Patient Name: **Appointment Date/Time:**

Welcome to Tri-County Rheumatology

1650 Huntingdon Pike, Suite 352 Meadowbrook, PA 19046
Phone: 267-571-2151 Fax: 215-379-8387

We are located on the campus of Holy Redeemer Hospital, in the Medical Office Building.
Please use the hospital's address for GPS – 1648 Huntingdon Pike Meadowbrook, PA 19046

*** Please ARRIVE 20 MINUTES BEFORE YOUR SCHEDULED TIME so that we may complete the registration process. Failure to arrive early with your completed paperwork WILL require your appointment to be rescheduled. ***

Please prepare the following items to bring with you for this visit:

☐ **Completed attached patient information sheets**

☐ **Insurance Cards** and **Prescription Cards**

☐ **Referral** from your primary physician if required by your insurance (NPI# 1033311840)

☐ **Co-pay** by check, cash or credit card (No bills larger then $20)

☐ **Medical records faxed prior to your appointment. (Include blood work, imaging and doctor's office visit note stating why you are being sent to Rheumatology.) These records are required prior to your appointment or the appointment will need to be rescheduled.**

*** DON'T FORGET TO LOG ON TO OUR PORTAL FOUND ON OUR WEBSITE AT www.tricountyrheum.com TO COMPLETE THE DOCTOR'S QUESTIONAIRE PRIOR TO YOUR APPOINTMENT. CHECK YOUR EMAIL FOR ADDITIONAL INFORMATION. ***

If you are unable to keep the above appointment, please call the office at least 24 hours in advance to cancel or reschedule. If you do not cancel in advance, you may be charged a $100 no show fee.

INCLEMENT WEATHER: Please note in cases of inclement weather, kindly call the office before coming to your appointment. There will be a message stating if the office is closed, opening late, etc.

LATE ARRIVALS: Anytime you suspect you may arrive late for your appointment, please call to inform us as much in advance as possible. If you are more than 10 minutes late, it will be at the discretion of the front staff and providers to determine if there will be adequate time to see you without impacting patients whose appointments follow yours. We certainly take traffic and weather conditions into consideration, and we will always try to accommodate as we all run late sometimes.

CANCELATIONS: We request 24 hour notice. If notification prior to the appointment time is not provided, the appointment will be considered a no-show. There is a $50 no-show fee.

COMMUNICATIONS: We kindly request up to 48 hours for all medication **REFILLS** and **RETURN CALLS**. (Do NOT send urgent communications thru the portal or on our voicemail.)

Disability/FMLA: Paperwork will not be discussed and/or completed until you have become an established patient with our practice, receiving care for 6 months and seen in the office at least 3 times.

Holy Redeemer Hospital

Meadowbrook Campus

Main Hospital

- A Cancer Center Entrance
- B Patient Pick Up
- C Pediatric UrgiCare Emergency Entrance
- D Hospital Admissions
- E Pedestrian Bridge from Garage to Hospital
- F Medical Office Building
- G Fitness and Rehabilitation Center
- H Child Care Center
- J St. Joseph Manor
- K Province Center
- L Helipad

Parking

1. Cancer Center Parking
2. Physician Parking
3. Visitor Parking
   Handicapped Parking on Green Level
4. Valet Parking
5. Health & Fitness and Rehabilitation Center Parking
6. Employee Only Parking
7. Employee Only Parking
8. Parking for St. Joseph Manor Visitors

Handicapped Parking

Health Redeemer

HAQ-II (Health Assessment Questionnaire-II)

http:// Rheuminfo.com
your rheumatology resource

We are interested in learning how your illness affects your ability to function in daily life. Place an X in the box which best describes your usual abilities **OVER THE PAST WEEK**. *Are you able to:*

	Without any difficulty (0)	With some difficulty (1)	With much difficulty (2)	Unable (3)
Get on and off the toilet?	☐	☐	☐	☐
Open car doors?	☐	☐	☐	☐
Stand up from a straight chair?	☐	☐	☐	☐
Walk outdoors on flat ground?	☐	☐	☐	☐
Wait in a line for 15 minutes?	☐	☐	☐	☐
Reach and get down a 5-pound object (such as a bag of sugar) from just above your head?	☐	☐	☐	☐
Go up 2 or more flights of stairs?	☐	☐	☐	☐
Do outside work (such as yard work)?	☐	☐	☐	☐
Lift heavy objects?	☐	☐	☐	☐
Move heavy objects?	☐	☐	☐	☐

TRI-COUNTY RHEUMATOLOGY

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PATIENT NAME:_____ **DOB:**_____

CURRENT MEDICATIONS/SUPPLEMENTS:

MEDICATION NAME	*DOSAGE*	*FREQUENCY*	*PRESCRIBING MD*

ALLERGIES:

MEDICATION NAME	*REACTION*

SURGICAL HISTORY:

SURGERY	*DATE of SURGERY*

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PATIENT NAME:_____ **DOB:**_____

DOCTORS YOU WISH US TO SHARE YOUR RECORDS WITH REGARDING YOUR CARE (ex- PCP, Specialists):

MD NAME	***TYPE OF MD***	***ADDRESS***	***PHONE***	***FAX***

Local Pharmacy: _____

Mail Away Pharmacy: _____

Specialty Pharmacy: _____

MAY WE LEAVE MESSAGES ON YOUR HOME PHONE? YES or NO

MAY WE LEAVE MESSAGES ON YOUR CELL PHONE? YES or NO

Patient Signature: _____

Date: _____

RECORDS REQUEST

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient Name**:**_____

Patient's Date of Birth:_____

A. Person(s) or Organization(s) authorized to provide the information (records are coming from):

B. Person(s) or Organization(s) authorized to receive the information:

TRI COUNTY RHEUMATOLOGY
1650 HUNTINGDON PK, STE 352, MEADOWBROOK PA 19046
PH: 267-571-2151 FAX: 215-379-8387

C. Specific description of the information that may be used or disclosed (including dates):

D. Specific description of how the information will be used: CONTINUED MEDICAL TREATMENT

1) I understand that this authorization will **expire** on _____.
2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying the person or organization mentioned in **A** (above) in writing.
3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits if applicable.
4) I may **inspect or copy** any information used or disclosed under this agreement.
5) I understand that if person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would **no longer be protected** by these regulations.

_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

You have the right to know specifically what information you are authorizing for release *(e.g., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information.")*.

You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information *(e.g., the names of your health care provider(s)).*

You have the right to know who is going to use it and what it is going to be used for. *(e.g., John Smith, PhD / Research).*

You have the right to alter this request. We have preprinted options for your convenience. You may alter these items if needed.

You have the right to receive a copy of this form.