ARTHRITIS & OSTEOPOROSIS CLINIC OF BRAZOS VALLEY

1725 Birmingham Rd., Ste. 200, College Station, TX 77845 · (979) 696-8000 · (979) 696-8100 fax

Board Certified in Rheumatology

Ricardo Pocurull, MD, FACR **Rajpreet Singh, DO, FACR**

Kati Langston, PA-C **Laura Smith, PA-C**

Welcome to the Arthritis & Osteoporosis Clinic of Brazos Valley. We are pleased that you have scheduled an appointment with our Clinic. Enclosed you will find new patient information.

We ask that you please come in 30 minutes before your scheduled time to allow for mailed and in office paperwork to be completed. We apologize in advance for any inconvenience this may cause.

Please take the time to fill the paperwork out prior to your appointment and bring it with you to your first appointment. Please also bring the following to your appointment:

- Currently effective insurance card(s),
- A photo I.D.,
- A list of all medications that you are currently taking **(required at every visit)** and,
- **If your insurance requires a referral authorization, it must be available and in our office at the beginning of appointment or you will be asked to reschedule.** To obtain a referral authorization, contact your primary care physician in advance of your appointment.

If you are unable to keep your appointment, please kindly give a 24 hour advance notice.

Thank you for your cooperation and we look forward to seeing you.

Sincerely,

AOCBV

Appointment Date: ___________________________________

Appointment Time: ____________________

PATIENT REGISTRATION FORM

Patient Name ____
Last **First** **Middle**

Birthdate ______/_____/_______ ☐**Male** ☐**Female** ☐**Married** ☐**Single** ☐**Widowed** ☐**Divorced**

Social Security _________-______-________ **Spouse Name:** _________________________________

Street Address ____ (_____)__________________
Home Phone

City, State, Zip____ (_____)__________________
Cell or Pager

Employer____ (_____)__________________
Work Phone

Insurance Information

Is your insurance an affordable care plan? ☐Y ☐N **If yes, you will immediately be cash pay.

*Did you sustain an injury at work? ☐Y ☐N Are you covered under an employer or union policy? ☐Y ☐N

We do not accept Workman's Compensation Insurance. If you answered Yes, STOP.

*Are your injuries accident related? ☐Y ☐N Is your spouse or other family member employed? ☐Y ☐N

*auto and personal injury claims are not filed by our office and the patient is responsible for payment.

Are you currently employed? ☐Y ☐N Do you have a secondary insurance policy? ☐Y ☐N

Are you the primary policyholder/subscriber ☐Yes ☐No **If no, please fill out the following:**

Name of primary policyholder/subscriber____

Policyholder/Subscriber's Birthdate ______/_____/_______ **Social Security**_______-______-______

Your relationship to policyholder ☐**Spouse** ☐**Child** ☐**Stepchild** ☐**Other:**________________________

Nearest friend or relative that does not live with you:

___________________________________(_____)_________________ __________________________
Name **Phone** **Relationship**

How will you pay for visit? _____________________**Who referred you?**_________________________

Who is your primary care physician?____

What is the reason for today's visit?____

Have you seen another physician for this condition? ☐**Yes** ☐**No** **If yes, who?**______________________

Have you ever had a MEDICATION ALLERGY? ☐**Yes** ☐**No** **If YES, list medications allergy:**

____

I voluntarily authorize the rendering of medical care, including examination, diagnostic procedures, and medical treatment by Ricardo Pocurull M.D., Rajpreet Singh D.O., Kati Langston PA-C, Laura Smith PA-C, his/her staff and designees, as may in his professional judgment be deemed necessary or beneficial. I acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition. I understand that I have the right to make decisions concerning my health care, including the right to refuse medical and surgical procedures.

____ ________________
Signature of Patient or Personal Representative Date

ARTHRITIS & OSTEOPOROSIS CLINIC OF BRAZOS VALLEY

Acknowledgement of Review of Notice of Privacy Practices

I acknowledge that I have had the opportunity to review the Arthritis & Osteoporosis Clinic of Brazos Valley's Notice of Privacy Practices. This document explains how my medical information will be used and disclosed. I understand that diagnosis or treatment of me by my physician may be conditional upon my consent as evidenced by my signature on this document. I understand that I am entitled to receive a copy of this document. I am aware that copies are available in the lobby of the Arthritis and Osteoporosis Clinic of Brazos Valley and online at www.aocbv.com.

____ ______________

Signature of Patient or Personal Representative Date

____ ______________

Print Patient or Personal Representative's Name Date

Do you feel comfortable with your ability to read and write? ☐ Yes ☐ No

Authorization to Release/Discuss Medical Information

I, ____, authorize Ricardo Pocurull M.D., Rajpreet

Print Patient Name

Singh D.O., Kati Langston, PA-C, Laura Smith PA-C, or their designated representative to release or discuss information in my

health records to or with ____.

Print Name(s)

I realize that I have the right to rescind this designation at any time by writing the staff at Arthritis & Osteoporosis Clinic of Brazos Valley, PLLC.

____ ______________

Patient/Legal Representative Date

____

Printed Name, if signed on behalf of the patient

ARTHRITIS & OSTEOPOROSIS CLINIC OF BRAZOS VALLEY

Financial Policy

We are dedicated to providing the best possible care and service to you and regard the complete understanding of your financial responsibilities as an essential element of your care and treatment. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs. If you have any questions about the policy, please discuss them with the billing office at (979)696-8000. Please direct your questions about your financial responsibility *first* to your insurance company. However, do not hesitate to call us for questions about our statements to you.

Payment Options: For your convenience, we will accept cash, check, money order, VISA, MasterCard, and Discover. A $25.00 service charge will be added to your account for all returned checks and must be paid before additional appointments will be scheduled. Restitution of the check must be made within 10 days or check will be given to the County Attorney for prosecution.

Appointments: Broken appointments represent a cost to us, to you and to the other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed appointments. Currently, our no show fee is $50 and may increase at any time. Excessive abuse of scheduled appointments may result in discharge from the practice. Reminder phone calls are a courtesy to you; you are responsible for your appointment even if you do not receive a reminder phone call.

Insurance: You must provide proof of your currently effective insurance at each appointment. Unless you have health coverage, full payment is due at the time of service. We bill participating insurance companies as a courtesy to you. All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your health care provider, our relationship is with you, our patient, not with your insurance company. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

HMO's: HMO's usually require authorization prior to all visits. It is the patient's responsibility to get that authorization from your primary care physician with the dates of service of your appointments. If we do not have a copy of this authorization at the time of service, we will reschedule your appointment until that authorization is available or you may pay for your entire visit prior to being seen by your provider. Amounts that your insurance pays will be refunded to you.

Medicaid: Medicaid requires all recipients to present their card when seeking medical attention, failure to do so may result in the rescheduling of your appointment.

Cash Pay: We utilize a standard self-pay policy based off Medicare rates. 125% of Medicare allowable amount is our fee for services updated annually. Payment is due at the time services are rendered.

Services Rendered in the Hospital: We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

PRINT NAME:____

ARTHRITIS & OSTEOPOROSIS CLINIC OF BRAZOS VALLEY

Financial Policy

Workmen's Compensation: We do not take Workmen's Compensation. We do not treat injuries incurred at work.

Minor Patients: For all services rendered to a minor patient, we will look to the adult accompanying the patient and/or the parent or guardian with custody for payment.

Collection Agency: Any account that is given to our collection agency due to non-payment will have a 30% collection charge added to the account. Our collection agency will then collect the past due amount plus the 30% collection charge.

Disclosure of Financial Interest in AOCBV Laboratory and Intrafusion Infusion Suite

This disclosure is provided to you prior to any referral to the facility for laboratory services or the infusion suite in order for you to have an opportunity to select a different laboratory or infusion clinic to provide the services, if you choose to not come to the AOCBV laboratory and/or intrafusion infusion suite.

I understand that I am financially responsible for all charges for service to me, including the balance remaining after payment of possible insurance benefits. I authorize payment of medical benefits to Ricardo Pocurull, MD, FACR, Kati Langston, PA-C, Rajpreet Singh, DO, FACR, Laura Smith, PA-C for professional services rendered. I authorize the release of any medical information needed to process claims. I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_______________________________________ _______________

Signature of Patient or Responsible Party Date

____

Printed Name

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Joint Aspiration and Injection Acknowledgement Form

Patient: ____

1. Arthrocentesis or aspiration and injection of a joint are procedures commonly used by the AOCBV to improve joint function and provide pain relief as well as evaluation measures. This is an acknowledgement form for patient record identifying my acknowledgement of such procedures.
2. I understand that these are procedures performed by placing a needle into the joint or surrounding area. The goal is to withdraw fluid from the joint to provide pain relief, analyze the fluid under the microscope, and, possibly, inject medication into the joint to provide additional pain relief. I understand that the removal of fluid may be needed to find out why the fluid was present. I understand that fluid may re-accumulate after the removal. I understand that the medication that may be injected is a corticosteroid and may not provide long-lasting or permanent relief, and that no guarantee can be made about the outcome of my planned procedure.
3. Risks associated with joint aspiration and injection include the following:
    - Pain associated with the procedure if the needle touches joint surfaces
    - Increased bleeding, especially for those patients on blood thinning medications.
    - Damage to a nerve or joint surface from the needle or medication
    - Rare introduction of infection into the joint
    - Increased joint pain after injection of medication, or post-injection flare reaction
4. **I understand that I can refuse any procedure that is offered to me during my care at AOCBV.**

Initials: ________________

Date: __________________

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Controlled Substance Agreement For Narcotics Prescribed by AOCBV

I, ______________________________, agree if AOCBV is prescribing a controlled substance that they will be the only physicians prescribing this medication for me and that I will obtain all of my prescriptions for controlled substances at one pharmacy. I will not seek controlled substances from another physician.

- I will not take controlled substances in larger amounts or more frequently than is prescribed.
- I will not give or sell my medication to anyone else, including family members; nor will I accept any controlled substances from anyone else. I agree to be responsible for the secure storage of my medication at all times. I understand that lost or stolen medication will not be replaced.
- I will attend all reasonable appointments, treatments and consultations as requested by my physician.
- I understand that the long-term use of controlled substances to treat chronic pain may result in physical dependence on this medication, and that sudden decreases or discontinuation of the medication will lead to the symptoms of controlled substances withdrawal. I understand that controlled substances withdrawal is uncomfortable but not life threatening.
- I understand that there is a risk that I may become addicted to the controlled substances I am being prescribed. The risk is small where medication is taken as prescribed for pain.
- I understand that my physician will require that I have urine monitoring monthly for *Schedule II* medications, every 3 months for *Schedule III* medications. Should a concern about addiction arise during my treatment my physician may ask me to see a specialist in addiction medicine. I will comply with all requests for laboratory tests including random or scheduled urine monitoring for appropriate narcotic management as ordered by my physician.
- I understand that the use of any mood altering substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as cannabis, cocaine, heroin or hallucinogens), can cause adverse effects or interfere with opioid therapy. Therefore I agree to refrain from the use of all of these substances without prior agreement from my physician.
- I consent to open communication between my doctor and any other health care professionals involved in my management, such as pharmacists, other doctors, emergency departments, etc.
- I understand that if I break this agreement, my physician reserves the right to stop prescribing controlled substances and I may be discharged from this practice.
- I will comply with requests by my physician to go to the office for a pill count between scheduled visits.

Refills Only:

- Please call ahead and leave message with patient name, date of birth, medication name, dosage and a phone number where you can be reached. Triplicate prescriptions may only be picked-up by the patient, spouse or caregiver. We cannot mail this prescription to you. We will **NOT** write these prescriptions on weekends or Holidays. Please allow time for refill needs based on in-office process times and holidays accordingly.

____ _____________

Signature of Patient or Personal Representative Date

FREQUENTLY ASKED QUESTIONS CONT'D…

1. Where do I find information about my condition?
   There is plenty of information on our website. We recommend you read about the condition and then ask any further questions on your next visit. If you want to get answers or clarification prior to your next visit, we recommend you use the online function. You will have a better understanding of your condition this way.
2. How do I find out about my blood test?
   Please allow 2 weeks for results. A letter will be mailed with results or you will be contacted by phone call from our office. If there are any questions regarding your lab results they will be handled by appointment only. No phone calls please.
3. How do I get refills?
   a. Refills may be obtained through your pharmacy, calling us for a new prescription, or using the online refill request.
   b. No refill will be done on weekends or after office hours.
   c. ABSOLUTELY NO NARCOTIC REFILLS ON WEEKENDS OR AFTER HOURS, ESPECIALLY WHEN ANOTHER DOCTOR IS ON CALL. NO EXCEPTIONS. Please do not contact us for after hour's refills on narcotics because it will be denied.
   d. Narcotics are only refilled once a month. "I lost my prescription," "my medication was stolen," I accidently spilled them into the toilette," etc…, are not excuses. The only way to obtain a narcotic refill prior to one month is to see the doctor and be assessed.
4. What happens if I have a problem after hours?
   A Provider is on call 24/7. We do ask for your consideration and that you try to contact us during office hours. This is where the online function is especially helpful. For emergencies please call any time.

NEXTGEN Patient Portal

What is the Online Patient Portal?

The Online Patient Portal is a secure, intuitive website that enables patients and providers to quickly access and manage health information. It provides easy communication tools, promoting patient-provider interaction and improving patient care.

With the Online Patient Portal, you can:

- Quickly and securely access your health information
- Instantly request and schedule appointments
- Send secure messages to billing and clinical staff
- Easily request prescription refills
- Reduce wait time by filling out forms online
- View and pay statements

Ask a staff member how to get started today!

Enrollment

- Request an **Enrollment Token** during your visit. (must have an email address)
- Visit www.NextMD.com
- Click Enroll Now and simply follow the steps