Please complete packet and bring to your office visit.

Rheumatology of Brazos Valley

Nancy Scheinost, M.D.
3201 University Drive East Suite 205
Bryan, Texas 77802
979-774-7896
979-774-2821 (fax)

Date: ____________________

Dear _________________________________

Welcome to Rheumatology of Brazos Valley, Dr. Nancy Scheinost's medical practice. We hope that your first visit to our office will be a pleasant one. In order to get some of the patient details out of the way enclosed you will find our new patient information forms for your completion (**please use black ink**). Please bring your most recent bone density test, x-ray results and/or labs to your appointment. Please also bring your insurance card(s) and a photo I.D. (drivers license is sufficient) with you the day of your appointment.

Your appointment is ____________________ at _____: _____ A.M./P.M.

We will call to confirm your appointment 1 to 2 days in advance. If you cannot make it, please call us **24 hours** so that we can place another new patient from our waiting list into your slot. We appreciate your consideration. If your insurance is an HMO and requires a referral, please make sure you have obtained a referral from your primary physician and either bring it with you or have it faxed over prior to your visit. We are happy to file your insurance; however it is the **patient's responsibility** to verify that Dr. Scheinost is on your current network provider list.

Sincerely,

Dr. Nancy Scheinost

Dr. Nancy Scheinost & Staff

How did you learn about Rheumatology of Brazos Valley?

Referred by Physician _____ Relative _____ Friend _____ Website _____ Other: _____________

Patient Information

First Name: ______________________ Last Name: ______________________ Middle Initial:_____

Mailing Address: __________________________ Apt #:__________

City: _______________________ State: ______________ Zip Code: ______________

Email Address: ____

Cell #:(_____)-______________ Home #:(_____)-______________ Work #:(_____)-______________

Date of Birth: _____/_____/_____ Sex: Male/Female SS #: _____-_____-_____

Primary Language: _________________________

Ethnicity: Asian ____ African American____ Caucasian____ Hispanic____ Other: _____________

Marital Status: Single____ Married____ Divorced____ Separated____ Other: _____________

Employer Name: __________________________ Address: ________________________________

Spouse's Name: ___________________________ DOB: ____/____/____

Cell #:(_____)-______________ Work #:(_____)-______________ SS #: _____-_____-_____

Emergency Contact: ___________________________ Relationship: _________________________

Contact #: _________________________________

Insurance Information

Primary Insurance Information:

Insurance Name: _____________________________________ Phone #:(_____)-______________

Address: ____________________________ City: ______________ State: ____ Zip Code: _____________

Policy Number (ID number):______________________________ Group Number: ____________________

Subscriber Name: ______________________________

Date of Birth: _____/_____/_____ SS #: _____-_____-_____

Secondary Insurance Information:

Insurance Name: _____________________________________ Phone #:(_____)-______________

Address: ____________________________ City: ______________ State: ____ Zip Code: _____________

Policy Number (ID number):______________________________ Group Number: ____________________

Subscriber Name: ______________________________

Date of Birth: _____/_____/_____ SS #: _____-_____-_____

Medication List

Including OTC medications, please list prescribed medications first.

Medications	Dose	Directions	Prescriber

Are you allergic to any medications? **Yes/No**

If **YES** please list below with the type of reaction you had to the medication:

Medication:	Reaction:

Are you currently receiving or have you previously received prednisone pills? **Yes/No**

If **YES**: Previously? ______ Currently? ______ Dose: ______ How many pills a day? __________

Patient Questionnaire

Name of Primary Care Physician: ______________________________

Name of Referring Physician: ________________________________

Please list any current chronic medical conditions (Diabetes, Hypertension, Heart problems):

1) ______________________________
2) ______________________________
3) ______________________________
4) ______________________________
5) ______________________________
6) ______________________________
7) ______________________________
8) ______________________________
9) ______________________________
10) ______________________________

Please list any surgeries or procedures that have taken place:

Surgery:	Date of Surgery:	Performing Doctor:	Reason of surgery:

Have you ever broken/fractured a bone? **Yes/No**
If **YES**, please list and explain:

____

____

Have you fallen in the last year? **Yes/No**
If **YES**, please list occurrences:

____

____

Continued

-Do you currently smoke? **Yes/No** If **YES**, how much per day? : _________
If you have quit smoking, when? _______________

-Do you drink alcohol? **Yes/No** If **YES**, how much a week/day? __________________

-Is there a chance you are pregnant? **Yes/No**

-Have you ever had a bone density test? **Yes/No**
If **YES**, when and where? ____

-Have you had a recent weight change? **Yes/No**
If **YES**, explain: ___________________________

Please list **ALL** prior medications you have tried taking for your symptoms/diagnosis:

Medication:	When medication was taken:	Reason of stopping medication:

For Women only:

1) Are you still having menstrual periods? **Yes/No**

2) Have you had your menopause? **Yes/No**
If **YES**, at what age? _______________

3) Have you had a hysterectomy? **Yes/No**
If **YES**, at what age? _______________

4) Have you had both of your ovaries removed? **Yes/No**
If **YES**, at what age? _______________

Financial Agreement

I understand that I am responsible for deductibles, co-pays, non-covered services, coinsurances and items considered "not medically necessary" by my insurance company. I agree to pay copayments and coinsurances as services are rendered. The remaining balance will be taken care of within 30 days of notice from the insurance company. Although my insurance company may estimate what they may pay, it is the insurance company that makes the final determination. I agree to pay any portion of the charges not covered by insurance. If a referral and/or preauthorization are required by my insurance company, I will assist the office of Nancy Scheinost, M.D. in obtaining the referral and/or preauthorization. If payment cannot be made at each visit, I will notify the front desk staff to make other arrangements. I understand that I am ultimately responsible for any balance on my account.

Assignment of Benefits

I hereby assign to Nancy Scheinost, M.D. such insurance benefits to which are entitled under my insurance plan(s).

Release of Information

I hereby allow Nancy Scheinost, M.D. to furnish any information pertaining to my medical treatment to my insurance carrier, attorney, or other providers of service as necessary to obtain payment of services and provide additional care.

Cancellations are requested 24 hours prior to the appointment. If you miss an appointment or do not give 24 hours notice you will be charged a $50.00 fee. You will not be able to schedule your next appointment until the $50.00 fee is paid in full.

I have read and agree to the Financial Agreement, Assignment of Benefits, Release of Information, and Cancellation/No show fee.

______________________________ ____________________

Patient or responsible party signature — Date

______________________________ ____________________

Person signing on behalf of patient (print name) — Date

I give the following people permission to inquire about my medical records.

Name: _________________________ Relationship: ________________

Name: _________________________ Relationship: ________________

______________________________ ____________________

Patient Signature — Date

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the document.

____

Signature of patient of Personal Representative

____

Date

____

Name of Patient or Personal Representative

____

Description of Personal Representative's Authority

Informed Consent Regarding Nutritional and Herbal Supplements

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g)(1), the term *drug* is defined as an "article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease." Technically, vitamins, minerals, trace elements, amino acids, herbs or homeopathic remedies are not classified as drugs. However, these substances can have significant effects on physiology and must be used rationally.

At Rheumatology of Brazos Valley we provide nutritional counseling and make individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patient's diet and to supply nutrition to support the physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional supplement may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

Sale of Nutritional Supplements recommended by Physicians at Rheumatology of Brazos Valley

You are under no obligation to purchase nutritional supplements at our clinic.

As a service to you, we make nutritional supplement available only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering: (1) the quality of science behind the product; (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process; and (4) the synergism among product components. The brands of supplements that we carry in our facility are those that meet our high standards and tend to produce predictable results.

While these supplements may come at a higher financial cost than those found on the shelves of retailers or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to properly absorbed and utilized by the body), and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely.

If you have concerns about this issue, please discuss them with our staff.

I have read and understand the above statement regarding nutritional supplements.

____

Date

____

Patient/Legal Guardian Signature

____

Printed Patient Name

NOTICE OF PRIVACY PRACTICES

(Specialty Physician)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

A. Treatment, Payment, Health Care Operations

Treatment

We are permitted to use and disclose your medical information to those involved in your treatment. **For example**, the physician the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment

We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you. **For example**, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as a description of the medical services provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations

We are permitted to use or disclose your medical information for the purpose of health care operations which are activities that support this practice and ensure that quality care is delivered. **For example**, we may ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that this practice provides only the best health care or we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law.

B. Disclosure That Can Be Made Without Your Authorization

There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization.

Public Health, Abuse or Neglect, and Health Oversight

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like birth and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contraction or spreading a disease or condition. We may disclose your medical information to report reactions to medication, problems with products, or to notify people of recalls of products they may be using.

Because Texas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPPA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections, which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by law enforcement official, we may disclose your medical information under limited circumstances provided:

•The information is released pursuant to legal process, such as a warrant or subpoena.

•The information pertains to a victim of crime and you are incapacitated.

•The information pertains to a person who has died under circumstances that may be related to criminal conduct.

•The information is about a victim of crime and we are unable to obtain the person's agreement.

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

You also may request that we limit disclosure to family members, other relatives, or close personal friends who may not be involved in your care.

To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting (i.e., on the use of information, disclosure of information, or both), and (c) to whom the limits apply. Please send the request to the address and person listed at the end of this document.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only reasonable request. Please, specify in your correspondence exactly how you want us to communication with you and, if you are directing us to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information

You may insect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that request for copies to be made in writing, and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document.

We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies.

We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons.

•The information is psychotherapy notes.

•The information reveals the identity of a person who provided information under a promise of confidentiality.

•The information is subject to the Clinical Laboratory Improvements Amendments of 1988.

•The information has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some in formation for other reasons, provided that we arrange for a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.

•The information is released because of a crime that has occurred on these premises: or

•The information is released to locate a fugitive, missing person, or suspect.

We also may release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation

We may disclose your medical information as required by workers' compensation law.

Inmates

If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the president of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors

When a research project and its privacy protections have been approved by an institutional review board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your information to a coroner or medical examiner to identify a deceased person or cause of death. Further, we may release your medical information to a funeral director when such a disclosure is necessary for the director to carry out his duties.

Required by Law

We may release your medical information when the disclosure is required by law.

C. Your Rights Under Federal Law

The U.S. Department of Health and human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA right.

Request Restrictions

Texas Law requires us to be ready to provide copies or a narrative within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.
HIPAA permits us to charge a reasonable cost-based fee.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reason:

•The information wasn't created by this practice or the physician to include a patient.

•The information is not part of the designated record set.

•The information is not available for inspection because of an appropriate denial.

•The information is accurate and complete.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing.

If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we now have the incorrect information.

Accounting of Certain Disclosures

HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person at the end of this document. Your first accounting of disclosures (within a 12-month period) will be free. For additional request within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may chose to withdraw or modify your request *before* any cost are incurred.

D. Appointment Reminders, Treatment Alternatives, and Other Benefits

We may contact you by (telephone, mail, or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

E. Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed at the end of this document. You may also send a written complaint to the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government.

F. Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information and to abide by the terms of the notice of privacy practices in effect.

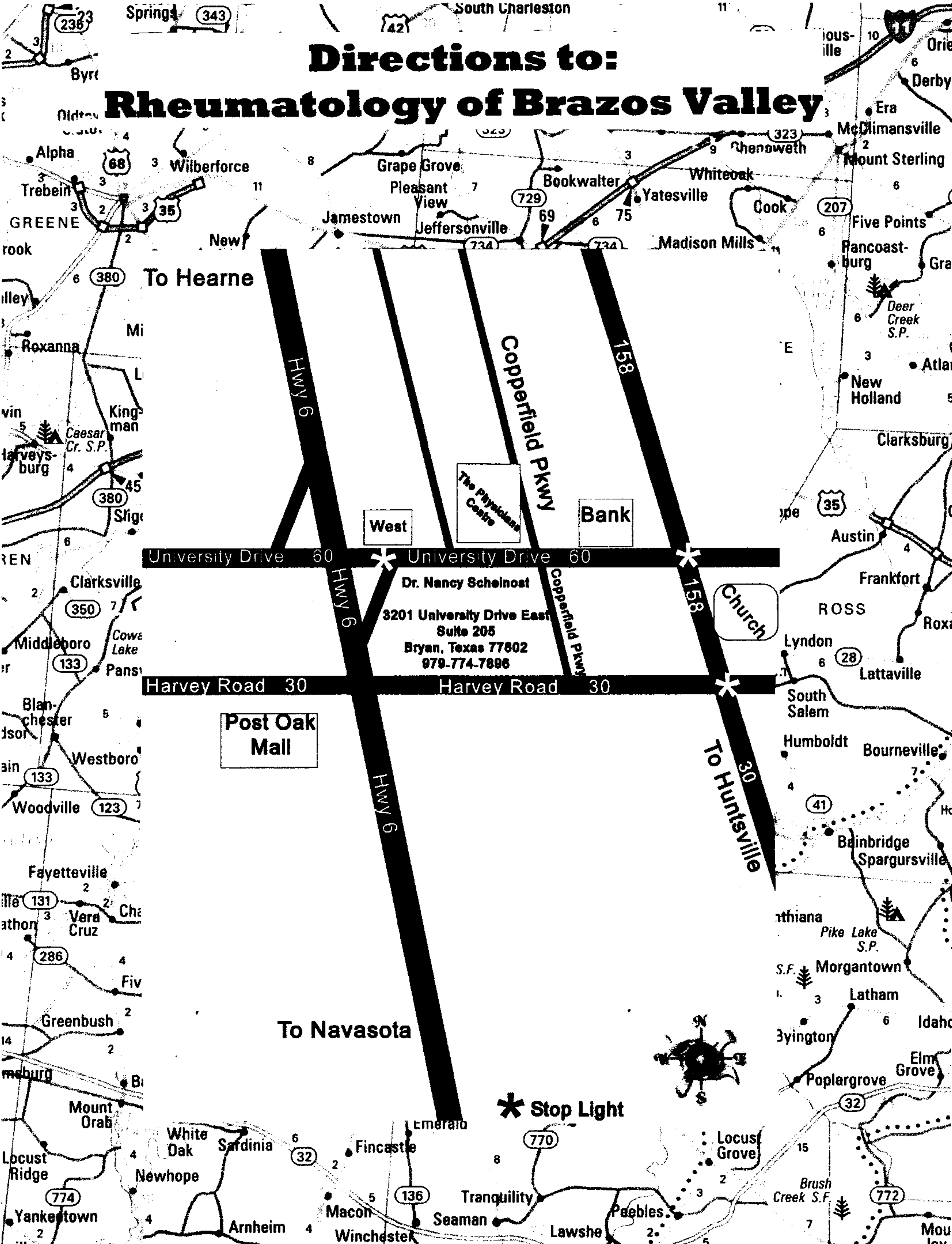
G. Questions and Contact Person Request

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Kris Clifford
3201 University Drive Suite # 205
Bryan, TX 77802
979-774-7896
979-776-5264 (fax)

NOTICE: The Office of the General Counsel of the Texas Medical Association provides this information with the express understanding that 1. No attorney-client relationship exists, 2. Neither TMA nor its attorney's are engaged in providing legal advice and 3. That the information is of a general character. You should not rely on this information when dealing with personal legal matters: rather legal advice from retained legal counsel should be sought.

This notice is effective as of April 14, 2003.


Directions to:
Rheumatology of Brazos Valley
To Hearne
Hwy 6
Copperfield Pkwy
158
The Physicians Centre
West
Bank
University Drive 60
University Drive 60
Dr. Nancy Scheinost
3201 University Drive East
Suite 205
Bryan, Texas 77802
979-774-7896
Church
Harvey Road 30
Harvey Road 30
Post Oak Mall
To Huntsville
30
To Navasota
* Stop Light