PENNSYLVANIA
RHEUMATOLOGY
ASSOCIATES, PC

822 Pine Street
Suite 3A
Philadelphia, PA 19107
T: 215-829-5358 F: 215-923-6442
parheumatologyassociates.com

Scheduled Date:

Scheduled Time:

With Dr:

Welcome to PA Rheumatology Associates, P.C. Our doctors, Alan L. Epstein, MD, David Chen, MD, and Andrew Kelly, DO, look forward to meeting with you and participating in your care. We have set aside an hour for your appointment, and because of this require 24 hours notice for all cancellations in order to avoid a fee ($75 for new patients and $35 for follow-ups).

Please plan to arrive promptly, leaving adequate time to park. There is meter parking on the street as well as parking within the hospital parking lot at 8th & Delancey Street. We do not validate for the parking lot, but the "Welcome Desk" in the main entrance of the hospital can assist you with validation.

**** Bring the following to your visit:**

1. Insurance Card
2. Prescription Card
3. Completed Forms (enclosed)

It is important for any medical reports, laboratory test results and/or x-ray reports be forwarded to this office prior to your appointment. All medical records can either be mailed or faxed to our office. We have enclosed a record release form if your doctor requires your signature to send us records. Please do not fax the enclosed forms back to us.

If we do not participate in your insurance plan, or you have no insurance, payment is due at the time of the visit. If your insurance plan requires a referral, please request it from your Primary Doctor's office at least 1 week prior to your visit with us. Our provider number for referrals from Aetna, Bravo/HealthSprings, or Keystone Health Plan East is 1801841739.

Any applicable co-pays are due at the time of your visit. The amount due is shown on your insurance card listed under "Specialist". If you have Healthspring, we do not accept Access. This means that you will have a copay in our office. We do accept Personal Choice "PennCare" co-pays. If your insurance does not have any separation between various doctors and simply states "Office Visit" or "OV", then that is the co-pay for specialists also.

*****If your Plan requires a referral, you will not be seen in this office without it*****

Driving directions can be found on the back of this page.

North

(From Wilkes Barre area) WILKES BARRE BLVD becomes PA-2022. Merge onto PA-309 S. PA-309 S becomes PA-115 S. Turn SLIGHT LEFT onto HILL CREST RD. Turn SLIGHT LEFT onto PA-115/BEAR CREEK BLVD. Merge onto I-476 S toward ALLENTOWN (Portions toll). Merge onto I-76 E via exit number 16 toward PHILADELPHIA. Merge onto VINE ST EXWY/I-676 E/US-30 E via exit number 344- on the left- toward CENTRAL PHILADELPHIA. Take the exit toward BROAD STREET/CENTRAL PHILA. Take the 15TH STREET ramp toward CENTRAL PHILA. Turn RIGHT onto N 15TH ST. Turn LEFT onto S PENN SQ. Turn RIGHT onto S BROAD ST/AVENUE OF THE ARTS/PA-611. Continue to follow S BROAD ST/PA-611. Turn LEFT onto PINE ST. End at 822 PINE ST PHILADELPHIA PA

South

(From Baltimore area) S HOWARD ST becomes I-395 S. Merge onto I-95 N toward NEW YORK (Portions toll). Merge onto I-495 N via exit number 5D toward PORT OF WILM/PHILADELPHIA. Merge onto I-95 N. Take the COLUMBUS BLVD exit- exit number 20- toward WASHINGTON AVE. Take the ramp toward WASHINGTON AVE/PENNS LANDING. Turn LEFT onto S COLUMBUS BLVD. Turn LEFT onto WASHINGTON AVE. Turn RIGHT onto S 5TH ST. Turn LEFT onto LOMBARD ST. Turn RIGHT onto S 9TH ST. Turn RIGHT onto PINE ST. End at 822 PINE ST PHILADELPHIA PA

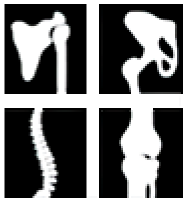
West

(From Harrisburg area) Start out going Southeast on N 7TH ST toward BASIN ST. N 7TH ST becomes WALNUT ST. Turn LEFT onto N FRONT ST. Merge onto I-83 N via the ramp- on the left- toward HERSHEY/AIRPORT. Merge onto I-283 S via exit number 46A toward AIRPORT/LANCASTER/I-76/PENNA TURNPIKE. I-283 S becomes HARRISBURG EAST INTERCHANGE (Portions toll). Merge onto I-76 E via the exit- on the left- toward PHILADELPHIA (Portions toll). Merge onto VINE ST EXWY/I-676 E/US-30 E via exit number 344- on the left- toward CENTRAL PHILADELPHIA. Take the exit toward BROAD STREET/CENTRAL PHILA. Take the 15TH STREET ramp toward CENTRAL PHILA. Turn RIGHT onto N 15TH ST. Turn LEFT onto S PENN SQ. Turn RIGHT onto S BROAD ST/AVENUE OF THE ARTS/PA-611. Continue to follow S BROAD ST/PA-611. Turn LEFT onto PINE ST. End at 822 PINE ST PHILADELPHIA PA

East

(From Atlantic City area) N ARKANSAS AVE becomes ATLANTIC CITY EXWY W (Portions toll). ATLANTIC CITY EXWY W becomes NJ-42 N. NJ-42 N becomes I-76 W. Merge onto I-676 N via exit number 2 toward CAMDEN/B FRANKLIN BR (Portions toll). Take the I-676 W/US-30 W exit on the left. Turn SLIGHT LEFT onto ramp. Turn LEFT onto N 8TH ST. Turn RIGHT onto LOMBARD ST. Turn RIGHT onto S 9TH ST. Turn RIGHT onto PINE ST. End at 822 PINE ST PHILADELPHIA PA

The above directions come from MapQuest



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Personal information *(please print)*

Name____Gender__________

Social Security Number________________________ Date of Birth____________________

Address____

City_____________________________ State__________ Zip Code_______________

Primary Phone Number______________________ Alternate phone____________________

Email ____

Language *(if other than English*) ____

Emergency Contact

Name____

Phone #_________________________ Relationship to patient______________________

Primary Care Doctor

Name __________________________

Address ________________________

Phone #_________________________

Fax#___________________________

Local Pharmacy

Name __________________________

Address ________________________

Phone #_________________________

Fax#___________________________

Referring Doctor

Specialty ________________________

Name __________________________

Address ________________________

Phone #_________________________

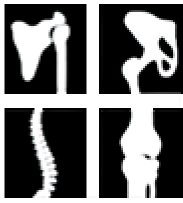
Fax#___________________________

Mail Order Pharmacy

Name __________________________

Phone #_________________________

Fax#___________________________



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Insurance information

Plan Name ____

ID# ____ Group/Account# ____________________________

Relationship to insured (self, spouse, other) ____

Employer ____

Primary Insurance Holder

Name ____ Date of Birth ___________________________

Secondary Insurance

Plan Name ____

ID# ____

Relationship to insured____

Prescription Plan

Plan Name ____

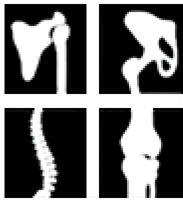
ID#____ Pre-auth phone #___________________________

For legal purposes, we require your signature at the bottom of the following statement:

"I request that payments by authorized insurances be made on my behalf to PA Rheumatology Associates, PC, for services furnished by their physicians. I understand that payment is due at the time of my visit if I do not have insurance. I understand that my co-pay (if applicable) is due at the time of my office visit and if it is not paid at that time, there will be an additional $30 fee. I understand that any deductibles are my responsibility. I also agree to give ***at least 24 hours*** *notice of all cancellations or else I will be charged an appropriate fee."*

Print Name: ____

Signature: ____ Date______________________



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Name ____ DOB _______________________

Personal Health History

Height:	**Weight:**

Medications including strength/ frequency *(example: Aspirin 81mg once a day, Calcium 500mg twice a day)*

1) ____ 6) ____

2) ____ 7) ____

3) ____ 8) ____

4) ____ 9) ____

5) ____ 10) ____

Past or current medical conditions *(Please circle all that apply)*

Diabetes	High blood pressure	Cholesterol	Heart Attack	Stroke	Acid reflux
Kidney disease	Liver disease	Hepatitis	HIV/AIDS	Hypothyroid (low thyroid)	Asthma
Emphysema/COPD	Anemia	Anxiety	Depression	Fibromyalgia	Osteoporosis/ Osteopenia
Rheumatoid Arthritis	Osteoarthritis	Lupus	Psoriasis	Psoriatic arthritis	Gout

Other Medical Problems Not Listed Above

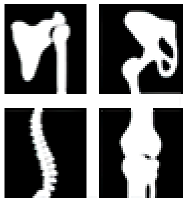
1) ____ 6) ____

2) ____ 7) ____

3) ____ 8) ____

4) ____ 9) ____

5) ____ 10) ____



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Name ________________________________ DOB ______________

Personal Health History (Continued)

Allergies to Medications and/or Foods and Type of Reaction *(example: penicillin – hives)*

1) ______________________ 6) ______________________

2) ______________________ 7) ______________________

3) ______________________ 8) ______________________

4) ______________________ 9) ______________________

5) ______________________ 10) ______________________

Previous Surgeries and Dates *(example: Gall bladder removal April 2010)*

1) ______________________ 6) ______________________

2) ______________________ 7) ______________________

3) ______________________ 8) ______________________

4) ______________________ 9) ______________________

5) ______________________ 10) ______________________

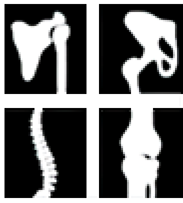
Family Health History

Mother: ______________________ DOB __________ Current Age ________

Father: ______________________ DOB __________ Current Age ________

Siblings: ____

Children: ____



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Name ____ DOB ____________________

Review of systems

Do you or have you had any of the following in the past six months *(Please circle all that apply)*

General	HEENT	Skin	Cardio/Pulmonary	Gastrointestinal
Fevers Weight loss Night sweats	Dry eyes Dry mouth Oral ulcers Vision problems Hearing loss Nasal congestion Nosebleeds	Rash Psoriasis Hair loss Nail changes	Chest Pain Palpitations Shortness of breath Cough Leg swelling	Heartburn Ulcers Abdominal pain Nausea Vomiting Diarrhea Constipation Blood in the stool
Genitourinary	**Neurological**	**Musculoskeletal**	**Psychiatric**	**Hematological**
Pain with urination Incontinence Blood in urine STDs Miscarriages	Numbness Tingling Weakness Headache Migraines Seizures	Joint pain Joint swelling Muscle pain Back pain Neck pain	Anxiety Depression Difficulty sleeping	Bleeding disorder Easy bruising Anemia Blood clots

Other

Occupation (*if retired, what did you previously do?*): ______________________________________

Marital status: ______________________________ Children? ___________________________

Do you drink alcohol? *(yes or no)* ________ If Yes, how many? _______ drinks per *(day, week, month, year)*

Do you smoke? *(yes/no/former)*______________ How many?____________ Date Stopped _______________

Do you consume caffine? (yes/no) ____________________ How many cups per day? ___________________

Do you do any drugs? (*marijuana, cocaine, etc*)?____

Any Additional Information

____
____
____

Date: ____________________

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing, we may not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notices of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS/FACILITIES IN THE FUTURE.

____ ____

Please PRINT your name Please SIGN your name

____ ____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: ____

____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA

_____ First Name Only _____ Proper Sur Name _____Other _____________________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION

This includes step parents, grandparent, and any care takers who can have access to this patient's records

Name ____ Relationship _____________________________________

Name ____ Relationship _____________________________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT, & BILLING INFORMATION VIA:

_____ Cell Phone _____ Text Message _____ Home Phone _____ Work Phone _____ Email

_____ Any of the above

I AUTHORIZE INFORMATION ABOUT MY HEALTH TO BE CONVEYED VIA:

_____ Cell Phone _____ Text Message _____ Home Phone _____ Work Phone _____ Email

_____ Any of the above

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING ERROFTS, OR NEW HEALTH INFO ON BEHALF OF THIS HEALTHCARE FACILITY VIA:

_____ Phone Message _____ Text Message _____ Email

_____ Any of the above _____ None of the above (opt out)

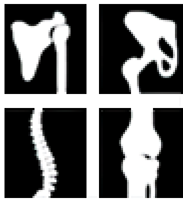
In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only: As Privacy Office, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

___ It was emergency treatment ___ I could not communicate with the patient ___ The patient refused to sign ___ Other ___________________

____

Signature of Privacy Officer



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Date: ____

To: ____

Address: ____

____

Fax: ____

Patient Name: ____

Patient DOB: ____

Please forward a copy of my complete records, including all doctors' reports, labs, and imaging to:

Pennsylvania Rheumatology Associates, P.C.
822 Pine Street Suite 3A
Philadelphia, PA 19107
Fax: 215-923-6442

Signature: ____

Date: ____