JOINT & MUSCLE MEDICAL CARE
332 Lillington Avenue
Charlotte, NC 28204
(704) 377-1216
Fax: (704) 377-4661

BALLANTYNE RHEUMATOLOGY
8840 Blakeney Professional Dr Ste 101
Charlotte, NC 28277
(704) 541-2111
Fax: (704) 377-4661

Alireza Nami, MD, FACR
John Brendese, MD, FACR

INITIAL APPOINTMENT DATE_____ / _____/ _____

NAME_____DATE OF BIRTH_____ /_____/_____

SEX_____ MARITAL STATUS _____ SPOUSE/PARTNER'S NAME_____

ADDRESS_____
Street Address

ADDRESS_____
City State Zip Code

HOME PHONE_____ WORK PHONE_____x_____CELL PHONE_____

SOCIAL SECURITY_____-_____-_____

EMAIL ADDRESS: _____

EMERGENCY CONTACT _____ _____
Name Phone #

REFERRING DOCTOR_____
Name Address Phone #

PRIMARY DOCTOR _____ _____ _____

PHARMACY NAME: _____ _____ _____
Name Address Phone #

PLEASE BRING YOUR INSURANCE CARDS AND PICTURE ID WITH YOU FOR US TO PHOTOCOPY

PRIMARY INS. _____ _____
Name Member ID / Group Numbers

SUBSCRIBER NAME _____ DOB_____/ _____/ _____RELATION_____

ADDRESS_____PHONE _____
If different from above

SECONDARY INS. _____ _____
Name Member ID / Group Numbers

SUBSCRIBER NAME _____ DOB_____/ _____/ _____RELATION_____

ADDRESS_____PHONE _____
If different from above

I realize that my insurance coverage is a contract between myself and the insurance company and that not all services may be covered benefits in all health plans. By signing this agreement I am acknowledging that I am ultimately responsible for any unpaid balance on my account for services rendered. I hereby assign to_____, the medical benefits to which my dependents and/or I am entitled. I authorize the release of any medical or other information necessary to process this claim and/or to collect this debt. I hereby agree to pay my personal balance within 30 days of receiving a statement. I agree to pay a $35 service charge on all returned checks. I am aware that my account will be charged $25 for any appointments I fail to make without calling within 24 hours notice. By signing below, I do affirm that I have read all the above information and have answered all questions truly and to the best of my ability. I also affirm that I understand the contents of this document.

I am aware that AHA's HIPAA policy is posted in the office and can be viewed by me at anytime.

SIGNATURE_____DATE_____/ _____/ _____
Patient

SIGNATURE_____DATE_____/ _____/ _____
Parent / Guardian / Power of Attorney

Ballantyne Rheumatology and Joint and Muscle Medical Care

In order to meet the government requirements for your care, please complete the following questionnaire. Thank you.

Patient Name: _____

Date of Birth: _____

1. What is your preferred language?
    - English
    - Spanish
    - Other : _____

2. Are you …..
    - Male
    - Female

3. What is your race:
    - American Indian or Alaska Native
    - Asian
    - Black or African American
    - Native Hawaiian or Pacific Islander
    - White
    - Decline to Specify

4. What is your Ethnicity:
    - Hispanic or Latino
    - Not Hispanic or Latino
    - Decline to Specify

Current Medications:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature: _____
Date: _____

Ballantyne Rheumatology and Joint and Muscle Medical Care

SYSTEMS REVIEW

As you review the following list, **please check any of those problems which apply to you.**

GENERAL:
_____ Recent weight gain/Amount ,
_Recent loss of weight/Amount
_____ Fatigue
_____ Weakness
_____ _____ Fever

NERVOUS SYSTEM:
_____ Headaches
_____ Dizziness
_____ Fainting
_____ Muscle spasm
_____ Loss of consciousness
_____ Sensitivity or pain of hands and/or feet "
_____ Memory loss

EARS:
_____ Ringing in ears
_____ Loss of hearing

EYES:
_____Pain
_____Redness
_____ Loss of vision
_____ Double or blurred vision
_____ Dryness
_____ Feels like something in eye
_____
_____
_____ Nosebleeds

NOSE: Loss of smell
Dryness

MOUTH:
_____ Sore tongue
_____ Bleeding gums
_____ Sores in mouth
_____ Loss of taste
_____ Dryness

THROAT:
_____ Frequent sore throats
_____ Hoarseness
_____ Difficulty in swallowing

NECK:
_____ Swollen glands
_____ Tender glands

HEART AND LUNGS:
_____ Pain in chest
_____ Irregular heart beat
_____ Sudden changes in heart beat
_____ Shortness of breath
_____ Difficulty in breathing at night
_____ Swollen legs or feet
_____ High blood pressure
_____ Heart murmurs
_____ Cough
Coughing of blood
_____ Wheezing
_____ Night sweats

STOMACH AND INTESTINES:
_____ Nausea
_____ Vomiting of blood or coffee ground material
_____ Stomach pain relieved by food or milk
_____ Yellow jaundice
_____ Increasing constipation
_____ Persistent diarrhea
_____ Blood in stools
_____ Black stools
_____ Heartburn

KIDNEY/URINE/BLADDER:
_____ Difficult urination
_____ Pain or burning on urination
_____ Blood in urine
_____ Cloudy, "smoky" urine
_____ Pus in urine
_____ Discharge from penis/vagina
_____ Frequent urination
_____ Getting up at night to pass urine
_____ Vaginal dryness
____ Rash/ulcers
_____ Sexual difficulties
_____ Prostate trouble

BLOOD:
Anemia
Bleeding tendency

Date of last eye examination
Date of last chest X-Ray
Date of last Tuberculosis Test _____

SKIN:
_____ Easy bruising
_____ Redness
_____ Rash
_____ Hives
_____ Sun sensitive (sun allergy)
____ Tightness
____ Nodules/bumps
____ Hair loss
____ Color changes of hands or feet in the cold

MUSCLES/JOINTS/BONES:
__ Morning stiffness
Lasting how long
_____ Minutes
_____ Hours
____ Joint pain
____ Muscle weakness
____ Muscle tenderness
____ Joint swelling —

_____
_____
_____
_____
_____
_____
List joints affected in the last 6 months:

HABITS:
Do you drink coffee? _____
Cups per day? _____
Do you smoke? Yes No Past
Cigarettes per day? _____
Has anyone ever told you to cut down on your drinking? Yes No
Do you use drugs for reasons that are not medical? If so, please list:

PAST PERSONAL HISTORY:

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

Cancer	Heart Problems	Asthma	Goiter
Leukemia	Stroke	Cataracts	Diabetes
Epilepsy	Nervous breakdown	Stomach ulcers	Rheumatic Fever
Bad Headaches	Jaundice	Colitis	Kidney Disease
Pneumonia _____	Psoriasis _____	Anemia_____	

Other Significant Illness (Please list) _____

Previous Operations:

Type	Year	*Surgeon*	*City*
1) _____			
2) _____			
3) _____			
4) _____			
5) _____			
6) _____			
7) _____			

Any previous fractures? . ❑ No ❑ Yes Describe_____

Any other serious injuries? ❑ No ❑ Yes Describe _____

	If Living		If Deceased	
Age		Health	Age at Death	Cause
Father				
Mother ,				

Number of Brothers_____ Number Living _____ Number Deceased _____

Number of Sisters _____ Number Living _____ Number Deceased _____

Number of children _____ Number Living _____ Number Deceased _____ List ages of each _____

Serious illnesses of children _____

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

Cancer	Heart disease	Rheumatic fever	Tuberculosis
Leukemia	High Blood Pressure	Epilepsy	Diabetes
Stroke	Bleeding tendency	Asthma .	Goiter
Colitis _____	Alcoholism _____		

HOME CONDITIONS

Check one: ❑ House ❑ Apartment

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

Number of people in household Relationship, and age of each?

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

On the scale below, circle a number which best describes your situation; Most of the time, I function ...

1	2	3	4	5
VERY POORLY	POORLY	OK	WELL	VERY WELL

Because of health problems, do you have difficulty:
(Please check the appropriate response for each question)

	Usually	Sometimes
Using your hands to grasp small objects? (buttons, toothbrush, pencil., etc.)		
Walking?		
Climbing stairs'?		
Descending stairs?		
Sitting down?		
Getting up from chair?		
Touching your feet while seated?		
Reaching behind your back?		
Reaching behind your head?		
Dressing yourself?		
Going to sleep'		
Staying asleep due to pain?		
Obtaining restful sleep?		
Bathing?		
Eating?		
Working?		
Getting along with other family members?		
Engaging in leisure time activities?		
With morning stiffness?		

Do you use a cane, crutches, a walker, or a wheelchair? (circle item) .....

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_____

Joint and Muscle Medical Care
332 Lillington Avenue
Charlotte, NC 28204
Phone: 704-377-1216
Fax: 704-377-4661

Alireza Nami, M.D.
John Brendese, M.D.

Ballantyne Rheumatology
8840 Blakeney Professional Drive, 101
Charlotte, NC 28277
Phone: 704-541-2111
Fax: 704-377-4661

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____ Date of birth: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records to the physician or facility listed below.

Information Disclosed FROM:

Name: _____

Phone: _____

Fax: _____

Information Disclosed TO:

Name: _____

Phone: _____

Fax: _____

This authorization permits Ballantyne Rheumatology/Joint and Muscle Medical Care to use and/or disclose the following individually identifiable information about myself.

The type of information to be used or disclosed is as follows (check all that apply):

_____Most recent office visit
_____ Last 3 months of records
_____Last 6 months of records
_____Radiology Reports
_____Laboratory Reports
_____Clinic Notes
_____Progress Notes
_____Consultation Notes
_____Bone density Report
_____MRI's Report

_____Other _____

Patient Rights

- I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice name above. Any cancellation will apply only to information not yet released by facility.
- This is full released including information related to behavioral/mental health, drug and alcohol abuse treatment, genetic information, HIV/AIDS, and other sexually transmitted diseases.
- I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.
- Ballantyne Rheumatology/Joint and Muscle Medical Care will not share or use my health information without my permission other than by ways listed Ballantyne Rheumatology/Joint and Muscle Medical Care Notice of Privacy Practices or as required by law.
- I have the right to receive a copy of this form upon request.

This permission expires one year after the date of my signature unless another date or event is written here: _____.

Signature: _____ Date: _____

Joint & Muscle Medical Care

Ballantyne Rheumatology

Alireza Nami, MD, FACR
John Brendese, MD, FACR

332 Lillington Ave
Charlotte, NC 28204
Tel: (704) 377-1216
Fax: (704) 377-4661

8840 Blakeney Prof Drive Ste 1(
Charlotte, NC 28277
Tel: (704) 541-2111
Fax: (704) 377-4661

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Joint & Muscle Medical Care

Ballantyne Rheumatology

Alireza Nami, MD, FACR

John Brendese, MD, FACR

332 Lillington Ave
Charlotte, NC 28204
Tel: (704) 377-1216
Fax: (704) 377-4661

8840 Blakeney Prof Drive Ste 101
Charlotte, NC 28277
Tel: (704) 541-2111
Fax: (704) 377-4661

CANCELLATION AND NO-SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, please provide at minimum a 24-hour notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24-hour notice, your rescheduled appointment can be delayed up to 1-2 months or placed on a waiting list in the event an appointment is cancelled (this list is on a first come first served basis).

Office appointments which are cancelled with less than 24 hours' notification or any no show appointments will be subject to a $25.00 cancellation fee. T**he cancelation and No-Show fees are the sole responsibility of the patient and must be paid in full in addition to any copays before the patient's next appointment. If you have no showed three (3) appointments in a one (1) year period, you will be dismissed from the practice immediately.**

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to the billing department 704-541-2111 or 704-377-1216

Please sign that you have read, understand and agree to this Cancellation and No-Show Policy. Policy takes affect from date of signature.

_____ _____

Patient Name (Please Print) **Date of birth**

_____ _____

Signature of Patient or Patient Representative **Date**

_____

Office staff/ Witness