Arthritis Center

3440 DePaul Lane Suite 113 Bridgeton, MO 63044
Phone: 314-942-6464 Fax: 314-492-4636 Email: info@drbaak.com

Dear Patient,

Welcome. We look forward to caring for you at the Arthritis Center. Our goal is to ensure you are treated with dignity and compassion during your visit. Your mission is simply to heal. You do this by attending your scheduled appointments, taking the medications and therapies we recommend and by providing us with your medical information.

Arthritis problems can be tiring and confusing. If at any time you do not understand what you have been told, please ask questions. We want to be aware of your concerns, so we can address and resolve them together as we create the best treatment plan that allows you to regain your strength and ability to function at your peak.

Getting Ready for Your Visit:

- Allow an estimated 1 ½ - 2 hours for your first appointment
- Please arrive 15 minutes before your appointments to check-in and bring:
  - The completed patient forms attached to this letter
  - A list of all medications you are currently taking (including vitamins/herbals)
  - Your current insurance card, photo ID, copay (due at the time of the appointment), and be ready to provide a credit or debit card to put on file for any patient balances that may occur

Please Contact:

Your Primary Care Physician and have their office fax us at 314-492-4636:

- A copy of your most recent labs and office notes
- A referral if your insurance requires one to see a specialist

Our Location:

The office is located at 3440 DePaul Lane, Suite 113 Bridgeton, Missouri 63044. We are on the DePaul Hospital Campus in a free standing, two story building across from the emergency room. There is an "Arthritis Center" sign on our building. The Arthritis Center is located on the ground floor with private parking for you directly adjacent to our entrance.

New Patient Appointment Policy:

To Reschedule or Cancel any appointments we ask for at least a 24-hour notice. If you Same Day Cancel the appointment, there will be a $50.00 fee. If you No Call No Show the appointment, you will not be able to reschedule with our office. If you need to get ahold of our office after hours to change your appointment, please email us at info@drbaak.com

Follow Up Appointments:

Please make your follow-up appointment before you leave. Most follow-up appointments will be with Dr. Baak's mid-level team. If you need to see a provider before your next scheduled visit, or you have an urgent rheumatology matter, please call our office at 314-942-6464.

Family and Medical Leave (FMLA)

Due to the high volume of FMLA and disability paperwork please allow 2 to 3 weeks for completion **after** we receive your paperwork and fee of $25.00 has been paid. Please prepare accordingly.

For more information about our practice, please visit our website at www.drbaak.com.
We look forward to caring for you.
Steven Baak, MD – Rheumatologist – Medical Director

RHEUMATOLOGY PATIENT HISTORY FORM

Date: _____

Name: _____ Birthdate: _____

Address: _____

Email: _____

Cell Phone: _____Pharmacy: _____ Pharmacy Phone_____

Whom do we thank for referring you here? _____

Name of your Primary Care Physician: _____

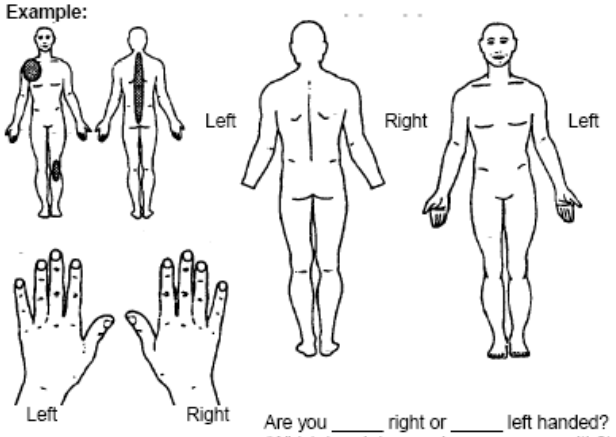
Briefly describe your present symptoms: _____

When did your symptoms start? _____

What diagnosis have you been given, if any?

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

Example:



Are you _____ right or _____ left handed?
(Which hand do you sign your name with?)

Names of other Physicians that are caring for you that we should consult: _____

Previous treatment for this problem (include physical therapy, surgery, and injections)

RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

	Yourself	Relative	→	Relationship
Arthritis (type unknown)	❑	❑	→	_____
Osteoarthritis	❑	❑	→	_____
Rheumatoid arthritis	❑	❑	→	_____
Gout	❑	❑	→	_____
Lupus or "SLE"	❑	❑	→	_____
Ankylosing spondylitis	❑	❑	→	_____
Childhood arthritis	❑	❑	→	_____
Sjogren's syndrome	❑	❑	→	_____
Osteoporosis	❑	❑	→	_____
Psoriasis/psoriatic arthritis	❑	❑	→	_____

PAST MEDICAL HISTORY

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

❑ Diabetes
❑ High blood pressure
❑ High cholesterol
❑ Hypothyroidism
❑ Goiter
❑ Cancer (type) _____
❑ Leukemia
❑ Psoriasis
❑ Angina
❑ Heart problems
❑ Heart murmur
❑ Pneumonia
❑ Pulmonary embolism
❑ Asthma
❑ Emphysema
❑ Stroke
❑ Epilepsy (seizures)
❑ Cataracts
❑ Kidney disease
❑ Kidney stones
❑ Crohn's disease
❑ Colitis
❑ Anemia
❑ Jaundice
❑ Hepatitis
❑ Stomach or peptic ulcer
❑ Rheumatic fever
❑ Tuberculosis
❑ HIV/AIDS

Other significant illnesses (please list): _____

Previous Operations

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

Any previous fractures? ❑ No ❑ Yes Describe _____

Any other serious injuries? ❑ No ❑ Yes Describe _____

Do you smoke? ❑ Yes ❑ No ❑ In the past - How long ago? _____

What is your current or past occupation? _____

SYMPTOM REVIEW

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

- ❑ Morning Stiffness
  - Lasting How long?
  - ___Minutes or
  - ___Hours
- ❑ Loss of Vision
- ❑ Double or Blurred Vision
- ❑ Dry Eyes
- ❑ Pain in Eyes
- ❑ Dry Mouth
- ❑ Loss of taste
- ❑ Sore Tongue
- ❑ Bleeding Gums
- ❑ Rash
- ❑ Hives
- ❑ Sun Sensitivity
- ❑ Skin tightness
- ❑ Nodules/bumps
- ❑ Hair Loss
- ❑ Color changes to skin
- ❑ Easy Bruising
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory Loss
- ❑ Muscle Weakness
- ❑ Depression
- ❑ Excessive Worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Joint pain/stiffness

Other significant illnesses (please list): _____

MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what? _____

Please list any medications that you are now taking. Include non-prescription medications, such as aspirin, vitamins, glucosamine, laxatives, calcium, etc.

Name of drug	**Dose (include strength and number of pills per day)**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

Name: ***Date of Birth:*** ***Appt time:***

Email: ***Have you had your flu shot within the last year? Y or N***

OVER THE PAST WEEK, were you able to:	Without **ANY** difficulty	With **SOME** difficulty	With **MUCH** difficulty	Unable to do
Dress yourself, including tying shoe laces, 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 items from the floor?	□ 0	□ 1	□ 2	□ 3
Wait in line for 15 minutes?	□ 0	□ 1	□ 2	□ 3
Get in and out of a car, bus, train, or airplane?	□ 0	□ 1	□ 2	□ 3
Lift and move heavy objects?	□ 0	□ 1	□ 2	□ 3
Stand up from a chair?	□ 0	□ 1	□ 2	□ 3

When you get up in the morning, do you feel stiff? □Yes □No

How much pain have you had because of your condition in the last 24 hours? Please indicate how severe your pain has been:

No Pain	□ 0	□ .5	□ 1	□ 1.5	□ 2	□ 2.5	□ 3	□ 3.5	□ 4	□ 4.5	□ 5	□ 5.5	□ 6	□ 6.5	□ 7	□ 7.5	□ 8	□ 8.5	□ 9	□ 9.5	□ 10	Pain as bad as it could be

Consider all the ways in which illness and health conditions may affect you at this time. Please indicate how well you are doing:

Very Well	□ 0	□ .5	□ 1	□ 1.5	□ 2	□ 2.5	□ 3	□ 3.5	□ 4	□ 4.5	□ 5	□ 5.5	□ 6	□ 6.5	□ 7	□ 7.5	□ 8	□ 8.5	□ 9	□ 9.5	□ 10	Very Poorly

How much trouble have you had getting a good night's sleep this past week?

No Trouble	□ 0	□ .5	□ 1	□ 1.5	□ 2	□ 2.5	□ 3	□ 3.5	□ 4	□ 4.5	□ 5	□ 5.5	□ 6	□ 6.5	□ 7	□ 7.5	□ 8	□ 8.5	□ 9	□ 9.5	□ 10	Much Trouble

Indicate the severity of your stomach problems (nausea, heartburn, pain, bloating) this week:

No Pain	□ 0	□ .5	□ 1	□ 1.5	□ 2	□ 2.5	□ 3	□ 3.5	□ 4	□ 4.5	□ 5	□ 5.5	□ 6	□ 6.5	□ 7	□ 7.5	□ 8	□ 8.5	□ 9	□ 9.5	□ 10	Pain as bad as it could be

Please indicate how severe your fatigue has been this week:

No Fatigue	□ 0	□ .5	□ 1	□ 1.5	□ 2	□ 2.5	□ 3	□ 3.5	□ 4	□ 4.5	□ 5	□ 5.5	□ 6	□ 6.5	□ 7	□ 7.5	□ 8	□ 8.5	□ 9	□ 9.5	□ 10	Much Fatigue

Arthritis Center: Notice of Privacy Practices Acknowledgement

Arthritis Center will only obtain my written authorization to release information about me if it is not permitted or required by law to disclose this information without authorization.

Patient Full Name: _____ Date of Birth:_____

If there have been no changes to your address, email, or phone number please initial here. ____

Patient Address:	City:	State:	Zip:
E-mail address:			
Home Phone:	Cell Phone:	Work Phone:	
Primary Care Physician	PCP Phone:		

Record of Disclosure

HIPAA privacy rules give individuals the right to request restrictions on disclosure of their protected health information (PHI). Individuals are also provided the right to request confidential communication of PHI be given or prohibited by alternative means, such as, sending correspondence to the individual's office or cell phone instead of the individual's home telephone.

Please check all methods of phone communications that you are permitting disclosure of PHI:

Home Phone: ☐ Leave Message with Detailed Information ☐ Leave Message with call back number only

Cell Phone: ☐ Leave Message with Detailed Information ☐ Leave Message with call back number only

Work Phone: ☐ Leave Message with Detailed Information ☐ Leave Message with call back number only

Written Communication: Note address(es) that we have permission to mail Protected Health Information (PHI)

Address:	City:	State:	Zip:

I give consent to Arthritis Center to discuss or release detail of my medical care, including test results, medications, appointments, etc. to persons below:

Name:	Phone Number:	Relationship:
Name:	Phone Number:	Relationship:

Emergency Contact – Person to call in case of emergency.

Name:	Phone Number:	Relationship:

Authorization to Release Medical Information and Pay Benefits consent for Treatment/Privacy Notice Acknowledgement

I hereby authorize the release of any medical information necessary to bill my insurer and process claims, and I authorize payment of medical benefits be made to Arthritis Center.

Signature of Patient/ Parent or Legal Guardian: _____ Date:_____

Front Desk Initials_____

Arthritis Center

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Statement of Consent for Treatment
As the Patient/Guardian, I consent to medical treatment considered necessary to correct an immediate medical problem, and that such treatment and procedures (i.e., Labs, Ultrasounds) will be performed by medical practitioners who are staff members of the Arthritis Center. The undersigned hereby consents and grants authorization for such treatment and certifies that no guarantee or assurance has been made as to the results of such care. I authorize the Arthritis Center to release any health or financial information requested by my insurance company(s) or other third-party payers in connection with this assignment. I do hereby appoint the Financial Manager of Arthritis Center as my lawful attorney to endorse for me any checks payable to me for debts or claims collected under this assignment and to apply any credit balance to any other debt, I may owe to Arthritis Center.

Statement of Financial Responsibility:
All services rendered are the financial responsibility of the patient. We will bill your insurance(s), however the patient is responsible for all fees, regardless of insurance coverage. This includes the usual and customary fees applied by your insurance company. If your account reaches collection status, your account will be locked, and our office will be unable to process prescription and/or appointment requests. Your account will be assessed an additional $50 fee should it be sent to an outside collection company. You will be required to pay the collection balance plus the $50 fee before future care is administered.

As of January 1st, 2023, Due to an increase in patients wanting to schedule appointments with our office, we ask that you respect our no call/no show policy. We require 24 hours of notice to cancel or reschedule your appointment. Should you fail to call, your account will be charged a $50 no call/no show fee. Should you want to be seen at a later date, the no call/no show fee must be paid AND a credit/debit card must be placed securely on file. **Arthritis Center guarantees only <u>ONE</u> paper statement will be sent to you regarding patient balances. Additional notices regarding your account balance will be sent electronically via email, where you will be given the opportunity to pay your balance via a secure online portal. We ask you to provide a valid email to be on file and that you notify our office should this email address be changed.**

Code of Conduct for all Patients/Visitors:
Arthritis Center expects patients and visitors to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights and safety of other patients/staff. If you have questions about the care, contact our practice manager. The Arthritis Center follows a zero-tolerance policy for aggressive behavior directed by patients/visitors against our staff.

Consent for Appeal:
I, with my signature, authorize (Arthritis Center), and any employee working under the direction of the physician to appeal any insurance claims/prior authorizations that are denied on my (the patient's) behalf regarding medication, medical devices, and/or medical procedures prescribed by the physician.
By signing below, you are acknowledging you understand and agree to all above statements.
Patient Signature: _____ Patient Date of Birth ___/___/____
Patient Printed Name: _____ Date: _____

Rheumatology Principal Care Management

You are being treated for a chronic condition that requires complex medical management. Our goal is to provide you with the best care possible, to keep you out of the hospital for your condition. Providers from the Arthritis Center will review your chart in between your routine visits and handle issues related to your Rheumatology care, all supervised by Dr. Baak.

Participating in this service allows Dr. Baak authorization of electronic communication of medical information with other doctors, as allowed by state and local regulations, and to bill insurance for Principal Care Management. You can discontinue this service at any time by signing a Principal Care Management stop form.

I agree to participate in the Principal Care Management Program Yes___ No___

_____

Print Name

_____ _____/_____/_____

Patient Signature Date