EAST COAST RHEUMATOLOGY, PLLC
PREM C. CHATPAR, M.D., LLC & ASSOCIATES

524 Old Country Road
Plainview, New York 11803
(516) 931-3988

877 Stewart Avenue Ste. 16
Garden City, New York 11530
(516) 745-0202

180 E. Pulaski Road
Huntington Station, NY 11746
(631) 629-4588

PATIENT INFORMATION & CONTACT

NAME: _____ HOME PHONE: _____

ADDRESS: _____ WORK PHONE: _____ CELL PHONE: _____

CITY: _____ STATE: _____ ZIP CODE: _____

D.O.B.: ___/___/___ AGE: ____ STATUS: S M W D EMAIL ADDRESS: _____

EMPLOYER: _____ S.S. No: _____ SEX: ____ **Referring M.D. or P.C.P** _____

EMERGENCY CONTACT _____ TEL NO: _____

RESPONSIBLE PARTY (INSURED) INFORMATION
(IF SAME, WRITE SAME)

NAME: _____ HOME PHONE: _____

ADDRESS: _____ WORK PHONE: _____

CITY: _____ STATE: _____ ZIP CODE: _____

D.O.B.: ___/___/___ S.S. No.: _____ SEX: _____

EMPLOYER: _____ PATIENT RELATIONSHIP: _____

INSURANCE INFORMATION

PLEASE PROVIDE ALL INSURANCE CARDS AND **COMPLETE THE FOLLOWING INFORMATION:**

PRIMARY:

INSURANCE NAME: _____ INSURED PARTY: _____

ADDRESS: _____ INS. ID No.: _____

_____

SECONDARY:

INSURANCE NAME: _____ INSURED PARTY: _____

ADDRESS: _____ INS. ID No.: _____

_____

How would you prefer we contact you? Please be very specific. If we can leave a message and with whom. **Please choose two method of contact.**
You may / may not call me at home number _____
You may / may not leave a message on my answering machine.
You may leave a message with (please circle) no one, my spouse, my children, other, _____
You may / may not call me at work number _____
You may / may not leave a message on my voicemail _____
You may / may not call me on my cell phone number _____
You may / may not leave a message on cell phone _____
You may / may not fax me at number _____
You may call my preferred pharmacy for prescriptions at number _____

PATIENT OR AUTHORIZED SIGNATURE (REQUIRED): _____ **DATE:** _____ **2016**

East Coast Rheumatology Authorization to Treat
Prem C. Chatpar, M.D., LLC & Associates

524 Old Country Road
Plainview, NY 11803
(516)931-3988

877 Stewart Ave. Ste. 16
Garden City, NY 11530
(516)745-0202

180 E. Pulaski Road
Huntington Station, NY 11746
(631)629-4588

Authorization to Treat & HIPAA Notice

I, hereby authorize the staff of Prem C. Chatpar, M.D., LLC & Associates / East Coast Rheumatology (ECR) to provide me with medical treatment. I agree to inform ECR if I have any concerns about my medical treatment at the time services are being rendered. We / I, the parent(s) / guardian(s) of give East Coast Rheumatology and its employees the right to treat my son / daughter or legal ward.

Your privacy is important to us. Upon request, a printed copy of Prem C. Chatpar, M.D., LLC & Associates / East Coast Rheumatology (ECR) HIPAA Notice of Privacy Practices is available for your review. If you have requested and received a copy, your signature below indicates the date of receipt. If you have already received a copy and are declining a duplicate copy, your signature below indicates date of refusal.

Release of Information and Assignment of Benefits for Payment of Claims

The medical records concerning patient care are the property of Prem C. Chatpar, M.D., LLC & Associates / East Coast Rheumatology and are maintained for the benefit of the patient and the medical center. I hereby authorize Prem C. Chatpar, M.D., LLC & Associates to release information and/or copies of my medical records to physicians, any guarantor of payment on my account (and other third party payers) for which I have assigned benefits for my treatment or care. I may revoke this authorization at any time by notifying ECR in writing. This revocation, however, would not apply to information already released in response to this authorization. I understand that ECR will not condition treatment or payment on my providing this authorization. Unless revoked, this authorization will expire upon the conclusion of the work-related purposes for which this authorization is provided. ***Medicare Release of Information and Assignment of Benefits*** **(Applicable to CMS):** I certify that the information given by me in applying for payment under Title XV111 of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the social security Administration and Health Care Financing Administration or its intermediaries or carriers any information (including information relating to mental illness and/or AIDS/ARC/HIV) needed for this or any related Medicare claim. I request that the payment of authorize benefits be made on my behalf. I assign benefits payable to the Physician(s) or Clinician providing services. I understand that if I have selected a Medicare managed care plan, Prem C. Chatpar, M.D., LLC & Associates may or may not participate with this plan, and I will be billed for any balances that the plan does not pay.

The undersigned, whether signing as a patient, representative or guarantor, hereby authorizes direct payment of any insurance benefits otherwise payable to or on behalf of the patient to Prem C. Chatpar, M.D., LLC / East Coast Rheumatology. I hereby assign to Prem C. Chatpar, M.D., LLC & Associates all medical benefits otherwise payable to me by virtue of my visit to ECR. I hereby direct the insurer to pay such benefits directly to Prem C. Chatpar, M.D., LLC & Associates/East Coast Rheumatology in consideration of the professional services rendered to me or my insured dependent or any insured person designated in my policy. I understand I will be responsible for payment of services not covered and/or denied by health insurance.

Financial Agreement & Guarantee of Payments

I agree that all services rendered by Prem C. Chatpar, M.D., LLC & Associates that is considered beyond the normal scope of medical care will be additionally billed. This additional charge will be incurred for Reviews of Disability, Insurance Examinations Statements, Social Security Evaluation, and Medical Records request by counsel at your request. (Fee schedules are available upon request).

No-Show Fee

I understand that Prem C. Chatpar, M.D., LLC & Associates / East Coast Rheumatology, reserves the right to charge a “No-Show Fee” of $25.00 for missed appointments cancelled less than 24 hours’ notice.

Credit/Debit Card Authorization Consent

During today’s visit, we will charge your credit/debit card for your co-pay, co-insurance, deductibles, non-covered services, and services not meeting Medical Criteria amounts. Within three days we will submit a claim to your insurance carrier. Your insurance carrier will send us payment for its portion of your treatment and notify us of any remaining financial responsibility that you may have. This remaining balance will be charged to your credit/debit card at that time (usually within 45 to 60 days). I hereby authorize ECR to securely maintain my credit/debit card information on file to cover my financial responsibility for services rendered today, and agree that this authorization is valid for up to one year.

I have read, understand, and agree with the above items and terms of Prem C. Chatpar, M.D., LLC & Associates/East Coast Rheumatology, PLLC.

Signature: _____ Date: _____
Signature of Patient or Authorized Representative

_____ _____
Relationship to Patient Witness Signature

Patient Name_____ Today's Date___ Date of Birth _____

This questionnaire includes information not available from blood tests, X-rays, or any source other than you. Please try to answer each question, even if you do not think it is related to you at this time. <u>There are no right or wrong answers.</u> Please answer exactly as you think or feel. Thank you.

Please check (√) the ONE best answer for your abilities at this time:

OVER THE LAST WEEK, were you able to:	Without **ANY** <u>Difficulty</u>	With **SOME** <u>Difficulty</u>	With **MUCH** <u>Difficulty</u>	**UNABLE** <u>To Do</u>
a. Dress yourself, including tying shoelaces and doing buttons?	0	1	2	3
b. Get in and out of bed?	0	1	2	3
c. Lift a full cup or glass to your mouth?	0	1	2	3
d. Walk outdoors on flat ground?	0	1	2	3
e. Wash and dry your entire body?	0	1	2	3
f. Bend down to pick up clothing from the floor?	0	1	2	3
g. Turn regular faucets on and off?	0	1	2	3
h. Get in and out of a car, bus, train, or airplane?	0	1	2	3
i. Walk two miles or three kilometers, if you wish?	0	1	2	3
j. Participate in recreational activities and sports as you would like, if you wish?	0	1	2	3
k. Get a good night's sleep?	0	1	2	3
l. Deal with feelings of anxiety or being nervous?		1	2	3
m. Deal with feelings of depression or feeling blue?	0	1	2	3

2. How much pain have you had because of your *condition* OVER THE PAST WEEK? Please indicate below how severe your pain has been:

NO PAIN 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 PAIN AS BAD AS IT COULD BE

3. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

VERY WELL 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 VERY POORLY

4. Please place a check (√) in the appropriate spot to indicate the amount of pain you are having today in each of the joint areas listed below:

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
<u>LEFT FINGERS</u>	☐ 0	☐ 1	☐ 2	☐ 3	<u>RIGHT FINGERS</u>	☐ 0	☐ 1	☐ 2	☐ 3
<u>LEFT WRIST</u>	☐ 0	☐ 1	☐2	☐ 3	<u>RIGHT WRIST</u>	☐ 0	☐ 1	☐ 2	☐ 3
<u>LEFT ELBOW</u>	☐ 0	☐ 1	☐ 2	☐ 3	<u>RIGHT ELBOW</u>	☐ 0	☐ 1	☐ 2	☐ 3
<u>LEFT SHOULDER</u>	☐ 0	☐ 1	☐ 2	☐ 3	<u>RIGHT SHOULDER</u>	☐ 0	☐ 1	☐ 2	☐ 3
<u>LEFT HIP</u>	☐ 0	☐ 1	☐ 2	☐ 3	<u>RIGHT HIP</u>	☐ 0	☐ 1	☐ 2	☐ 3
<u>LEFT KNEE</u>	☐ 0	☐ 1	☐ 2	☐ 3	<u>RIGHT KNEE</u>	☐ 0	☐ 1	☐ 2	☐ 3
<u>LEFT ANKLE</u>	☐ 0	☐ 1	☐ 2	☐ 3	<u>RIGHT ANKLE</u>	☐ 0	☐ 1	☐ 2	☐ 3
<u>LEFT TOES</u>	☐ 0	☐ 1	☐ 2	☐ 3	<u>RIGHT TOES</u>	☐ 0	☐ 1	☐ 2	☐ 3
<u>NECK</u>	☐ 0	☐ 1	☐ 2	☐ 3	<u>BACK</u>	☐ 0	☐ 1	☐ 2	☐ 3

Do Not Write Below This Line- For Doctor's Use Only –MD Global

VERY WELL 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 VERY POORLY

FOR OFFICE USE ONLY

1.a-j FN 0-10 ☐

1=0.3 2=0.7 3=1.0 4=1.3 5=1.7 6=2.0 7=2.3 8=2.7 9=3.0 10=3.3 11=3.7 12=4.0 13=4.3 14=4.7 15=5.0 16=5.3 17=5.7 18=6.0 19=6.3 20=6.7 21=7.0 22=7.3 23=7.7 24=8.0 25=8.3 26=8.7 27=9.0 28=9.3 29=9.7 30=10

PN: 0-10 ☐

PT GL: 0-10 ☐

RAPID 3 ☐

JT CT: 0-10 ☐

1=0.2 2=0.4 3=0.6 4=0.8 5=1.0 6=1.3 7=1.5 8=1.7 9=1.9 10=2.1 11=2.3 12=2.5 13=2.7 14=2.9 15=3.1 16=3.3 17=3.5 18=3.8 19=4.0 20=4.2 21=4.4 22=4.6 23=4.8 24=5.0 25=5.2 26=5.4 27=5.6 28=5.8 29=6.0 30=6.3 31=6.4 32=6.7 33=6.9 34=7.1 35=7.3 36=7.5 37=7.7 38=7.9 39=8.1 40=8.3 41=8.5 42=8.8 43=9.0 44=9.2 45=9.4 46=9.6 47=9.8 48=10

RAPID 4 ☐

MDGL: 0-10 ☐

RAPID 5 ☐

DEAR PATIENT:

IN ORDER FOR YOUR CONSULTATION TO BE AS PRODUCTIVE AS POSSIBLE, PLEASE COMPLETE THE INFORMATION SHEET BELOW. THIS INFORMATION WILL BE KEPT CONFIDENTIAL AND WILL BE INCLUDED IN YOUR MEDICAL RECORDS. THANK YOU VERY MUCH.

DR. PREM C.CHATPAR AND ASSOCIATES

PLEASE PRINT

NAME: (Last) _____ First) _____

NATURE OF VISIT: _____

WHICH JOINTS HURT? (Please check ALL that apply to you.)

_____NECK	_____HANDS	_____HIPS	_____FEET
_____JAW	_____WRISTS	_____KNEES	_____TOES
_____SHOULDERS	_____FINGERS	_____ANLLES	_____BACK PAIN

PAST HISTORY: (Please check ALL that apply to you.)

_____ARTHRITIS	_____TUBERCULOSIS	_____EPILEPSY
_____CANCER	_____STROKE	_____HYPERTENSION
_____PSORIASIS	_____KIDNEY DISEASE	_____HEART DISEASE
_____GOUT	_____MIGRANE	_____STOMACH ULCER
_____DIABETES	_____MENTAL ILLNESS	_____GASTRITIS
_____HEPATITIS	_____OSTEOPORSIS	
_____CONNECTIVE TISSUE DISEASE		

PAST SURGICAL HISTORY _____

MEDICATIONS: (Please list ALL medications with dosages.)

_____

_____

_____

_____

_____

_____

ALLERGIES: (Please list ALL allergies.

_____

_____

_____

_____

_____

_____

SYMPTOMS AND COMPLAINTS: (Please check ALL that apply to you.)

GENERAL:
- _____FATIGUE
- _____FEVER/CHILLS
- _____WEIGHT LOSS
- _____HEAD PAIN
- _____DRY EYES
- _____ EYE INFLAMATION/REDNESS
- _____RINGING IN EARS
- _____MOUTH ULCERS
- _____DRY MOUTH
- _____ENGLARGED GLANDS

SKIN:
- _____LOSS OF HAIR
- _____RASH
- _____PHOTOSENSITIVITY
- _____EYE SWELLING, REDNESS
- _____RAYNAUD'S PHENOMENON
- _____SKIN TIGHTENING
- _____SKIN ULCERS
- _____PSORIASIS

GASTROINTESTINAL:
- _____DECREASED APPETITE
- _____SWALLOWING DIFFICULTY
- _____BURNING STOMACH PAIN
- _____ABDOMINAL PAIN
- _____VOMITING/NAUSEA
- _____DIARRHEA/CONSTIPATION
- _____ BLEEDING
- _____JAUNDICE (YELLOW SKIN)

HEART / LUNG:
- _____ANGINA
- _____CHEST PAIN
- _____SHORTNESS OF BREATH
- _____COUGH, PERSISTANT/WHEEZING
- _____LEG SWELLING
- _____PREVIOUS HEART ATTACK (DATE: _____)

GENITOURINARY:
- _____BURNING OF URINATION
- _____DISCHARGE
- _____KIDNEY STONE
- _____LAST MENSTRUAL PERIOD (_____)
- _____MENSTRUAL ABNORMALITIES
- _____BLOOD IN URINE

BLOOD:
- _____ANEMIA
- _____OTHER BLOOD DISORDER (Please specify_____)

NEUROMUSCULAR:
- _____SEIZURES
- _____NUMBNESS/TINGLING
- _____MUSCLE PAIN
- _____MUSCLE WEAKNESS
- _____ALTERED SENSATION
- _____HEADACHE

PERSONAL HISTORY: (Please complete as fully as possible.)

TYPE OF WORK: _____
DISABILITY: _____
STAIRS/CHAIRS: _____
A.M. STIFFNESS: _____
NIGHT PAIN_____
DRESSING/GROOMING: _____
CIGARETTES/DAY: _____
ALCOHOL (oz./week):_____

THANK YOU FOR YOUR PATIENCE AND COOPERATION!