Central Florida Rheumatology Consultants

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Corey Heichel, PA-C MPAS
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Rebecca Heichel, PA-C MPAS

Consent to Treat

Patient Name (printed):_______________________________________ DOB:___________________

- I voluntarily consent to receive medical care and treatment by the healthcare providers and staff at Central Florida Rheumatology Consultants.
- I understand that this may include routine diagnostic procedures, physical examinations, and medical treatments, including emergency services, as deemed necessary by the provider.
- I understand that the practice of medicine is not an exact science and that no guarantees have been made to me about the outcome of my treatment or examination.
- I understand that I have the right to refuse any service or treatment to the extent permitted by law and that it is my responsibility to ask questions if I do not understand any information or instructions given to me.

By signing below I agree to the above terms.

Patient Signature:____Date:_________________

1639 N Volusia Ave, Suite B, Orange City, FL 32763
795 Primera Blvd, Suite 1001, Lake Mary, FL 32746
901 E Oak St, Suite C, Kissimmee, FL 34744

Phone (386) 561-9967
Fax (844) 815-1446
myrheumatology.com

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:____ DOB:_____________________

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Signature:____ Date:______________

For Office Use Only

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient, but this form could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation, it was not possible to obtain acknowledgement.

☐ We were not able to communicate with the patient.

☐ Other (Please provide specific details):____
____
____

Employee Signature:____________________________________ Date:____________________

HIPAA Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state, law.

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Cancellation Notice Agreement

Please be advised that our office requires 24-hour advanced notice for all cancelled or rescheduled routine appointments.

Without proper notice, you will be charged a $50.00 fee for a NO SHOW appointment.

By signing below, I agree that I am financially responsible for any charges incurred for missed appointments that were not cancelled within the required time. Any emergencies with verification will receive a one-time courtesy adjustment.

____________________________________ Patient Printed Name

________________________ Date of Birth

____________________________________ Patient Signature

________________________ Date

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Records Release Request

To:

PCP:____

Other:____

____
____

I, ________________________________, hereby request that you release my Medical Records to:
Central Florida Rheumatology Consultants, LLC
915 Harley Strickland Blvd
Orange City, FL 32763
Phone: (386) 561-9967
Fax: (844) 815-1446

This includes a report of my diagnosis, treatment, prognosis and recommendations, as well as any other data pertinent to your treatment of me. I request ALL of my records to be sent unless specific dates or specific tests are listed below. Thank you.

- Release records only for the following period:

  FROM:______/______/______ TO:______/______/_______ or ☐ Present

- Release records only for the following test(s)/report(s): (Please Include Dates)
  ☐ Labs____________________ ☐ CT Scans:_________________________
  ☐ X-rays___________________ ☐ Last Visit Note
  ☐ MRI_____________________ ☐ Other:____________________________________

REASON FOR REQUEST:

Date of Request:________________________

____Continuity of Care/Treatment ____At the Request of Individual please include all sensitive information

Patient Printed Name:_______________________________________ DOB:__________________________

Patient Phone Number:__________________________________

I understand and give my permission for my records to be sent via facsimilie (fax machine).

Patient Signature:____ Faxed:______/_______/_______

Authorization for Release of Protected Health Information to Family Members/Legal Guardian

Patient Name:____ DOB:___________________

1. Authorization
   I hereby authorize Central Florida Rheumatology Consultants and its representatives to disclose my protected health information (PHI) to the following individual(s):

   Name(s) of Family Member(s):

   ____

   ____

   ____

2. Type of Information

   (Initial next to each type of information you authorize to be released)

   _____General Medical Information (diagnosis/treatment plans)

   _____Lab reports

   _____Billing and Insurance Information

   _____Appointments and Scheduling

   _____Leave voice mails for family members with protected health information if requested.

   _____Other:____

3. Expiration of Authorization
   This authorization is valid:
   ☐ Until revoked in writing
   ☐ Until the following date or event:____

4. Right to Revoke
   I understand that I have the right to revoke this authorization at any time by submitting a written request to Central Florida Rheumatology Consultants. The revocation will not apply to information already released in reliance on this authorization.

5. Acknowledgement and Signature
   I understand that:
   - I am not required to sign this authorization in order to receive treatment.
   - Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.
   - I have the right to inspect or copy the information to be disclosed.

Signature of Patient or Legal Representative:_______________________________________

Printed Name:____

Relationship to Patient (if applicable):____

Date:______________

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

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NEW PATIENT INTAKE FORM

Demographics:

Date of Appointment:________/________/________

Name:____ DOB:________/________/________

Age:_____________________ Sex:____

Address:____
Street City State Zip

Mobile Phone:___________________________________ Best Contact Number:____________________________

Email Address:______________________________________ Birthplace:___________________________________

Occupation (if retired, prior occupation):____

Marital Status (circle): Never Married Married Divorced Separated Widowed

Race (circle): Caucasian(white) Hispanic African American Asian Other:_____________________

Primary Care Provider:____

Reason or concerns prompting rheumatology referral:____

____

Social History:

Do you currently smoke? __________________________ Are you a previous smoker?____________________

If yes, how many years have you smoked?___________ How many packs per day?______________________

Do you drink alcohol?_____________________________ if yes, how many per week?_____________________

Do you use any recreational drugs (not prescribed to you):____

If yes, please list:____

Do you exercise regularly?_____________if yes, what type of exercise?________________________________

Drug Allergies: Please list any drug allergy and the type of reaction to that medication.____

____

____

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Current Medications: List all meds you are taking, including over-the-counter medications:

Drug Name:	Dose (strength and # of pills per day):	How long have you been on this medication:

Previous Surgeries:

Type:	Year:	Reason:

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Medical History: Please circle if you have been diagnosed with any of the following:

Diabetes   Psoriasis   Rheumatoid Arthritis   Lupus   Stroke   Kidney Disease   Ulcerative Colitis

Crohn's Disease   COPD   Emphysema   Asthma   Heart Disease   High Blood Pressure   Hepatitis

High Cholesterol   Diverticulitis   HIV/AIDS   Tuberculosis   Other:_______________

Other Autoimmune Disease?_______________

Previous Cancer?________ If yes, what type?_______________ what year?_______________

If previous cancer, describe treatment?_______________

Any Previous Fractures?______ If yes, describe (include treatment):_______________

Family History: Do any blood relatives have any history of the following: (Please list relationship to you if yes)

Psoriasis?_______________ Lupus (SLE)?_______________

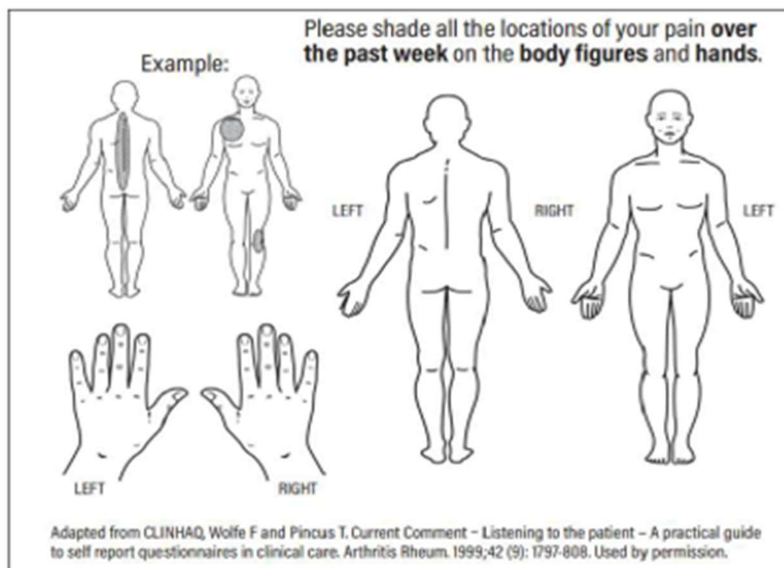
Rheumatoid Arthritis?_______________ Ankylosing Spondylitis?_______________

Gout?_______________ Osteoporosis?_______________

Any other family history we should be aware of?_______________

____

If applicable, please indicate areas of pain on the diagram below:



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Review of Systems: Please review the following list. Circle any symptoms you are having.

Constitutional: Weight Loss Weight Gain Fatigue Fever Night Sweats

Eyes: Pain Redness Dryness

Ears-Nose-Throat: Nosebleeds Sores in Mouth Mouth Dryness Difficulty Swallowing

Respiratory: Shortness of Breath Cough

Gastrointestinal: Nausea Vomiting Persistent Diarrhea Heartburn

Genitourinary: Blood in Urine

Musculoskeletal: Morning stiffness (how long?______mins_____hrs) Joint Pain Joint Swelling Muscle Weakness Muscle Tenderness

Skin: Easy Bruising Rash Sun Sensitivity Hair Loss Color change of hands/feet

Neurological System: Headaches

Hematologic/Lymphatic: Swollen Glands Anemia

WOMEN ONLY: Number of pregnancies?__________________Number of miscarriages?______________

HIV Screening: HIV screening is recommended by the CDC for all patients at least once in their lifetime.

As part of a public health initiative, Central Florida Rheumatology Consultants has partnered with Central Florida Health Care Services (CFHCS) to provide HIV screening to all patients at no cost. CFHCS is a not-for-profit organization that is working with the Florida Department of Health to provide Screening services to all patients who wish to be tested or have counseling regarding HIV risk and prevention. If you are interested in these services, please answer the questions below.

Your answers to these questions, like all protected health information (PHI), are confidential. If you answer "yes" to any of the following questions, CFHCS will provide you with free resources for testing, counseling and prevention services, including free HIV testing.

Option: ☐ Decline to answer all

1. Have you previously been tested for HIV? ☐ Yes ☐ No
2. Are you at risk of contracting HIV or Hepatitis through blood exposures or sexual activities? ☐ Yes ☐ No ☐ Decline to answer
3. Would you like to be provided free testing for HIV? ☐ Yes ☐ No ☐ Decline to answer
4. Would you like to be provided no cost counseling and preventative therapy for HIV? ☐ Yes ☐ No ☐ Decline to answer

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PAST RHEUMATOLOGY MEDICATIONS

Please review this list of Rheumatology medications. As accurately as possible, note the medications you have taken, how long you were on the medication, the results of taking the medication and list any reaction you may have had. **If you have not been previously diagnosed with an autoimmune disorder, osteoporosis or gout you may skip this form.**

Treatment for Autoimmune Diseases: (SKIP IF NOT APPLICABLE)

Drug name	IV, injection, oral	Did medication help? (yes/no)	Why Stopped?	Reactions, if any
Cimzia (certolizumab Pegol)				
Simponi (golimumab)				
Plaquenil (hydroxychloroquine)				
Methotrexate				
Imuran (azathioprine)				
Sulfasalazine				
Cytoxan (cyclophosphamide)				
Enbrel (etanercept)				
Remicade (infliximab)				
Actemra (tocilizumab)				
Taltz (ixekizumab)				
Cosentyx (secukinumab)				
Otezla (apremilast)				
CellCept (mycophenolate)				
Arava (leflunomide)				
Humira (adalimumab)				
Xeljanz (tofacitinib)				

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Rituxan (rituximab)				
Orencia (abatacept)				
Rinvoq (upadacitinib)				
Olumiant (baricitinib)				
Kevzara (sarilumab)				
Saphnelo (anifrolumab-fnia)				
Benlysta (belimumab)				
Tremfya (guselkumab)				
Skyrizi (risankizumab-rzaa)				
Bimzelx (bimekizumab-bkzx)				

Treatment for Osteoporosis: (SKIP IF NOT APPLICABLE)

Drug Name	**Did the medication help? (yes/no)**	**Why stopped?**	**Reactions**
Estrogen			
Fosamax (alendronate)			
Evista (raloxifene)			
Calcitonin			
Actonel (risedronate)			
Prolia (denosumab)			
Forteo (teriparatide)			
Evenity (romosozumab-aqqg)			
Tymlos (abaloparatide)			

Treatment for Gout: (SKIP IF NOT APPLICABLE)

Drug Name:	Did the medication help? (yes/no)	Why Stopped?	Reactions
Benemid (probenecid)			
Colcrys (Colchicine)			
Allopurinol			
Uloric (Febuxostat)			
Krystexxa (pegloticase)			