (no pain)	1	2	3	4	5	6	7	8	9	10 (as bad as it could be)

Please circle below to indicate how well you are doing overall.
Consider all the ways in which illness and health conditions affect you.

0 (no pain)	1	2	3	4	5	6	7	8	9	10 (as bad as it could be)

Past Medications
Please check if you have ever taken any of these medicines.

Cortisone/Prednisone		Humira/Adalimumab	
Colcrys/Colchicine		Remicade/Infliximab	
Zyloprim/Allopurinol		Rituxin/Rituximab	
Uloric/Febuxostat		Cellcept/Mycophenolate	
Plaquenil/Hydroxychloronique		Orencia/Abatacept	
Methotrexate/Otrexup,Rasuvo		Kineret/Anakinra	
Imuran/Azathioprine		Simponi/Golimumab	
Cytoxan/Cyclophosphamide		Cimzia/Certolizumab	
Enbrel/Etanercept		Xeljanz/Tofacitinib	

Local Pharmacy: _____ **Phone Number:** _____

Address (w/ street): _____

IMPORTANT NOTICE/ACKNOWLEDGEMENT: I am aware that I may be requested to give a urine screen for monitoring of medication compliance. I am also aware that my name may be submitted to the Tennessee Controlled Substance Monitoring Database to check for "Doctor Shopping" (illegally obtaining controlled substances from more than one physician).

_____ _____

Patient/Guardian Signature Date