Arthritis, Autoimmune & Allergy, LLC

Infusion Center & Clinical Research

1893 N. Clyde Morris Blvd., Suite 110 • Daytona Beach, FL 32117-5536 • (386) 676-0307 • FAX (386) 677-7842

Yong H. Tsai, M.D.
Board Certified Rheumatology & Allergy

Aimee Wiener, ARNP, MSN

Notice of Privacy Practices & Patient Consent for Use & Disclosure of Protected Health Information

_____ _____

Printed Patient Name Date

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) I have certain Patient Rights regarding my protected health information.

I understand that Arthritis Autoimmune & Allergy, LLC may use of disclose my protected health information for treatment, payment or health care operations, which means for providing healthcare to me, the patient, handling billing and payment, and taking care of other health care operations. Unless required by law, there will be no other uses and disclosure of this information without my authorization.

Arthritis, Autoimmune & Allergy, LLC has a detailed document called the "Notice of Privacy Practices." It contains a more complete description of your rights to privacy and how we may use and disclose your protected health information.

I understand that I have the right to read the "Notice of Privacy Practices" before signing this agreement. If I ask, Arthritis Autoimmune & Allergy LLC, will provide me with the most current "Notice of Privacy Practices."

My signature below indicated that I have been given the opportunity to review such copy of the "Notice of Privacy Practices." My signature means that I agree to allow Arthritis Autoimmune & Allergy, LLC to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Arthritis, Autoimmune & Allergy, LLC has taken action relying on this consent.

Patient Signature: _____ Date: _____

Relationship to Patient if signed by other party: _____

*You may obtain a copy of our "Notice of Privacy Practices" including any revisions of our notice at any time by contacting: Arthritis, Autoimmune & Allergy, LLC

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Patient Intake Form

First:	**Last:**	
D.O.B. :	**Marital Status:**	**Ethnicity:**
Street Address:		
Phone: (Home)	**(Cell)**	
Email:		
How would you like to receive a reminder for your next appointment? Phone: ☐ **Text:** ☐		
Emergency Contact: _____	**Phone:** _____	
Primary Care Doctor: _____		
Referring Doctor: _____		
Has your insurance changed recently? Yes: ☐ **No:** ☐ • **If your insurance has changed or if you have received a new insurance card please notify the front staff when you check in.**		

Financial Policy

I authorize the release of any medical or other information that may be necessary for my medical care. I authorize the direct payment of surgical/medical benefits for services rendered. I understand that if my insurance requires a referral it is ultimately my responsibility to obtain one. I understand that I am financially responsible for my deductible, coinsurance, copays or any other balance not covered by my insurance.

Patient Signature: _____ Date: _____

9 Pine Cone Drive, Suite 101 • Palm Coast, FL 32137-8683

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Office Visit Policy

- **Cancellations:**

  If you need to cancel your appointment please notify our office 24 hrs. of your scheduled appointment. We understand emergencies happen but please mindful of our other patients that want and need to be seen.

- **No Shows:**
  - **Not confirming your appointment reminder.**
  - **Confirming your appointment and then no-show.**

*** You will not be charged a service fee if you no-show.** However, we will give you two warnings. We understand and take into consideration that emergencies happen and we sometimes forget. Unfortunately, if you continue to no-show we will have no other choice but to discharge you.

1. First offense: No action will be taken but the staff will call to reschedule.

2. Second offense: You will receive a warning letter.

3. Third offense: You will be discharged from our practice and your referring doctor will be notified.

If you agree to and understand our policy, please sign your name and today's date.

Name: _____ **Date:** _____

9 Pine Cone Drive, Suite 101 • Palm Coast, FL 32137-8683

Name: _____ DOB: _____

Social History

Do You Smoke ☐ YES ☐ NO ☐ FORMER When Did You Quit? _____

Do You Drink Alcohol: ☐ NEVER ☐ OCCAISIONAL ☐ MODERATE ☐ HEAVY

Do You Exercise Regularly: ☐ YES ☐ NO

If yes, what type & how often: _____

Family History

Please list what family member if any, have the following conditions:

Gout: _____ Lupus (SLE): _____

Rheumatoid Arthritis: _____ Osteoporosis: _____

Ankylosing Spondylitis: _____ Alcoholism: _____

Asthma: _____ Psoriasis: _____

Tuberculosis: _____ Arthritis (unknown): _____

Personal Past Medical History

Do you now or have you ever had the following conditions:

Cancer: ☐ Goiter: ☐ Headaches: ☐

Kidney Disease: ☐ Anemia: ☐ Emphysema: ☐

Heart Disease: ☐ Diabetes: ☐ Stomach Ulcers: ☐

HIV/AIDS: ☐ Asthma: ☐ Stroke: ☐

Epilepsy: ☐ Colitis: ☐ Psoriasis: ☐

High Blood Pressure: ☐ Tuberculosis: ☐

Do you have any known drug allergies: ☐ YES ☐ NO

If Yes, please list : _____

Name: _____ DOB: _____

Past Surgical History

Surgery	Year	Reason

Current Medications

Name of Medication	Strength & Dosage

Release of Personal Medical Information

I, _____ give Arthritis, Autoimmune & Allergy, LLC permission to share my medical information with the following people:

Name: _____ Relationship:_____ Phone:_____

Name: _____ Relationship:_____ Phone:_____

Name: _____ Relationship:_____ Phone: _____

Print Patient Name:_____

Patient Signature:_____ Date: _____

Name: _____ DOB: _____

Long-Term Controlled/Opioid Substances Therapy Agreement

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe medication for you.

The Dangers of Co prescribing Opioids and Benzodiapines such as Diazepam (Valium), Alprazolam (Xanax) and Clonazepam (Klonopin) are associated with increased risk of drug over dose and death. The office will not allow such combinations of drugs.

Because these drugs have potential for addiction, abuse or diversion, accountability is necessary for the Long-Term Use of controlled substance.

- **All controlled substances must come from one prescribing physician and must be obtained at the same pharmacy. If your pharmacy changes you must inform us.**

  The pharmacy that you have selected is:
  Pharmacy: _____ Phone: _____.

- **You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.**

- **The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or police officers for purposes of maintaining accountability.**

- **You may not share, sell, or otherwise permit others to have access to these medications.**

- **Unannounced drug screens will be done in the office and your cooperation is required.**

- **If your medication has been stolen, you will need to complete a police report regarding the theft.**

- **Dr. Tsai has the right to decrease or discontinue the controlled substances if he feels that the medications hinder the wellbeing and safety of the patient.**

- **The risks of these therapies include drowsiness, lethargy, addiction, constipation, fatigue and dizziness. Patients taking the medication must assume all responsibility of the potential risks of long-term control medication therapy.**

- **Effective January 1, 2020, due to the changes in the regulations of prescribing controlled substances, Patients will be required to have an office visit to obtain refill every 30 days. Early refills will not be given.**

- **All controlled substances will be E prescribed to the pharmacy. We will no longer write for controlled substances on prescription pad.**

- **I have read, understand, and accept all of its terms. It is understood that failure to adhere to these policies may result in discontinue of therapy with controlled substance prescribed by the physician and/or discharge from the office.**

Patient Signature: _____ **Date:** _____

Directions to: Arthritis Autoimmune & Allergy, LLC

1893 N. Clyde Morris Blvd, Suite 110

Daytona Beach, FL 32117

From the South:

1. Travel North on I-95 to the LPGA Blvd exit (#265)
2. Turn Right onto LPGA Blvd
3. Turn Left onto Clyde Morris Blvd
4. Continue driving North on Clyde Morris Blvd one mile.
5. The office will be on the right side directly across from Hinson Middle School, after the traffic light at Strickland Range Road

From the North:

1. Travel South on I-95 to the Granada Blvd Exit (#268)
2. Turn Left onto Granada Blvd
3. Turn Right onto Clyde Morris Blvd
4. Continue driving southbound on Clyde Morris Blvd until you reach the traffic light at Strickland Range Road.
5. Make a U-Turn at this light.
6. The office is ¼ mile back up Clyde Morris Blvd on the right side just past Integra Shores Apartment Complex.

From the West:

1. Travel East on US 92 towards Daytona Beach
2. Turn Left onto LPGA Blvd
3. Travel 6.5 miles on LPGA Blvd
4. Turn Left onto Clyde Morris Blvd
5. Continue North for 1 mile
6. The office is on the right side directly across the street from Hinson Middle School.