

**Acknowledgement of Review of
Notice of Privacy Practices**

I have had the opportunity to review the Arthritis & Osteoporosis Clinic of Brazos Valley's Notice of Privacy Practices. This folder explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Print Patient or Personal Representative's Name

Date

Arthritis & Osteoporosis Clinic of Brazos Valley Financial Policy

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with the billing office. We are dedicated to providing the best possible care and service to you and regard the complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health coverage carrier, full payment is due at the time of service. For your convenience, we will accept cash, check, money order, VISA, MasterCard, and Discover.

Appointments

Broken appointments represent a cost to us, to you and to the other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

Insurance

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

Medicaid

Medicaid requires all recipients to resubmit their card when seeking medical attention, failure to do so may result in the rescheduling of your appointment

Return Checks

A \$25.00 service charge will be added to your account for all returned checks and must be paid before additional appointments will be scheduled. Restitution of the check must be made within 10 days or check will be given to the County Attorney for prosecution.

Collection Agency

Any account that is given to our collection agency due to non-payment will have a 22% collection charge added to the account. Our collection agency will then collect the past due amount plus the 22% collection charge.

Services Rendered in the Hospital

We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients

For all services rendered to a minor patient, we will look to the adult accompanying the patient and/or the parent or guardian with custody for payment.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF THE PRACTICE AND I AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND AND AGREE THAT SUCH TERMS MAY BE AMENDED FROM TIME TO TIME BY THE PRACTICE.

Signature of patient or responsible party if patient
is a minor

Date

Printed name of the patient

Joint Aspiration and Injection Acknowledgement Form

Arthritis & Osteoporosis Clinic of the Brazos Valley

Dr. Ricardo Pocerull MD

Kelle Harper FNP-BC

Rajpreet Singh DO, CCD

Patient: _____

1. Arthrocentesis or aspiration and injection of a joint are procedures commonly used by the AOCBV to improve joint function and provide pain relief as well as evaluation measures. This is an acknowledgement form for patient record identifying my acknowledgement of such procedures.
2. I understand that these are procedures performed by placing a needle into the joint or surrounding area. The goal is to withdraw fluid from the joint to provide pain relief, analyze the fluid under the microscope, and, possibly, inject medication into the joint to provide additional pain relief. I understand that the removal of fluid may be needed to find out why the fluid was present. I understand that fluid may re-accumulate after the removal. I understand that the medication that may be injected is a corticosteroid and may not provide long-lasting or permanent relief, and that no guarantee can be made about the outcome of my planned procedure.
3. My doctor has explained to me that this procedure generally is safe, but that certain risks accompany any surgical procedure. Risks associated with joint aspiration and injection include the following:
 - Pain associated with the procedure if the needle touches joint surfaces
 - Increased bleeding, especially for those patients on blood thinning medications.
 - Damage to a nerve or joint surface from the needle or medication
 - Rare introduction of infection into the joint
 - Increased joint pain after injection of medication, or post-injection flare reaction

4. I understand that I can refuse any procedure that is offered to me during my care at AOCBV.

Initials: _____

Date: _____



Arthritis & Osteoporosis Clinic of Brazos Valley
Board Certified in Rheumatology

Ricardo Pocurull, MD, PA, CCD

Kelle Harper, FNP

RAJPREET SINGH, DO, CCD

Controlled Substance Pain Management Agreement
For Narcotics Prescribed by AOCBV

I, _____ agree if, and only if, AOCBV is prescribing a controlled substance, that they will be the only physicians prescribing this medication for me and that I will obtain all of my prescriptions for controlled substances at one pharmacy. I will not seek controlled substances from another physician.

- I will not take controlled substances in larger amounts or more frequently than is prescribed.
- I will not give or sell my medication to anyone else, including family members; nor will I accept any controlled substances from anyone else. I agree to be responsible for the secure storage of my medication at all times. I understand that lost or stolen medication will not be replaced.
- I will attend all reasonable appointments, treatments and consultations as requested by my physician.
- I understand that the long-term use of controlled substances to treat chronic pain may result in physical dependence on this medication, and that sudden decreases or discontinuation of the medication will lead to the symptoms of controlled substances withdrawal. I understand that controlled substances withdrawal is uncomfortable but not life threatening.
- I understand that there is a risk that I may become addicted to the controlled substances I am being prescribed. The risk is small where medication is taken as prescribed for pain.
- I understand that my physician will require that I have urine monitoring monthly for *Schedule II* medications, every 3 months for *Schedule III* medications. Should a concern about addiction arise during my treatment my physician may ask me to see a specialist in addiction medicine. I will comply with all requests for laboratory tests including random or scheduled urine monitoring for appropriate narcotic management as ordered by my physician.
- I understand that the use of any mood altering substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as cannabis, cocaine, heroin or hallucinogens), can cause adverse effects or interfere with opioid therapy. Therefore I agree to refrain from the use of all of these substances without prior agreement from my physician.
- I consent to open communication between my doctor and any other health care professionals involved in my pain management, such as pharmacists, other doctors, emergency departments, etc.
- I understand that if I break this agreement, my physician reserves the right to stop prescribing controlled substances and I may be discharged from this practice.
- I will comply with requests by my physician to go to the office for a pill count between scheduled visits.

Patient's signature: _____

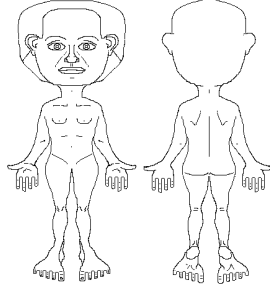
Physician's signature: _____

Date: _____

Medical History- Multiple Joint Pain

Please fill out COMPLETELY to the best of your knowledge (use reverse if necessary)

Name: _____ **Please, Briefly Describe your Symptoms. Circle where appropriate.**



Please, indicate where you hurt :

Quality: burningstabbing aching gnawing deep Other:_____

Duration - How many..._____ years _____months _____days ?

Considering all the ways in which illness and health conditions may affect you at this time, please make a mark below to show how you are doing:

Very Well |-----| Very Poorly

How much pain have you had because of your condition over the past week? Place a mark on the line below to indicate how severe your pain has been:

No Pain |-----| Pain as Bad as It Could Be

If you feel stiff in the morning, how long does it last? _____Hours _____Minutes

Activity Level

Right now, are you able to:

1. Dress yourself, including tying shoelaces and doing buttons?

Not difficult Somewhat Very difficult Can't do at all

_____0 _____1 _____2 _____3

2. Get in and out of bed?

_____0 _____1 _____2 _____3

3. Lift a full cup or glass to your mouth?

_____0 _____1 _____2 _____3

4. Walk outdoors on flat ground?

_____0 _____1 _____2 _____3

5. Wash and dry your entire body?

_____0 _____1 _____2 _____3

6. Bend down to pick up clothing from the floor?

_____0 _____1 _____2 _____3

7. Turn regular faucets on and off?

_____0 _____1 _____2 _____3

8. Get in and out of a car, bus, train or airplane?

_____0 _____1 _____2 _____3

9. Walk two miles?

_____0 _____1 _____2 _____3

10. Participate in sports and games as you like?

_____0 _____1 _____2 _____3

Total Score:_____ (office use only)

- | | | | | |
|---|--------|--------|--------|--------|
| 11. Get a good night's sleep? | _____0 | _____1 | _____2 | _____3 |
| 12. Deal with anxiety or being nervous? | _____0 | _____1 | _____2 | _____3 |
| 13. Deal with depression or feeling blue? | _____0 | _____1 | _____2 | _____3 |

CONSTITUTIONAL SYMPTOMS (please circle)

Tired Fever Weak Night sweats
 Unintentional Weight loss (pounds) _____ Weight gain (pounds) _____

EYES:

Pain redness Blurry vision Dryness Feels like something in the eye Vision Problems

EARS/NOSE/MOUTH/THROAT:

Ulcers Mouth sores Hoarseness Dental caries Dryness of mouth
 Heavy snoring Wake up choking at night

CARDIOVASCULAR:

Chest pain irregular heartbeat palpitations swollen legs difficulty breathing at night

RESPIRATORY:

Shortness of breath cough wheezing

GASTROINTESTINAL:

Nausea vomiting diarrhea blood in stools black stools Heartburn
 Constipation Problems swallowing

GENITOURINARY:

Difficulty urinating burning with urination blood in urine foul smell
 going to the bathroom at night ... frequently

INTEGUMENTARY:

Rashes easy bruising hair loss changes in color of hands

NEUROLOGICAL:

Headaches Dizziness Fainting Numbness/Tingling (where?) _____

PSYCHIATRIC:

Hear voices Racing Thoughts Seeing things that are not there
 Previous admission to a Psychiatric hospital history of bipolar disorder or schizophrenia

Past Medical History

Osteoarthritis Diabetes Lupus Stroke Gout High Blood Pressure
Spondylitis Seizures Osteoporosis Asthma Rheumatoid Arthritis Stroke
Scleroderma Raynaud's Fibromyalgia Psoriasis Sjogren's Syndrome
Low Thyroid Ankylosing Spondylitis Crohn's Disease Tuberculosis Blood Clots
Heart Disease Ulcerative Colitis Cancer(specify)_____

Kidney problems(specify) : _____

Other: _____

Surgeries (please circle):

Hysterectomy year?_____ Ovaries removed? One both none

Appendix removed Tonsils removed Gall Bladder Removed

Left / Right Knee replacement Left / Right Hip replacement

Other: _____

Obstetrics: Please state how many... Pregnancies____ Births____ Miscarriages____ Abortions_____

Family History (please list any illnesses)

Father: _____

Mother: _____

Siblings: _____

Social History

Do you smoke? Yes No Packs per day? _____

Alcohol? Yes No Ocassional Drinks per day? _____

Drugs? Yes No Type: _____

What line of work? _____

Allergies to medications: _____

Please list ALL medications you are currently taking (use reverse if necessary):

Epworth Sleepiness Scale

Use the Scale below and circle the appropriate number for each situation.

<u>Situation</u>	<u>Chance of dozing</u>			
	Would never doze	Slight chance	Moderate chance	High Chance
Sitting and reading	1	2	3	4
Watching T.V.	1	2	3	4
Sitting inactive in a public place	1	2	3	4
As a passenger in a car for 1hr straight	1	2	3	4
Lying down to rest in the afternoon	1	2	3	4
Sitting and Talking to someone	1	2	3	4
Sitting quietly after lunch	1	2	3	4
In a car, stopped in traffic	1	2	3	4

Total Score (Office use only):

AMERICAN ACADEMY OF NURSE PRACTITIONERS

SCOPE OF PRACTICE FOR NURSE PRACTITIONERS

PROFESSIONAL ROLE

Nurse practitioners are primary care providers who practice in ambulatory, acute and long term care settings. According to their practice specialty these providers provide nursing and medical services to individuals, families, and groups. In addition to diagnosing and managing acute episodic and chronic illnesses, nurse practitioners emphasize health promotion and disease prevention. Services include, but are not limited to ordering, conducting, supervising, and interpreting diagnostic and laboratory tests, and prescription of pharmacologic agents and non pharmacologic therapies. Teaching and counseling individuals, families and groups are a major part of nurse practitioner practice.

Nurse practitioners practice autonomously and in collaboration with health care professionals and other individuals to diagnose, treat and manage the patient's health problems. They serve as health care researchers, interdisciplinary consultants and patient advocates.

EDUCATION

Entry level preparation for nurse practitioner practice is a master's degree. Didactic and clinical courses prepare nurses with specialized knowledge and clinical competency to practice in primary care, acute care and long term care. Self-directed continued learning and professional development beyond the formal advanced education is essential to maintain clinical competency.

ACCOUNTABILITY

The autonomous nature of the nurse practitioner's advanced clinical practice requires accountability for health care outcomes. Ensuring the highest quality of care requires certification, periodic peer review, clinical outcome evaluations, a code for ethical practice, evidence of continuing professional development and maintenance of clinical skills. Nurse practitioners are committed to seeking and sharing knowledge that promotes quality health care and improves clinical outcomes. This is accomplished by leading and participating in both professional and lay health care forums, conducting research and applying findings to clinical practice.

RESPONSIBILITY

The role of the nurse practitioner continues to evolve in response to changing societal and health care needs. As leaders in primary and acute health care, nurse practitioners combine the roles of provider, mentor, educator, researcher, and administrator. Members of the profession are responsible for advancing the role of the nurse practitioner and ensuring that the standards of the profession are maintained. This is accomplished through involvement in professional organizations and participation in health policy activities at the local, state, national and international levels.

AMERICAN ACADEMY OF NURSE PRACTITIONERS

Administration: P.O. Box 12846 – Austin, TX 78711 – (512) 442-4262 – Fax (512) 442-6469 – www.aanp.org

Office of Health Policy: P.O. Box 40130 – Washington, DC 20016 – (202) 966-6414 – Fax (202) 966-2856

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Arthritis & Osteoporosis Clinic of Brazos Valley

FREQUENTLY ASKED QUESTION

1. Why use the online system? Is it secure?
 - a. Online consults and questions take priority.
 - b. Except for weekends, we respond within 24 hours, usually sooner.
 - c. When using the online system you don't have to deal with being on hold or busy signals.
 - d. You don't have to play PHONE TAG with us.
 - e. You can be as verbose as you want with your questions, concerns, or comments.
 - f. You can request refills, appointments, test results, ask question, or do online consultations (non-emergencies only).
 - g. Those who use the online system report much more satisfaction in communicating with our office and getting their issues addressed in a timely fashion.
 - h. The online system is encrypted and endorsed by the American Medical Association and Texas Medical Association.
2. Who answers the online questions?

The online consultations are addressed directly by the doctor. All other questions and request are handled by the nursing staff.
3. How long before I get my test result?

As a general rule, 2 weeks. Once the results are received, they are reviewed by the nurse to identify abnormal results. Abnormal results take priority. The nurse then gives the tests to the doctor for review. The doctor then gives the nurse instructions regarding the test results. This process takes roughly 2 weeks unless it is urgent. Calling sooner than this for routine studies, only ties up our staff. However, if by two weeks you have not heard from our office, please contact us.
4. How do I find out my test results? Do I assume they are negative if I don't hear from anyone?

No. We always contact you either way. Generally, if the results are negative, we will call or send you a note in the mail within 2 weeks. If there is something wrong we will call you right away. If you have an appointment within two weeks, the doctor will usually wait until your office visit to discuss them with you. Lastly, if you do not hear from our office within two weeks of having your tests done, please contact us.
5. How do I find out the results of my Bone Density Test?

Unless the bone density is normal, the doctor likes to discuss the results with the patient. This includes result interpretation, treatment options, and expectations. We prefer not to give these results over the phone.

FREQUENTLY ASKED QUESTIONS CONT'D...

6. Where do I find information about my condition?

There is plenty of information on our website. We recommend you read about the condition and then ask any further questions on your next visit. If you want to get answers or clarification prior to your next visit, we recommend you use the online function. You will have a better understanding of your condition this way.

7. How do I find out about my blood test?

Please allow 2 weeks for results. A letter will be mailed with results or you will be contacted by phone call from our office. If there are any questions regarding your lab results they will be handled by appointment only. No phone calls please.

8. How do I get refills?

- a. Refills may be obtained through your pharmacy, calling us for a new prescription, or using the online refill request.
- b. No refill will be done on weekends or after office hours.
- c. **ABSOLUTELY NO NARCOTIC REFILLS ON WEEKENDS OR AFTER HOURS, ESPECIALLY WHEN ANOTHER DOCTOR IS ON CALL. NO EXCEPTIONS.** Please do not contact us for after hour's refills on narcotics because it will be denied.
- d. Narcotics are only refilled once a month. "I lost my prescription," "my medication was stolen," I accidently spilled them into the toilette," etc..., are not excuses. The only way to obtain a narcotic refill prior to one month is to see the doctor and be assessed.

9. What happens if I have a problem after hours?

A Provider is on call 24/7. We do ask for your consideration and that you try to contact us during office hours. This is where the online function is especially helpful. For emergencies please call any time.

At AOCBV, our goal is to provide our patients with the best experience possible when interacting with our practice. That's why we're pleased to offer secure, interactive patient self-service features that let you communicate with us from the convenience of your home or office. Please visit our website at www.aocbv.com and click on the email link for access.

Some things doctors **SHOULD** expect from the patient:

- That the patient will not hide facts about his/her illness.
- That the patient will try to follow the doctor's suggestions for treatment, or will tell the doctor when this has not been done.
- That the patient will keep his/her appointments or will cancel as soon as possible those which cannot be kept.
- That the patient will treat the doctor courteously and politely.
- That the patient will take responsibility to ask questions about those parts of his/her illness and its treatments that he/she does not understand well.
- That within the limits of the patient's ability, he/she will be responsible for knowing his/her past medical history and treatment.
- That the patient will not ask the doctor to act illegally or unethically.
- That the patient or a third party such as an insurance carrier will pay the doctor for his/her services.

Some things the doctor **SHOULD NOT** expect from the patient:

- That the patient will be grateful to the doctor for his/her care.
- That the doctor's opinion will never be questioned by the patient.
- That the patient will automatically follow the doctor's medical orders.
- That the patient will always be able to keep anger, depression or fear concerning his/her illness under control and will never displace it onto the doctor.
- That the patient will share the same moral customs and values as the doctor.
- That the patient has any obligation to continue under the doctor's care.