Revision Date: 09/25/2019

Pt # _____

Arthritis Center of Nebraska

Patient History Form

Advanced Directive Care Plan? ❑ Yes ❑ No

Date of first appointment: _____ /_____ /_____ Time of appointment: _____ Birthplace:_____
MONTH DAY YEAR

Name: _____ Birth date: _____ /____ /_____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Address: _____ Age: _____ Sex: ❑ F ❑ M
STREET APT #

_____ Telephone: Home (_____) _____
CITY STATE ZIP Work (_____) _____

MARITAL STATUS: ❑ Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse/Significant Other: ❑ Alive/Age _____ ❑ Deceased/Age _____ Major Illnesses_____

Spouse Occupation: _____

EDUCATION (circle highest level attended):

Grade school 7 8 9 10 11 12 College 1 2 3 4 Graduate school _____

Occupation _____ Number of hours worked/average per week _____

How did you hear about our clinic? ❑ Newspaper ❑ Yellow Pages ❑ Health fair ❑ Knowledge Night ❑ Radio ❑ Arthritis lecture ❑ Other

Referred here by: (check one) ❑ Self ❑ Family ❑ Friend ❑ Doctor ❑ Other health professional

Name of person making referral:_____

Name of the physician providing your primary medical care: _____ Name of city the MD is located in: _____

Do you have an orthopedic surgeon? ❑ Yes ❑ No If yes, name: _____
Name of physician you will be seeing today_____
Describe briefly your present symptoms: _____
_____
_____
_____
_____

Date symptoms began (approximate) _____

Diagnosis: _____

Indicate below any previous treatment for this problem

(medications to be listed later):

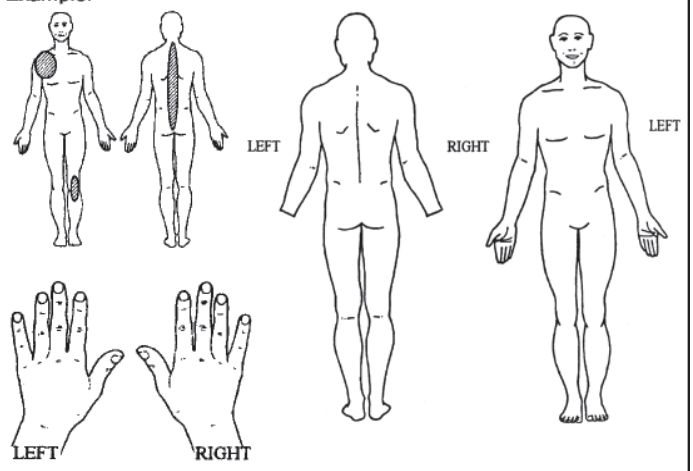
Physical therapy _____

Injections _____

Surgery _____

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

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.



RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	
Other arthritis conditions:					

Patient's Signature _____ Date _____ ACN Physician Initials _____

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what? _____

_____

Type of reaction: _____

CURRENT MEDICATIONS (Please write down all your medications even if you bring them with you to your appointment. Include such items as over the counter pain medications i.e. Tylenol, ibuprofen, aspirin, along with any vitamins, laxatives, calcium and other supplements)

Name of drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped? A lot	Some	Not at all
1.			❑	❑	❑
2.			❑	❑	❑
3.			❑	❑	❑
4.			❑	❑	❑
5.			❑	❑	❑
6.			❑	❑	❑
7.			❑	❑	❑
8.			❑	❑	❑
9.			❑	❑	❑
10.			❑	❑	❑
11.			❑	❑	❑
12.			❑	❑	❑
13.			❑	❑	❑
14.			❑	❑	❑
15.			❑	❑	❑

Have you participated in any clinical trials for new medications? ❑ Yes ❑ No

If yes list: _____

_____

PAST MEDICAL HISTORY

Do you now or have you ever had: (*check if "yes"*)

- ❑ Heart Problems
- ❑ High blood pressure
- ❑ Rheumatic fever
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Psoriasis
- ❑ Diabetes
- ❑ Goiter
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Colitis
- ❑ Jaundice/Hepatitis
- ❑ Stomach ulcers
- ❑ Anemia
- ❑ Cancer
- ❑ HIV/AIDS
- ❑ Severe headaches
- ❑ Seizure Disorder
- ❑ Nervous Breakdown
- ❑ Sleep apnea
- ❑ Asthma
- ❑ Emphysema
- ❑ Pneumonia (Hospitalized)
- ❑ Kidney Disease

Natural or alternative therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

SOCIAL HISTORY

Do you drink caffeinated beverages? ❑ Yes ❑ No
If yes, how many cups/glasses per day? _____
Are you a:
❑ Nonsmoker
❑ Current smoker ❑ Every day ❑ Some days, but not every day
How many cigarettes a day do you smoke? _____
How soon after you wake up do you smoke your first cigarette? _____minutes
Are you interested in quitting? ❑ Ready ❑ Thinking about it ❑ Not ready
❑ Former Smoker
How long has it been since you last smoked?_____
Do you smoke a pipe? _____
Do you chew tobacco? _____

Do you use street/recreational drugs? ❑ Yes ❑ No
If yes, please list: _____
_____
_____

Did you have a drink containing alcohol in the past year? ❑ Yes ❑ No

If 'Yes': How often did you have a drink containing alcohol in the past year?
❑ Never ❑ Monthly or less ❑ 2 to 4 times a month
❑ 2 to 3 times per week ❑ 4 or more times a week

If 'Yes': How many drinks did you have on a typical day when you were drinking in the past year?_____

If 'Yes': How often did you have six or more drinks on one occasion in the past year?
❑ Never ❑ Less than monthly ❑ Monthly
❑ Weekly ❑ Daily or almost daily

Do you exercise regularly?❑ Yes❑ No
Type of exercise _____
Number of times per week ____ Length of time in min. ____

Hobbies _____

How many hours of sleep do you get at night? _____

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

Do you wake up feeling rested? ❑ Yes ❑ No

Previous surgeries

Type	***Year***	***Reason***
1.		
2.		
3		
4.		
5.		
6.		
7.		

Any previous fractures? ❑ No ❑ Yes Describe: _____

Any other serious injuries? ❑ No ❑ Yes Describe: _____

Any hospitalizations – other than surgeries? ❑ No ❑ Yes Describe: _____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at death	Cause
Father				
Mother				

Number of brothers_____ # living _____ # deceased / cause of death_____
Number of sisters_____ # living _____ # deceased / cause of death_____

Number of sons _____ # living _____ # deceased / cause of death_____ List ages of each _____
Number of daughters_____ # living _____ # deceased / cause of death_____ List ages of each _____

Health of children: _____

Do you know of any blood relative who has or had: (check and give relationship)

-

❑ Alcoholism _____ ❑ Colitis_____ ❑ Psoriasis_____ ❑ Thyroid disease _____

❑ Asthma _____ ❑ Diabetes_____ ❑ Rheumatic fever_____ ❑ Tuberculosis_____

❑ Bleeding tendency _____ ❑ Heart disease_____ ❑ Seizures_____

❑ Cancer_____ ❑ High blood pressure_____ ❑ Stroke_____

Patient's Name _____ Date _____ ACN Physician Initials _____

SYSTEMS REVIEW

Mammogram ❑ No ❑ Yes _____/_____ (MONTH YEAR) Eye Exam ❑ No ❑ Yes _____/_____ (MONTH YEAR) Chest X–ray ❑ No ❑ Yes _____/_____ (MONTH YEAR)

Tuberculosis Test ❑ No ❑ Yes _____/_____ (MONTH YEAR) Bone Densitometry ❑ No ❑ Yes _____/_____ (MONTH YEAR)

Influenza (Flu) Vaccination ❑ No ❑ Yes _____/_____ (MONTH YEAR) Pneumonia Vaccination ❑ No ❑ Yes _____/_____ (MONTH YEAR)

Tetanus (DTaP) ❑ No ❑ Yes _____/_____ (MONTH YEAR) Shingles Vaccination ❑ No ❑ Yes _____/_____ (MONTH YEAR)

As you review the following list, please check any of those problems which have significantly affected you.

Constitutional

- ❑ Night sweats
- ❑ Change in weight
- ❑ Loss of appetite
- ❑ Fever

Cardiovascular

- ❑ High blood pressure
- ❑ Chest pain

Dermatology

- ❑ New hair loss
- ❑ Allergy to sun
- ❑ Finger color change in cold
- ❑ Rash
- ❑ Psoriasis
- ❑ Hives
- ❑ Easy bruising
- ❑ Skin cancer

Endocrinology

- ❑ New thyroid problem
- ❑ Excessive thirst

ENT

- ❑ Dry mouth or eyes
- ❑ Hearing loss
- ❑ Mouth sores

Eye

- ❑ Eye redness & pain
- ❑ Loss of vision

Female Reproductive

- ❑ Contraception
- ❑ Menopause

Gastroenterology

- ❑ Nausea/Vomiting
- ❑ Heartburn
- ❑ Difficulty swallowing
- ❑ Diarrhea
- ❑ Blood in stool

Male Reproductive

- ❑ Penile discharge

Musculoskeletal

- ❑ Back or neck pain
- ❑ Legs cramps
- ❑ Fracture

Neurology

- ❑ Weakness
- ❑ New headache
- ❑ Tingling numbness hands or feet
- ❑ Loss of balance/falls

Psychology

- ❑ Feeling blue or depressed
- ❑ Difficulty with sleep
- ❑ Mental or physical abuse
- ❑ Worries or anxiety

Respiratory

- ❑ Shortness of breath
- ❑ Coughing up blood
- ❑ Painful breathing / pleurisy
- ❑ Cough

Urology

- ❑ Blood in urine

Number of:

_____Pregnancies

_____Deliveries

_____Miscarriages/abortions

Ethnic origin

_____

Patient's Name _____ Date _____ ACN Physician Initials _____

PAST MEDICATIONS Please review this list of arthritis medications. As accurately as possible, try to remember which medications you have taken, **how long** you were taking the medication, the **results** of taking the medication and list any **reactions** you may have had. Record your comments in the spaces provided.

Drug names	Please check: Helped? A lot	Some	Not at all		Please check: Helped? A lot	Some	Not at all
Disease Modifying Antirheumatic Drugs (DMARDS)				**Non-Steroidal Pain Relievers**			
Abatacept (Orencia)	❑	❑	❑	Aspirin (including coated aspirin)	❑	❑	❑
Adalimumab (Humira)	❑	❑	❑	Diflunisal / (Dolobid)	❑	❑	❑
Apretuilast / Otezla	❑	❑	❑	Choline magnesium trisalicylate / (Trilisate)	❑	❑	❑
Azathioprine (Imuran)	❑	❑	❑	Disalcid / (Salsalate)	❑	❑	❑
Baricitinib / Olumiant	❑	❑	❑	Diclofenac / (Voltaren)	❑	❑	❑
Belimumab (Benlysta)	❑	❑	❑	Diclofenac + Misoprostil / (Arthrotec)	❑	❑	❑
Certolizumab (Cimzia)	❑	❑	❑	Etodolac / (Lodine)	❑	❑	❑
Cyclophosphamide (Cytoxan)	❑	❑	❑	Indomethacin / (Indocin)	❑	❑	❑
Cyclosporine / Tacrolimus	❑	❑	❑	Sulindac / (Clinoril)	❑	❑	❑
Etanercept (Enbrel)	❑	❑	❑	Tolectin / (Tolmetin)	❑	❑	❑
Golimumab (Simponi)	❑	❑	❑	Flurbiprofen / (Ansaid)	❑	❑	❑
Hydroxychloroquine (Plaquenil)	❑	❑	❑	Ketoprofen / (Oruvail)	❑	❑	❑
Infliximab (Remicade)	❑	❑	❑	Oxaprozin / (Daypro)	❑	❑	❑
Ixekizumab / Taltz	❑	❑	❑	Ibuprofen / (Motrin / Advil)	❑	❑	❑
Leflunomide (Arava)	❑	❑	❑	Naproxen / Naprosyn (Aleve)	❑	❑	❑
Methotrexate (Rheumatrex)	❑	❑	❑	Naproxen/Esomeprazole / (Vimovo)	❑	❑	❑
Mycophenolate mofetil (CellCept)	❑	❑	❑	Fenoprofen / (Nalfon)	❑	❑	❑
Risankizumab / Skrizi	❑	❑	❑	Meclofenamate / (Meclomen)	❑	❑	❑
Rituximab (Rituxan)	❑	❑	❑	Piroxicam / (Feldene)	❑	❑	❑
Sarilumab / Kevzara	❑	❑	❑	Meloxicam / (Mobic)	❑	❑	❑
Secukinumab / Cosentyx	❑	❑	❑	Nabumetone (Relafen)	❑	❑	❑
Sulfasalazine (Azulfidine)	❑	❑	❑	Celecoxib / (Celebrex)	❑	❑	❑
Tocilizumab (Actemra)	❑	❑	❑	**Other pain relievers**			
Tofacintanib (Xeljanz)	❑	❑	❑	Acetaminophen (Tylenol)	❑	❑	❑
Upadacitinib / Rinvoq	❑	❑	❑	Codeine/Hydrocodone (Vicodin, Tylenol 3)	❑	❑	❑
Other:	❑	❑	❑	Fentanyl	❑	❑	❑
Others				Oxycodone	❑	❑	❑
Cortisone/Prednisone	❑	❑	❑	Oxycontin	❑	❑	❑
Glucosamine	❑	❑	❑	Tramadol (Ultram or Ultracet)	❑	❑	❑
Herbal or nutritional supplements	❑	❑	❑	Other:	❑	❑	❑
Gout medications				**Osteoporosis medications**			
Allopurinol (Zyloprim/Lopurin)	❑	❑	❑	Alendronate / Fosamax	❑	❑	❑
Colchicine (Colcrys)	❑	❑	❑	Denosumab (Prolia)	❑	❑	❑
Febuxostat (Uloric)	❑	❑	❑	Estrogen (Premarin, etc)	❑	❑	❑
Probenecid (Benemid)	❑	❑	❑	Evenity	❑	❑	❑
Other:	❑	❑	❑	Ibandronate (Boniva)	❑	❑	❑
	❑	❑	❑	Raloxifene (Evista)	❑	❑	❑
	❑	❑	❑	Risedronate (Actonel)	❑	❑	❑
	❑	❑	❑	Teriparatide (Forteo)	❑	❑	❑
	❑	❑	❑	Zoledronic Acid (Reclast)	❑	❑	❑
	❑	❑	❑		❑	❑	❑
	❑	❑	❑		❑	❑	❑
	❑	❑	❑		❑	❑	❑

Please list supplements:

ACTIVITIES OF DAILY LIVING

I live in a (circle one): Home Town home Apartment Assisted living

Do you have stairs to climb? ❑ Yes ❑ No If yes, how many?_____

How many people in household? _____ Relationship and age of each _____

Who does most of the housework?_____ Who does most of the shopping? _____

Who does most of the yard work?_____

Please try to answer all of the following questions, answer exactly as you think or feel. There are no right or wrong answers. Check the one best answer for each question.

AT THIS MOMENT, are you able to:	Without **ANY** difficulty	With **SOME** difficulty	With **MUCH** difficulty	**UNABLE** to do
Dress yourself, including tying shoelaces, doing buttons?	0	1	2	3
Get in and out of bed?	0	1	2	3
Lift a full cup or glass to your mouth?	0	1	2	3
Walk outdoors on flat ground?	0	1	2	3
Wash and dry your entire body?	0	1	2	3
Bend down to pick up something from the floor?	0	1	2	3
Turn regular faucets on and off?	0	1	2	3
Get in and out of a car, bus, train or airplane?	0	1	2	3
Vacuum the house and do necessary yardwork?	0	1	2	3
Run errands and shop as you would like?	0	1	2	3
Get a good night's sleep?	0	1.1	2.2	3.3
Deal with feelings of anxiety or being nervous?	0	1.1	2.2	3.3
Deal with feelings of depression or feeling blue?	0	1.1	2.2	3.3

FOR OFFICE USE ONLY

1=0.33	**2=0.67**
3=1.0	**4=1.33**
5=1.67	**6=2.0**
7=2.33	**8=2.67**
9=3.0	**10=3.33**
11=3.67	**12=4.0**
13=4.33	**14=4.67**
15=5.0	**16=5.33**
17=5.67	**18=6.0**
19=6.33	**20=6.67**
21=7.0	**22=7.33**
23=7.67	**24=8.0**
25=8.33	**26=8.67**
27=9.0	**28=9.33**
29=9.67	**30=10.0**

HAQ SCORE =

How much pain have you had because of your condition OVER THE PAST WEEK?
Please indicate below how severe your pain has been **(0=No pain; 10=Worst Pain)**

_____Pain Score

❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
0	0.5	1.0	1.5	2.0	2.5	3.0	3.5	4.0	4.5	5.0	5.5	6.0	6.5	7.0	7.5	8.0	8.5	9.0	9.5	10.0

Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing? **(0=Very well; 10=Very Poorly)**

_____Global Score

❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
0	0.5	1.0	1.5	2.0	2.5	3.0	3.5	4.0	4.5	5.0	5.5	6.0	6.5	7.0	7.5	8.0	8.5	9.0	9.5	10.0

Rapid 3(0-30)
Cat:
HS=>12
MS=6.1-12
LS=3.1-6
R=<3

After you wake up, how long does it take you to limber up? AM stiffness:_____ (min or hours)

What is the hardest thing for you to do?_____

Are you receiving disability? ..... Yes ❑ No ❑

Are you applying for disability? ..... Yes ❑ No ❑

Do you have a medically related lawsuit pending? ..... Yes ❑ No ❑

Arthritis Center of Nebraska
3901 Pine Lake Road, Ste 120
Lincoln, NE 68516-5497
402-420-1212

ARTHRITIS CENTER OF NEBRASKA

PATIENT ACCOUNT#_____ **DR**_____

Family Physician _____ **Referred by** _____

PLEASE PRINT CLEARLY with BLACK or BLUE pen

APPOINTMENT DATE _____

PATIENT NAME_____
First **MI** **Last**

****NAME PREFERRED TO BE CALLED** _____

ADDRESS _____

CITY _____**STATE**_____**ZIP**_____

E-mail address _____

TELEPHONE #'s **Home** _____ **Work** _____ **Cell** _____

SEX ☐ **Female** ☐ **Male** ☐ **Transgender** **Birth date** _____/_____/_____ (mo day yr) **Marital Status** ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated** ☐ **Domestic Partner**

SOCIAL SECURITY # _____

EMPLOYER _____

OCCUPATION _____ ☐ **Full-Time** ☐ **Part-time**

IN CASE OF EMERGENCY NOTIFY:

IF MARRIED-SPOUSE

NAME _____ **Work** _____ **Cell** _____ **Birth Date** _____/_____/_____ (mo day yr)

ADDITIONAL EMERGENCY CONTACT NOT RESIDING WITH YOU _____

Relationship to patient _____

Home _____ **Work** _____ **Cell** _____

****THE GOVERNMENT IS REQUIRING US TO COLLECT THIS DATA - Please answer BOTH questions below about Hispanic Origin and Race ****

Are you Hispanic, Latino or Spanish in Origin? Please Note: Hispanic origins are not races.

- ☐ No, not of Hispanic, Latino or Spanish Origin
- ☐ Yes, Hispanic
- ☐ Yes, Mexican
- ☐ Yes, Mexican American
- ☐ Yes, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, Other

Please select your race:

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Other Race
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Other Pacific Islander
- ☐ Vietnamese
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan

Primary Language Spoken: _____

INSURANCE INFORMATION
Please be exact in listing identification numbers

Primary Insurance Co. Name _____

ID# _____ Group # _____

Patient relationship to insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other** _____

If relationship to insured "Other than Self" please complete below:

Policy Holder (Insured) Name _____

Address _____

City _____State _____Zip _____Phone # of Policy Holder _____

Date of Birth of Insured: _____ Employer _____

++++++++++++++++++++++++++++++++++++

Secondary Insurance Co. Name _____

ID# _____ Group # _____

Patient relationship to insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other** _____

If relationship to insured "Other than Self" please complete below:

Policy Holder (Insured) Name _____

Address _____

City _____State _____Zip _____Phone # of Policy Holder _____

Date of Birth of Insured _____ Employer _____

++++++++++++++++++++++++++++++++++++

Tertiary Insurance Co. Name _____
(3rd Insurance if applicable)

ID# _____ Group # _____

Patient relationship to insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other** _____

If relationship to insured "Other than Self" please complete below:

Policy Holder (Insured) Name _____

Address _____

City _____State _____Zip _____Phone # of Policy Holder _____

Date of Birth of Insured: _____ Employer _____

PRIOR AUTHORIZATION/REFERRAL FOR INSURANCE

It is my responsibility to obtain prior authorization and/or physician referrals if required by my insurance carrier. I understand that if I am treated without authorization, I will be responsible personally for all or part of the cost of professional services.

AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM (Please sign your name below). I hereby authorize photocopies of this form to be as valid as the original. I understand I can withdraw this authorization at any time, by notifying this office in writing. I hereby authorize treatment of the above patient and agree to pay all fees and charges for treatment regardless of insurance coverage or the pendency of insurance claims.

Date_____ **X** _____

Patient's or authorized person's signature

ARTHRITIS CENTER OF NEBRASKA

Melvin A. Churchill, MD | Rick C. Chatwell, MD | Robert M. Valente, MD
William J. Saalfeld, DNP, APRN-NP | Kristin A. Twidwell, PA-C | Heather A. Sorensen, APRN-NP
Karis A. Lange, PA-C | Samone M. Wulf, PA-C | Jaimie A. Russell, APRN-NP

Board Certified Rheumatologists Providing Comprehensive Rheumatologic Care and Osteoporosis Evaluation

Date_____

PLEASE NOTE

We are requesting the following information in order to better serve you and to ensure the proper routing of medical reports. Please complete the following using BLACK or BLUE INK:

*****It is **very important** the doctor's first and last name be listed along with the city and state.

Patient Full Name (please print): _____

DOB: _____

City, State (please print): _____, _____

Family Physician: _____ _____ _____
(First Name) **(Last Name)** **(MD, PA, NP)**

City, State (please print): _____, _____

***If PA (Physician Assistant) - which Doctor does he/she practice under?**

_____

Pharmacy Preferences:

Local Pharmacy

_____ _____ _____
(Name) **(Address-Example: 56th & Highway 2)** **(Phone #)**

Mail Order Pharmacy

_____ _____ _____
(Name) **(Address)** **(Phone #)**

Thank you for taking the time to provide this information to our office.

ARTHRITIS CENTER OF NEBRASKA

Name: _____ **Date of Birth:** _____

1. PRIOR AUTHORIZATION/ REFERRAL FOR INSURANCE

I understand that it is my responsibility to obtain prior authorization and/or physician referrals if required by insurance carrier. I understand that if I am treated without authorization, I will be responsible personally for all or part of the cost of professional services.

AUTHORIZATION TO RELEASE AND CONSENT TO OBTAIN HEALTH INFORMATION

- **I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM**
- I hereby authorize photocopies of the Patient Information Form to be valid as the original. I understand I can withdraw this authorization at any time, by notifying this office in writing.
- I hereby authorize treatment of the above patient and agree to pay all fees and charges for treatment, procedures and tests (including testing for HIV (AIDS) and Hepatitis, **if ordered by provider**) regardless of insurance coverage or the pending of insurance processing.
- I hereby authorize the Arthritis Center of Nebraska Providers to view the external prescription history via the RxHub service for the patient listed above.
- I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

X_____ Date_____

Patient's or authorized person's signature (if not the Patient, relationship to the patient) _____

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2. RELEASE OF MEDICAL AND BILLING INFORMATION

(Complete this section of this Form if you wish to allow family or others access to your Medical and Billing information.)

I, _____do hereby authorize personnel to release information concerning any and all diagnostic studies and findings contained within my clinic chart (whether performed here or elsewhere), my billing, insurance, or other account information to the family member(s)/ parties listed below:

Name_____**Relationship**_____

Name_____**Relationship**_____

Name_____**Relationship**_____

X _____ _____

Patient's or authorized person's signature **Date**

(Please note: This form is valid from the date signed until another form is requested by the patient.)

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3. I AUTHORIZE THAT VOICE MESSAGES MAY BE LEFT ON MY PHONE(S). ☐ Yes ☐ No

X _____ _____

Patient's or authorized person's signature **Date**

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4. ACKNOWLEDGEMENT PLEASE CHECK ONE AND SIGN:

☐ I acknowledge that I am aware of **Notice of Privacy Act Practices** & **decline** to be given a copy of the document.

☐ I request to be given a copy of the **Arthritis Center of Nebraska's Notice of Privacy Practices** document

X _____ _____

Patient's or authorized person's signature **Date**

Office Use Only: **Copy given to patient**	_____	_____	_____
	Staff Initials	**Date**	**Account Number**