

Department of Internal Medicine
University Rheumatologists
The Rush Arthritis and Orthopedic Institute
1611 W. Harrison St., Suite 510
Chicago, IL 60612

Tel: 312.942.6641
Apt: 312.563.2800
Fax: 312.563.2075
www.rush.edu



Dear Patient,

Welcome to University Rheumatologists. We are located at 1611 West Harrison Street, Suite 510 of the Orthopedic Building at Rush University Medical Center. Directions have been included for your convenience. Parking is available at the garage on the corner of Paulina and Harrison Street. If you park in this garage we are able to validate your ticket for a discounted rate, please inquire at our front desk. Valet parking is also available in the front of the Orthopedic Building but not at a discounted rate.

Please arrive 30 minutes prior to your appointment time to complete the registration process. Rush University Medical Center provides interpretive services when advance notice is given. If you require an interpreter, need to change or cancel an appointment please call us at 312-563-2800. We request that you notify us of your change or cancellation no less than 24 hours in advance. A timely notification will permit patients that are waiting to schedule a sooner appointment. If you fail to show up to your scheduled appointments it may result in being discharged from the practice.

We want your visit with us to be a success. Therefore, we have included a checklist to help you prepare for our time together. Please bring the completed packet with you on your appointment date. This will reduce your registration time on the day of your visit.

Thank you for choosing University Rheumatologists. We look forward to seeing you and participating in your care.

Sincerely,

University Rheumatologists

New Patient Checklist

What to Bring to Your Visit:

- Copies of medical records.** This includes physician progress notes, blood tests, x-ray reports or any other tests that might be of helpful to your doctor. You may have these records faxed prior to your visit. Please send to Attention: NP Medical Records (Fax) 312-563-2075 or to the Address on the front of this packet.
- A list of all current medications or the actual pill bottles (names, doses, frequency)**
- Please bring your current insurance card and photo ID to each visit.
- Your co-pay (look on your insurance card for amount) will be collected upon check-in at each visit. We accept cash, check, Visa, MasterCard, American Express and Discover credit cards.
 - If you will not be using insurance, please be prepared to pay the full fee for services. A discount of 50% will be offered on the professional fee and 65% off the facility fee only if you pay in full on the same day service was provided.
- If you have a HMO/Managed care plan: Please obtain a referral prior to your visit from your primary care physician and bring it with you. The referral must be valid for the date of your appointment and should indicate the services authorized.
 - Do you need a referral or authorization?
 - Yes
 - No

Forms Attached (Please fill out and bring with you):

- Multi-Dimensional Health Assessment Questionnaire: The questionnaire consists of 4 pages; please complete pages 2 through 4 prior to your visit and page 1 the morning of your visit.
- Authorization for release of patient health information. Please complete concerning the direction of your health information in and out of our practice.
- Authorization for Use and Disclosure of Protected Health Information for Fundraising and Related Communication (*This form is optional*).
- LupusPro: Only fill this form out if you have been diagnosed with or are thought to possibly have Lupus.

New Patient Checklist

PHARMACY

Retail Pharmacy

Name _____

Phone () _____

Address/Intersection

Mail-order Pharmacy (If Applicable)

Name _____

Phone () _____

Address/Intersection

PHYSICIANS

Primary Care Physician

Name _____

Phone () _____

Address/Intersection

Physician that referred you today

Same as PCP

Name _____

Phone () _____

Address/Intersection

16. Please check (✓) either "No" or "Yes" to indicate whether or not you have any of the conditions below:

<u>Have you ever had:</u>				<u>If you answer "Yes", please list AGE or YEAR when it began.</u>				<u>AGE or YEAR</u>
High Blood Pressure or Hypertension	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	Gynecological (Female)/ Prostate (Male) problem	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	
Heart attack	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	Rheumatoid arthritis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	
Other heart disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	Osteoarthritis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	
Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	Lupus	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	
Stroke	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	Back or spine problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	
Bronchitis or Emphysema	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	Fibromyalgia (Fibrositis)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	
Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	Osteoporosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	
Other Lung problem	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	Broken bones after age 50	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	
Anemia (Low Blood)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	Dry mouth	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	
Other hematologic problem	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	Dry eyes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	
Stomach ulcer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	Cataracts	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	
Other gastrointestinal (GI) problem	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	Parkinson's disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	
Thyroid problem	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	Depression	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	Mental illness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	
Kidney problem	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	Alcoholism	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____	
Severe allergies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ or _____					
Other _____ (Please name)			_____ or _____	Other _____ (Please name)			_____ or _____	

17. Please list below all operations you have ever had. Please check (✓) here if none: _____.

<u>Operation</u>	<u>Year</u>	<u>Surgeon</u>	<u>Hospital, City, State</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

(You may continue below or on a separate page)

18. Please list below all major illnesses or hospital admissions (other than for operations).

Please check (✓) here if none: _____.

<u>Illness or Reason for hospitalization</u>	<u>Year</u>	<u>Hospital, City, State</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

(You may continue below or on a separate page)

19. The questions below concern your family medical history:

	<u>If Living</u>		<u>If Deceased</u>	
	<u>Birth Year or Age</u>	<u>Any Major Medical Conditions</u>	<u>Year or Age at death</u>	<u>Cause(s) of death</u>
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
Son(s)	_____	_____	_____	_____
Daughter(s)	_____	_____	_____	_____

20. Any blood relative (parent, child, brother, sister, aunt, uncle) with: If "Yes", give relationship.

	<u>No</u>	<u>Yes</u>	<u>Relation(s)</u>		<u>No</u>	<u>Yes</u>	<u>Relation(s)</u>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lupus or SLE	<input type="checkbox"/>	<input type="checkbox"/>	_____

21. Any illnesses which run in the family?

22. Please write below all pills that you took over the last TWO WEEKS, with or without a prescription. Include aspirin, birth control pills, pain pills, alternative therapy, health supplements, pills sold in health food stores:

NAME OF DRUG, MEDICINE OR ALTERNATIVE THERAPY	DOSE (if known)	How Many per day or week?	NAME OF DRUG, MEDICINE OR ALTERNATIVE THERAPY	DOSE (if known)	How Many Per day or week?
1. _____	_____	_____	8. _____	_____	_____
2. _____	_____	_____	9. _____	_____	_____
3. _____	_____	_____	10. _____	_____	_____
4. _____	_____	_____	11. _____	_____	_____
5. _____	_____	_____	12. _____	_____	_____
6. _____	_____	_____	13. _____	_____	_____
7. _____	_____	_____	14. _____	_____	_____

23. What is your current occupation? (If you are not working now, what way your past occupation?)

24. How many other people live at home with you? _____

[Please check (✓) who lives with you.]

Spouse/partner Parents
 Sons or daughters I live alone
 Others (describe) _____

25. At this time, are you? [Please check (✓) all that apply.]

Working full time Retired
 Working part time Student
 Homemaker-full time Disabled
 Others (describe) _____

26. How many years of school have you completed?

Please circle the number of years of school.

1 2 3 4 5 6 7 8 9 10
 11 12 13 14 15 16 17 18 19 20

Your Name _____ Today's Date _____ Time of Day _____ AM | PM

First Middle Last

_____ Date of Birth _____

SEX: Female Male ETHNIC GROUP: Asian Black Hispanic White Other
 MARITAL STATUS: Single Married Divorced Widowed Separated

Please check if this questionnaire is completed **entirely by patient** or **with help from (name)** _____

WE ASK YOU FOR CONSENT TO REVIEW YOUR RECORDS FOR MEDICAL RESEARCH AND TO CONTACT YOU IN THE FUTURE. YOUR CARE WILL NOT BE AFFECTED IF YOU ANSWER "NO."

I agree to allow information from my medical record to be reviewed for medical research, and to send me similar questionnaires in the future, which I am not required to answer. I understand that this information will remain confidential with my doctor and his or her research associates only. Please check (✓) in **one** box. Thank you!

YES NO Signature _____ Date _____

Please list the name, address, and telephone number of your primary care physician:

Name _____ Address _____
 City, State ZIP _____ Telephone _____

Please list the name of your rheumatologist and insurance center:

Rheumatologist _____ Insurance _____

Please list the name, address, and telephone number of someone who lives at a different address from you, and who will be likely to know your whereabouts if we are unable to reach you:

Name _____ Address _____
 City, State ZIP _____ Telephone _____ Relationship _____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE TO MONITOR YOUR MEDICAL SITUATION.

**RUSH UNIVERSITY MEDICAL CENTER
AUTHORIZATION FOR RELEASE OF
PATIENT HEALTH INFORMATION**

HIM ROI Authorization
Authorization for Release of
Patient Health Information



IDN13151000

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Place Patient Label

INSTRUCTIONS: This authorization is made by you for the release of your healthcare information, as indicated. Please address questions about this form to: Rush University Medical Center, ATTN: Health Information Management Office, 1611 West Harrison Street, L1, Suite 001, Chicago, IL 60612, Telephone: (312) 942-7262, Fax: (312) 942-2264.

SECTION 1: Patient Information				
Name [Last, First, MI]				Date of Birth
Address [Street, City, State, Zip]				
Phone Number(s): Home	Cell	Business	Medical Record Number [if known]	Social Security Number (Last 4) XXX-XX- ____-____

SECTION 2: Authorized to Request Use or Disclosure (FROM)			
I request that my medical record information be sent FROM the person(s)/location(s) indicated below			
Name [Last, First, MI]			
Organization			
Address [Street, City, State, Zip]			
Phone Number(s): Home	Cell	Business	Fax

SECTION 3: Authorized Recipient to Receive (TO)			
I request that my medical record information be sent TO the person(s)/location(s) indicated below			
If you are requesting <u>access to your own medical record</u> , please fill in your own personal information.			
Name [Last, First, MI]			
Organization			
Address [Street, City, State, Zip]			
Phone Number(s): Home	Cell	Business	Fax

SECTION 4: Purpose of the Use or Disclosure
The use or disclosure of my health information is requested for the following purposes (such as continuing care, attorney, self, employer, other):

SECTION 5: Information to be Disclosed	
The following type of information is authorized for release [initial next to each type] for the period of _____ to _____.	
<input type="checkbox"/> General Medical _____	<input type="checkbox"/> Substance Abuse _____
<input type="checkbox"/> HIV Records _____	<input type="checkbox"/> Mental Health and Developmental Disability Treatment Records _____
<input type="checkbox"/> Genetic Testing Records _____	<input type="checkbox"/> Other _____

**RUSH UNIVERSITY MEDICAL CENTER
AUTHORIZATION FOR RELEASE OF
PATIENT HEALTH INFORMATION**

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Place Patient Label

SECTION 6: Disclosure to Include

This disclosure will include the following types of reports:

<input type="checkbox"/> X-Ray/Radiology Report	<input type="checkbox"/> Operative Report	<input type="checkbox"/> History and Physical	<input type="checkbox"/> Pathology Report
<input type="checkbox"/> Emergency Report	<input type="checkbox"/> Consulting Report	<input type="checkbox"/> Immunization Record	<input type="checkbox"/> Itemized Bill
<input type="checkbox"/> Progress/Physician Notes	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> EKG/EEG/EMG Report	
<input type="checkbox"/> Films/Slides	<input type="checkbox"/> Other: _____		
<input type="checkbox"/> Laboratory Report			

SECTION 7: Authorization Expiration Date

This authorization is approved for:

<input type="checkbox"/> This occurrence only	<input type="checkbox"/> 60 days from the date of signature
<input type="checkbox"/> On occurrence of the following event (which must relate to the individual or to the purpose of the use/or disclosure being authorized): _____	

SECTION 8: Please read the following statements carefully:

This authorization is voluntary. Rush will not condition your treatment on giving this authorization. However, Rush may condition the provision of research-related treatment on the provision of an authorization.

I understand that I may change my mind and revoke this authorization at any time by giving written notice of my revocation to the contact office listed above. I understand that revocation of this authorization will not affect action you took in reliance in this authorization before you received my written notice of revocation.

I authorize the use and/or disclosure of my Protected Health Information (PHI) as described above. I understand that this authorization is voluntary and made to confirm my decision so Rush may use and/or disclose my PHI for a specific purpose. I understand that, if the persons or organizations I authorized above to receive and/or use the PHI described above are subject to federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by federal health information privacy laws. However, any mental health, substance abuse, genetic testing, or HIV/AIDS information disclosed by Rush pursuant to the authorization may not be further disclosed except pursuant to my authorization.

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose to the persons and/or organizations named in this form the PHI described in this form.

SECTION 9: Signature

Patient Signature	Date
Personal Representative Name [Last, First, MI]	Personal Representative Phone Number
Personal Representative Relationship to Patient and Authority:	
Personal Representative Signature	Date
Witness Name [Last, First, MI] [Required for the release of mental health information]	Date
Witness Signature	Date

SECTION 10: Verification of Authority

How is the person's identity, authority, and relationship to the patient authorized?

<input type="checkbox"/> Personal Identification _____	<input type="checkbox"/> Personal representative status (identify as parent, guardian, executor, administrator, power of attorney) _____
<input type="checkbox"/> Government credentials _____	
<input type="checkbox"/> Authority is known _____	<input type="checkbox"/> Warrant, subpoena, order, summons, civil investigation, or other legal process _____

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Authorization for Use and Disclosure of Protected Health Information for Communications and Fundraising Opportunities

Patient's Name _____
Street Address _____
City/State/Zip _____
Phone _____ **Birth Date:** _____
E-mail _____
Physician/Practice _____

I authorize [insert name of practice] to use and disclose to Rush University Medical Center (RUMC) the name of my physician and the name of the department in which I was treated. Information regarding my medical condition, diagnosis or treatment will not be disclosed.

I understand that this authorization will permit RUMC to provide me with relevant information on health care issues and programs through newsletters, publications, and other materials. In addition, I understand I may be contacted about opportunities to provide charitable support to RUMC in the areas pertaining to my personal health concerns.

The above-named practice and RUMC fully support the protection of health information. My name will not appear on any patient list that will be loaned or sold by the above-named practice, RUMC or RUMC's medical practices nor will my name be used for telemarketing purposes.

My authorization is voluntary. My failure to sign this authorization will not affect my treatment, payment or eligibility for benefits in any way.

This authorization is valid until revoked. I may revoke this authorization at any time by submitting a request in writing to Rush University Medical Center, Philanthropy Office, 1700 W. Van Buren, Chicago, IL 60612. The revocation will be effective except to the extent that RUMC has already relied on my authorization.

Approved by the Rush Privacy Office September 2011