
Arthritis & Osteoporosis Treatment Center

*Meera R. Oza, M. D., FACR
Diplomate of American Board of Rheumatology
Diplomate of American Board of Internal Medicine*

Pinki Patel, PA-C

Maryann Leslie, ARNP, PhD

2100 Kinglsey Ave., Orange Park, FL 32073, Phone: (904)276-0001, Fax: (904)276-5333

Dear patient,

Welcome to our practice!

At our office we are committed to our patients. Our mission is to meet or exceed your expectations from your provider, our clinical staff will ensure your quality of care and, our billing staff will give you peace of mind in making sure that all your claims are billed correctly.

Attached are the forms that you need to fill out before coming to our office.

Please give us a call two days prior to your appointment to verify insurance information.

Remember to call your insurance company and double check if we do participate with your insurance. Also do not forget to bring your referral if required by your insurance. Patient will be responsible for any charges not covered by your insurance. All copays, co insurance and deductibles will be collected up front.

Please make sure you bring the following:

- 1. All enclosed pages, please fill in all requested information.*
- 2. All insurance cards.*
- 3. A list of all current medications you are taking, with the prescribing doctor's name(s).*
- 4. A copy of all blood work you have had done recently (within the last year). If you prefer you may have your doctor fax results to our office at (904) 276-5333.*
- 5. All x-rays within the last year.*
- 6. Reports of all other diagnostic tests you have had done within the last year, which is pertinent to your visit with us. (MRI, Bone Scan, Bone Density Test, etc.)*

Failure to bring this will result in having to reschedule your appointment.

Please note:

Dr. Oza suffers from severe allergies. Please do not wear any scented perfume, cologne, aftershave, body spray, lotion, etc. Thank you for your consideration.

If you have any questions or need directions to our facility, please call us at (904) 276-0001.

Thank you.

Arthritis and Osteoporosis Treatment Center

PATIENT REGISTRATION

Patient's Last Name: _____ **First Name:** _____ **M.I.:** _____

Home-Ph. #: (_____) _____ **Work Ph:** (_____) _____ **D.O.B.** _____

Cell Phone #: (_____) _____ **Email address:** _____

Address: _____ **City:** _____ **State/Zip:** _____

SS #: ____ - ____ - ____ **Race:** _____ **Ethnicity:** _____ **Language:** _____

Sex : M/F **Marital Status:** M S D W

Employer/School : _____ **Occupation:** _____

Policy Holder's Last Name: _____ **First Name:** _____ **M.I.** _____

SS #: ____ - ____ - ____ **D.O.B.** _____ **Relationship to Patient:** _____

Referring Physician: _____ **Phone #:** (_____) _____

Referring Pysician address: _____

Primary Care Physician: _____ **Phone #:** (_____) _____

Emergency Contact: _____ **P hone #:**(_____) - _____ - _____

Relationship to Pt. _____

Primary Insurance: _____ **ID #:** _____ **Policy Holder :** _____

Secondary Insurance: _____ **ID #:** _____ **Policy Holder :** _____

How did you hear about us? Yellow pages Friend Website Magazine Radio Family doctor Refer-
ring physician Internet search (which site? _____)

I consent to treatment necessary for the care of the above named patient.
I authorize the release of all medical records to the referring and family physician and to my insurance company, if applicable.
I allow fax transmittal of my medical records if necessary.
I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payments be made directly to Arthritis & Osteoporosis Treatment Center should they elect to receive such payment.
I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization

Patient Signature: _____ **Date:** _____

Note: Medicare Part B may require a separate signature authorizing release of information to the Health Care Financing Administration and Social Security Administration.

PATIENT NAME: _____ DOB _____ DATE: _____

PATIENT HISTORY:

OCCUPATION: _____ Number of hours worked/average per week? _____
The name of the physician providing your GENERAL medical care? _____

BRIEFLY DESCRIBE THE REASON FOR THIS VISIT: _____

Date symptoms began (approximately) _____ . Diagnosis given? (Please list) _____

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

Please list the names of other practitioners you have seen for this problem: _____

IF YOU HAVE PAIN, PLEASE DESCRIBE BELOW:

LOCATION: all over hands wrists elbows shoulders
 neck back hips knees ankles feet

DESCRIBE YOUR PAIN: dull achey sharp stabbing
 pins and needles burning constant intermittent

SEVERITY OF PAIN: (Circle a number for severity of pain on a scale of 1-10)

0 1 2 3 4 5 6 7 8 9 10

DURATION OF PAIN: (Fill in for how long ago your pain appeared for the first time)

_____ days _____ weeks _____ months _____ years _____ other

TIMING: (Mark when your pain is the worst)

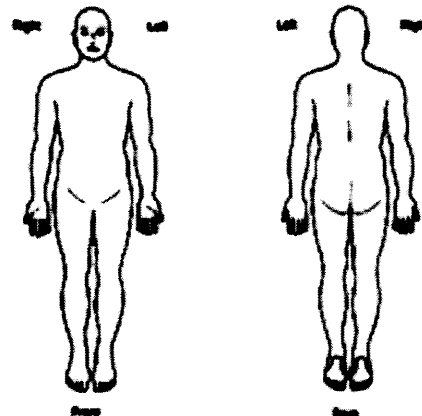
Morning Afternoon Evening Nighttime

WHAT MAKES YOUR PAIN WORSE: Pain increases with: activity rest

WHAT MAKES YOUR PAIN BETTER: Ice Heat Don't know/doesn't apply

WHAT MAKES YOUR PAIN WORSE: Sneezing Coughing Walking Standing
 Sitting Don't know/doesn't apply

ON THE DIAGRAM, PLEASE MARK THE LOCATION OF YOUR PAIN:



(OFFICE USE ONLY)

Reviewed by _____ Date _____

PATIENT NAME: _____ DOB _____ DATE: _____

REVIEW OF SYSTEMS: (*NOTE: ALL UNMARKED ITEMS INDICATE A NEGATIVE RESPONSE)

Please check each symptom as it pertains to you.

CONSTITUTIONAL:

- Recent weight loss/amount
- Fatigue
- Fatigue
- Chills
- Fever

CARDIOVASCULAR:

- Chest pain
- Swelling legs or feet
- Varicose veins
- High blood pressure
- Heart murmur
- Other _____

SKIN:

- Skin rash
- Boils
- Persistent itching
- Recent hair loss
- Other _____

NERVOUS SYSTEM:

- Headaches
- Dizziness
- Numbness
- Tremors
- Seizure disorder
- Others _____

RESPIRATORY:

- Shortness of breath
- Frequent cough
- Night sweats
- Snoring

PSYCHIATRIC:

- Depression
- Anxiety
- Mood swings

- Morning stiffness
- Lasting how long?
 - Minutes
 - Hours
- Joint pain
- Balance Problems
- Muscle weakness
- Joint swelling

ALLERGY/IMMUNOLOGY:

- Hay fever
- Drug allergy

- Other _____

GASTROINTESTINAL:

- Nausea/vomiting
- Stomach pain
- Heartburn
- Persistent diarrhea

GENITOURINARY:

- Pain or burning urination
- Urinary frequency
- Urinary retention
- Discharge from penis or vagina
- Genital sores/ulcers
- Other _____

EARS/NOSE/THROAT

- Sudden loss of hearing
- Ear infection
- Sinus problems
- Dry mouth
- Sore Throat
- Other _____

PSYCHIATRIC:

- Depression
- Anxiety
- Mood swings

EYES:

- Blurred vision
- Double vision
- Dry eyes
- Eye pain
- Other _____

RHEUMATOLOGIC

- Sun sensitive rash
- Red eyes/scleritis/
conjunctivitis
- Difficulty swallowing
- Frequent sores in mouth
- Color changes in hands or
feet with cold

ENDOCRINE:

- Excessive thirst
- Too hot/cold
- Tired/sluggish
- Other _____

OB/GYN (if applies)

- Last menstrual period _____
- # pregnancies _____
- # live births _____
- # children _____

HEMATOLOGIC/LYMPH:

- Anemia
- Blood clotting problem
- Swollen glands
- Other _____

Date of last eye exam: _____

Date of last chest x-ray: _____

Date of last tuberculosis test: _____

(OFFICE USE ONLY)

Reviewed by _____ Date: _____

Revised 3/22/17

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Permission to discuss Medical Case

Date: _____

Patient name: _____

Date of Birth: _____

I hereby give permission to Meera R. Oza M.D. and her staff to discuss my medical case and personal information with the following individuals:

{Please list **names** and **relationship** to you.}

- | | | |
|----------|--------------------------------|----------------|
| 1. _____ | Relationship to patient: _____ | phone #: _____ |
| 2. _____ | Relationship to patient: _____ | phone #: _____ |
| 3. _____ | Relationship to patient: _____ | phone #: _____ |
| 4. _____ | Relationship to patient: _____ | phone #: _____ |

I understand that the above mentioned individuals may speak to Dr. Oza or her staff about anything concerning my medical condition. The above also has my permission to sign for any prescriptions, x-rays or medical records that may need to be picked up from the office for me in the future.

I also authorized Arthritis and Osteoporosis Treatment Center to leave a message in my answering machine regarding my treatment, blood work results, appointments and, billing issues.

I understand that if in the future I wish to revoke my permission, I **must** notify Dr. Oza's office in writing to that effect.

Patient's signature

Date:

Witness Signature

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Statement of Policies

The following policies are laid down for mutual convenience and benefit, please read them carefully and sign at the bottom to indicate your agreement with it.

1. We strictly provide **Rheumatological services**; we **do not** provide primary care services. Patients are expected to have or arrange for a primary care physician.
2. We **do not** do evaluation or paper work for **disability**.
3. **Deductible and co-pay** associated with each visit are payable at the beginning of that visit. Any outstanding balance at the beginning of the visit is also fully payable at the time of your visit. A **\$25 billing fee will be added to any unpaid co-pays, co-insurance, deductibles or balance**. If you are not able to pay, please make special payment arrangements with our business office at the beginning of the visit.
4. Patient is responsible for referrals required by their insurance, also is responsible to call their insurance company to make sure Dr. Meera Oza is a participating provider for their insurance. Patient will be responsible for any charges not covered by your insurance.
5. If you are not able to keep your appointment for the medical visit, please call during office hours to cancel your appointment at least **48 hours in advance**. Failure to do so will result in a **\$50.00 (fifty dollars) charge for a broken appointment**.
6. **Dr. Oza is allergic to perfumes and other odors**. Please avoid wearing perfumes or anything with a strong smell during your visit.
7. During the first visit, the patients will be seen by any of the **nurse practitioners or the physician assistant** in order to obtain initial information. Then the patient will be seen by **Dr. Oza** who will evaluate the patient and make a treatment plan.
8. During the follow-up visits, the patient **may be seen** by any of the nurse practitioners or the physician assistant who work under the close supervision of a physician. The physician will see the patient if the nurse practitioners or the physician assistant feel the need to do so.

I acknowledge that I have read and understood the **Statement of Policies** carefully, and agree to abide by them.

Date

Patient's Signature

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CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the practice lobby. The notice will contain on the first page, in the top right hand corner, the effective date. In addition, each time you register for treatment or health care services we may offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the practice Privacy Official or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact the Privacy Official at (904) 276-0001. You will not be penalized for the filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reason covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

By signing below I acknowledge receipt of the Notice of Privacy Practices.

Patient Name (print)

Patient Signature

Date

Chart Number