☐ **3277 E Louise Drive, Suite 350, Meridian, ID 83642**
☐ **1818 S 10th Ave, Suite 120, Caldwell, ID 83605**
Phone (208) 887-9500 Fax (208) 887-9800
www.idahoarthritis.com

Idaho Arthritis Center…where compassionate care & advanced medicine meet.

Appointment With:

☐ Mikael Lagwinski, MD

☐ Svetlana Meier, MD ☐ Sara Romney, PA-C

☐ Eric Palfreyman, MD ☐ Alex Feil, APRN, FNP-C

Appointment Date: _____ Check-In Time: _____

PLEASE ARRIVE AT CHECK-IN TIME

Please note, if your paperwork is not completed by your check- in time we may have to reschedule.

PLEASE READ COMPLETELY

Welcome to Idaho Arthritis Center. Our Board-Certified Rheumatologists provide state-of-the-art care for a wide range of rheumatologic diseases such as Rheumatoid Arthritis, Lupus, Osteoporosis, Osteoarthritis, and more. We use the most advanced therapeutic and diagnostic modalities available to provide you with the very best care.

Idaho Arthritis Center has 2 locations for your convenience. We are located in Meridian off Eagle Road next to the Meridian campus of St. Luke's Regional Medical Center and in Caldwell next to West Valley Medical Center. Visit our website at www.idahoarthritis.com for more information about our physicians, staff, services, and locations.

NEW PATIENT APPOINTMENTS:

(Please advise us if you've had any insurance changes before your appointment)

When you arrive, please bring the following items:

- **Completed Patient Registration Form and Patient History Form**
- **Current list of medications and a list of questions you may have**
- **Insurance Card(s)/Billing Information/Photo Identification/Prescription Card**

At your initial visit your provider will review your history and discuss with you further testing that may be required to help in your diagnosis or treatment. In the specialty field of Rheumatology, blood tests, x-rays, ultrasounds, and physical therapy may be recommended and are continual throughout your care. These are all additional costs to your office visit charge. Blood tests are one of the best ways to track your condition and are ordered regularly for this specialty field. Blood tests can range from $500 to $1,500. Lab results will be reviewed at your follow up visit and/or can be obtained on our Patient Portal online. Results will NOT be mailed.

Please evaluate your medication supply prior to your office visit to correlate all anticipated refills.

CALLS TO OFFICE/PRESCRIPTION REFILLS

Questions or concerns for our physicians will be submitted through the Medical Assistant that works directly with your physician. If we can't answer your call immediately, our goal is to return calls the same day or within one business day. Any message left after 4:00 p.m. will be returned the following business day. Secure messages may also be sent via our Patient Portal on our website.

Routine refill requests must be received at least 2 business days in advance so that your chart may be reviewed by your provider. It is best to have your pharmacy fax us directly a refill request several days before you are out of medication. All prescription refills will be sent electronically to your pharmacy. We will only call you back if there is a problem with refilling your request. Please allow an extra two weeks for medication delivery for mail order prescriptions. It is our policy that we do not provide refills on some medications without physician approval, which may require an office visit.

APPOINTMENTS/ARRIVING LATE/CANCELLATIONS

Our goal is for you to be seen at your scheduled appointment time, but sometimes delays are unavoidable. We utilize an automatic phone reminder system that will call and text you 48 hours in advance of your appointment, and if you are registered in our patient portal, you will receive an email reminder as well. It is your responsibility to update us of any changes in phone numbers, emails, insurance, etc. ***We kindly ask that you provide a 24-hour notice if you are unable to keep your appointment. A $50 fee will be charged to you for any no show appointments or any appointments that are rescheduled or cancelled within 24 hours of the appointment. 2 no shows in a 12-month period could result in a dismissal from the practice.***

Patients who arrive 10 minutes past their appointment time will need to reschedule.

HEALTH INSURANCE

For the benefit of our patients, we are contracted with several insurance carriers. It is patient responsibility to know your insurance policy and be familiar with your coverage. Each insurance company has its own rules for determining how much they will pay on each item. Your policy is a contract between **you** and **your insurance company**. You should contact your insurance company immediately if you have any questions regarding coverage or payment of your services. In the event your health plan determines a service or supply "not covered," the patient will be responsible for the complete charge for that particular service. If your insurance company denies your claim, you are responsible for payment in full. It is patient responsibility to know which procedures may require pre-authorization or a second opinion.

With this agreement, you authorize the payment of insurance benefits to IAC, and understand that you are financially responsible for all charges whether or not they are paid by insurance. In addition, you authorize the release of any information acquired in the course of your examination or treatment, to and from any medical facilities, physicians, and/or your insurance company.

FINANCIAL OBLIGATION/PAYMENT TERMS/OPTIONS

YOU'RE REQUIRED TO PAY ANY CO-PAYMENTS/CO-INSURANCE/DEDUCTIBLES AT THE TIME OF SERVICE. IF PROOF OF INSURANCE IS NOT PROVIDED, YOU WILL BE EXPECTED TO MAKE PAYMENT IN FULL AT THE TIME OF SERVICE.

To avoid incurring additional charges; account balances must be paid in full or with no more than 3 equal payments within 90 days from the date of service. There will be a $25.00 charge for any checks returned to us for non-payment.

Failure to pay for medical services delivered in good faith within 90 days will cause a patient's account to be turned over to collections. Upon failure to pay your balance, your account will be transferred to States Recovery Systems, Inc (SRS). If your account is turned to collections you will have to pay SRS in full before we can schedule another appointment. **We will also require you to pay all services rendered in full at the time of your appointment, regardless of insurance coverage.** If you should ever decide to file for bankruptcy proceedings against an outstanding debt to Idaho Arthritis Center, it is the policy of our practice to withdraw as a health care provider. All refunds go through our business office and require on average three weeks.

FMLA FORMS/DISABILITY FORMS/MEDICAL RECORDS

You will be charged for the processing of forms, including Family Medical Leave Act (FMLA) forms, at a $30 flat fee. This amount is due when the forms are picked up at our office. Please allow 5-7 working days for the completion of any forms, prior authorizations, or letters. Processing of disability or life insurance forms will not be done by our office.

Your medical records are strictly confidential. The Health Information Portability and Accountability Act (HIPAA) restricts us from releasing any information without your written consent. You may choose to fill out an Authorization to Release Medical Records at one of your visits to keep on file in case an urgent need arises for such records.

We do ask for your feedback regarding our services in the form of Patient Satisfaction Surveys. You will receive surveys via email and text. By signing this agreement, you consent to have Patient Satisfaction Surveys sent to you. You may opt out at any time.

Thank you for allowing us to assist you with rheumatologic care.

This is an agreement between Idaho Arthritis Center (IAC) and patient named below. By signing this agreement you are acknowledging that you understand our policies and are agreeing to all policies.

I have read, understand, and agree to comply with these policies. A photocopy of this agreement shall be as valid as the original. I acknowledge that I have been offered a copy of the Notice of Privacy Practices for IAC, and have been given a copy if requested.

Date: _____ Signature: _____

Printed Name of Patient: _____

Date of Birth:_____

IDAHO ARTHRITIS CENTER
PATIENT REGISTRATION FORM

TODAY'S DATE_____

Last Name _____ First Name _____ Middle Initial _____

Date of birth _____ Age _____ Gender_____ Social Security # _____

Address_____ City _____ State _____Zip _____

Home Phone_____Cell Phone _____Work Phone_____

Email _____

Is it OK if we leave a detailed voice mail regarding Appointments, Lab Results, Care Instructions, etc?: ___Yes ___No

Employer_____ Spouse_____Spouse's employer_____

Spouse's cell phone_____Spouse's date of birth_____ Spouse's work phone_____

RESPONSIBLE PARTY: (Person who should receive the bill)

Name _____ Relationship to patient: __ Self __ Spouse __ Parent __Other

Address_____ City _____ State _____Zip _____
Social Security #_____Home phone_____Work phone _____

PRIMARY CARE PROVIDER NAME _____

REFERRING PROVIDER NAME _____

INSURANCE **PLEASE BRING YOUR INSURANCE CARD(S) TO APPOINTMENT**

POLICY HOLDER (NAME) _____ **RELATIONSHIP:** _____DOB:_____

OPTIONAL:
RACE: ☐Decline to Specify ☐White ☐ Black/African American ☐ Asian ☐American Indian/Alaskan Native ☐Other

ETHNICITY: ☐ Decline to Specify ☐ Hispanic/Latino ☐Not Hispanic/Latino ☐ Unknown ☐ Other

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NOTIFY IN CASE OF EMERGENCY

Name_____ Relationship _____

Home/Cell phone _____ Work phone _____

PLEASE READ AND SIGN THE FOLLOWING:
I authorize the payment of insurance benefits to Idaho Arthritis Center, and understand that I am financially responsible for all charges, whether or not they are paid by insurance. I authorize the release of any information, acquired in the course of my examination or treatment, to and from any medical facilities, physicians, and/or my insurance company. I further agree that a photocopy of this agreement shall be as valid as the original. I hereby consent to examination and the performance of all treatments that may be considered medically necessary or advisable. I acknowledge that I have been offered a copy of the **Notice of Privacy Practices** for Idaho Arthritis Center, and have been given a copy if requested. I agree to notify the office of any changes to my address, phone number, employment, and insurance. I understand that as a courtesy to all of the patients in the clinic, if I am more than 10 minutes late for my appointment it will be rescheduled. I understand that multiple no-show or rescheduled appointments may be grounds for dismissal from the practice. Thank you for your cooperation.
I HAVE READ AND AGREE TO THE ABOVE INFORMATION.

SIGN HERE_____ **DATE** _____

Idaho Arthritis Center

Date:_____ **Patient History Form**

NAME: _____ **Birthdate:** _____
Last Middle First

Age: _____ **Gender:** ☐ **F** ☐ **M**

Who do we thank for referring you here: _____

Name of your Primary Care Physician: _____

Name of your preferred Pharmacy: _____

What are your symptoms: _____

_____

_____

_____

When did your symptoms start: _____

What makes your symptoms worse: _____

better: _____

Describe your pain in words (eg. Sharp, dull, burning, etc):_____

On a scale of 1 (no pain) to 10 (worst pain) how bad is your pain: _____

What medications/therapies have been tried so far: _____

_____

_____

Past Medical History: (check if "yes")

☐ Cancer: Type: _____	☐ Asthma	☐ Bad headaches	☐ Jaundice	☐ Colitis	☐ Anemia
	☐ Goiter	☐ Leukemia	☐ Stroke	☐ Pneumonia	☐ Bleeding tendency
☐ Heart Problems Type: _____	☐ Diabetes	☐ Seizures	☐ High Blood pressure	☐ HIV/AIDS	
	☐ Stomach ulcers	☐ Emphysema	☐ Rheumatic fever	☐ Glaucoma	
☐ Kidney disease Type: _____	☐ DVT	☐ Depression	☐ Pulmonary embolism	☐ Hypothyroid	
	☐ Cataracts	☐ Psoriasis	☐ Nervous breakdown	☐ Tuberculosis	

Arthritis History:

☐ Osteoarthritis	☐ Rheumatoid Arthritis	☐ Gout	☐ Lupus or "SLE"	☐ Osteoporosis
☐ Childhood arthritis	☐ Ankylosing spondylitis	☐ Fibromyalgia	☐ Sjogren's Syndrome	☐ Raynaud's

Other Significant illnesses or unknown arthritis (please list): _____

Family Medical History: (check and give relationship)

☐ Cancer _____	☐ Heart Disease _____	☐ Rheumatic fever _____	☐ Tuberculosis _____
☐ Leukemia _____	☐ High blood pressure _____	☐ Seizures _____	☐ Diabetes _____
☐ Stroke _____	☐ Bleeding tendency _____	☐ Asthma _____	☐ Goiter _____
☐ Colitis _____	☐ Alcoholism _____	☐ Psoriasis _____	☐ Osteoarthritis _____
☐ Gout _____	☐ Rheumatoid Arthritis _____	☐ Osteoporosis _____	☐ Lupus/SLE _____
☐ Ankylosing spondylitis _____			

Patient's Name: _____ Date: _____ Physician Signature: _____

Social History:

Do you smoke? ☐ Yes ☐ No ☐ Past – How long ago? _____

Do you drink caffeinated beverages? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No Number per week _____

Do you exercise regularly? ☐ Yes ☐ No

Do you get enough sleep at night? ☐ Yes ☐ No

How many hours of sleep do you get nightly? _____

Do you wake up feeling rested? ☐ Yes ☐ No

Surgical History: (Please state Type, Year and Reason)

_____

_____

_____

_____

_____

DRUG ALLERGIES: ☐ Yes ☐ No To what and what was the reaction? _____

_____

_____

Present Medications: (please include any over-the-counter, herbal supplements, alternative treatments)

Medication:	Dose:	How long:	Did it help:
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No

Past Arthritis Medications:

_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No

Patient's Name: _____ Date: _____ Physician Signature: _____

Systems Review: (As you review the following, please check any of those problems which have significantly affected you)

Constitutional
- ☐ Recent weight gain, amount:_____
- ☐ Recent weight loss, amount: _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever

Eyes
- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye
- ☐ Itching eyes

Ears-Nose-Mouth-Throat
- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Dryness in nose
- ☐ Runny nose
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness of mouth
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing

Cardiovascular
- ☐ Pain in chest
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat
- ☐ High blood pressure
- ☐ Heart murmurs

Respiratory
- ☐ Shortness of breath
- ☐ Difficulty in breathing at night
- ☐ Swollen legs or feet
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing (asthma)

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting of blood/"coffee grounds"
- ☐ Stomach pain relieved by food/milk
- ☐ Jaundice
- ☐ Worsening constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools
- ☐ Heartburn

Genitourinary
- ☐ Difficult urination
- ☐ Pain/burning on urination
- ☐ Blood in urine
- ☐ Cloudy, "smoky" urine
- ☐ Pus in urine
- ☐ Discharge from penis/vagina
- ☐ Getting up at night to pass urine
- ☐ Vaginal dryness
- ☐ Rash/ulcers
- ☐ Sexual difficulties
- ☐ Prostate trouble

For Women Only:

Age when periods began: _____

Periods regular? ☐ Yes ☐ No

How many days apart? _____

Date of last period? ___ / ___ / _____

Date of last pap? ___ / ___ / _____

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal
- ☐ Morning stiffness, lasting how long
  _____ Minutes _____ Hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint swelling

List joints affected in the last 6 months

_____

_____

_____

_____

_____

Integumentary (skin ± breast)
- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitivity (sun allergy)
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Hair loss in patches
- ☐ Color changes of hands or feet in the cold

Neurological system
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle spasm
- ☐ Loss of consciousness
- ☐ Numbness or tingling
- ☐ Memory loss
- ☐ Night sweats

Psychiatric
- ☐ Excessive worries
- ☐ Anxiety
- ☐ Easily losing temper
- ☐ Agitation
- ☐ Depression
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

Endocrine
- ☐ Excessive thirst

Hematologic/Lymphatic
- ☐ Swollen glands
- ☐ Tender glands
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Transfusion/when _____

Allergic/Immunologic
- ☐ Frequent sneezing
- ☐ Increased susceptibility to infection

Date of last Bone Density (DXA scan): ____ / ____ / _____

Date of last Mammogram: ____ / ____ / _____

Patient's Name: _____ Date: _____ Physician Signature: _____