Jose Antonio Pando, M.D.
Yale University, School of Medicine
Internal Medicine/Primary Care Program
National Institute of Health
Georgetown University Medical Center
Rheumatology Fellowships
Board Certified Rheumatology, Internal Medicine

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University of Maryland Baltimore County
Biological Sciences
University of Maryland School of Medicine Internal Medicine

Jennifer Rahn, PA-C
Eastern Virginia Medical School
Master of Physician Assistant
National Commission on Certification of Physician Assistants

Jennifer E. Willey, FNP-C
West Chester University
Wilmington University
American Academy of Nurse Practitioners Certification

At Delaware Arthritis our mission is to provide state of the art care to all of our patients and to restore them to their optimum level of wellness

delaware ARTHRITIS

Jose Antonio Pando, MD
Kelly A. Fanto, MD
Jennifer Rahn, PA-C
Jennifer Willey, FNP

Services

- Patient Evaluation
- Infusion Services
- Clinical Research - Trials
- Electrical Stimulation
- Bone Densitometry
- Ultrasound
- Laboratory Services
- MRI
- EMG's

20268 Plantation Road
Lewes, Delaware 19958
•
35141 Atlantic Avenue
Millville, Delaware 19967
•
907 North DuPont Highway, Suite 102
Airpark Plaza
Milford, Delaware 19963
•
Phone: 302-644-2633
Fax: 302-644-9192

www.delawarearthritis.com

We feel it is a privilege to serve you and your family. We would like to thank you for your anticipated cooperation with these policies

Please arrive with your completed paperwork and referral, if your insurance requires one.
If your paperwork is not completed upon arrival, it will delay your appointment and it is possible we may have to reschedule.

IF YOU ARRIVE WITHOUT YOUR REFERRAL YOU WILL NEED TO RESCHEDULE.

Please bring a written list or the actual medication bottles for **all** office visits. Please bring your pharmacy's telephone number as well.

Remember to bring your insurance cards and photo identification to each office visit.

If you have an out-of-state insurance plan, you will be expected to pay for your visit. We will provide you with the required documentation to submit to your insurance company.

Your co-pay must be collected at the time of service.

MEDICATION REFILL POLICY

Please allow **3 workdays** for non-narcotic prescriptions.

Please allow **5 - 7 workdays** for narcotic prescription refills. Narcotic prescriptions **must** be picked up by the patient at our office during regular office hours.

Prescriptions will only be mailed in special circumstances as determined by our providers. (MD, PA, NP).

Please remind the nurse or physician for prescription refills during your regular visits.

When leaving a message for prescription refills we need the following information:

- Full name, phone number, date of birth.
- Name of medication (please spell it).
- Strength (dosage).
- Directions (how to take it).
- Quantity.
- Name of physician who ordered it.
- Name and telephone of pharmacy.

LABORATORY/X-RAY RESULTS

All normal test (lab, x-ray, etc.) values will be reviewed with you on your next office visit.

All abnormal (if they are of an urgent matter per physician) will be called to you and appropriate corrective action will be put in place. (For example: making an appointment with your doctor, change of medications, etc.)

MEDICAL RECORD COPYING

Please allow 7 workdays for charts to be copied unless otherwise stated by your physician. Charge, according to the number of pages, may apply. Records will not be mailed to the patient directly.

Office Hours

Monday, Wednesday and Thursday
8:00a - 5:00p
Tuesday
9:00a - 5:00p
Friday
8:00a - 2:00p

Emergencies are to call 911 or go to the nearest emergency room.

Any calls made after office hours should be limited to **urgent** attention from your doctor.

We ask that all other calls be made during office hours or left on the general voicemail where calls will be returned the next day.

Appointments

So that we may give our patients premium care in a timely manner, if you are more than 15 minutes late for your appointment, we will try to make every effort to accommodate you. If this is not possible, we will need you to reschedule your appointment for another date and time.

All cancellations must be made at least 24 hours in advance.

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Jennifer Willey FNP

302-644-2633

To get the most out of your visit and to ensure that our provider is able to help you, please remember to bring the following to your appointment:

Your completed paperwork.

Copies of any blood work and/or x-rays that relate to your visit with us.

Your insurance referral, if needed.

Please arrive at least 15 minutes prior to your appointment to allow for processing paperwork.

Lewes office:
20268 Plantations Road is right behind Lowe's at Five Points. Coming south on Route 1 you can also make a right at Grotto's Grand Slam and we are at the end of the road on the left.

Millville Office:
25141 Atlantic Avenue
From Route 1 South - Turn right on to Route 26 West. Follow route 26 past Millville Pet Shop and look for Millville Medical Suites which will be on your right.

Milford Office
907 North Dupont Highway
Across the highway from WaWa, in the same shopping center as Subway, about 3 doors down.

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302-644-2633

NEW PATIENT PAPERWORK

Name: _____ _____ _____
First: Middle Last

Address: _____

_____ _____ _____
City State Zip Code

Phone: _____ _____ _____
Home Work E-mail address

Date of Birth: _____ SS#: _____ Sex: _____ Ethnicity: _____

Employer: _____ Business Phone: _____

Guarantor/Spouse/Parent: _____ Relationship: _____

Address: _____ DOB: _____

SS#: _____ Emergency Contact: _____ Phone: _____

Pharmacy: _____ Phone: _____ Location: _____

Do you have insurance? _____ Name of insurance company: _____

Primary Care Physician: _____ Phone #: _____

Address: _____

Referring Physician: _____ Phone #: _____

Address: _____

ALLERGIES:

HISTORY: Fill in health information about your family

RELATION	AGE	STATE OF HEALTH	AGE AT DEATH	CAUSE OF DEATH	Check (✔) if your blood relative had any of the following: Disease	Relationship to you
					Arthritis	
					Asthma, Hay Fever	
					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart disease, strokes	
					High blood pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS/SURGERIES YEAR	HOSPITAL	REASON AND OUTCOME	PREGNANCY HISTORY YEAR OF BIRTH	SEX OF CHILD	COMPLICATIONS IF ANY

HAVE YOU EVER HAD A BONE DENSITY SCAN? Y N WHEN? WHERE?

Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, please give approximate dates:

Diagnosis of Illness (diabetes thyroid)		DATE	OUTCOME

Medications	Dosage	Frequency

HEALTH HABITS: Check (✔) which substances you use and describe how much you use.

Caffeine	
Tobacco	
Drugs	
Other	

OCCUPATIONAL CONCERNS

Check (✔) if your work exposes you to the following:

- ☐ Stress
- ☐ Hazardous substances
- ☐ Heavy lifting
- ☐ Other
- ☐ Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her service responsible for any errors or omission that I may have made in the completion of this form.

Signature

Date

delaware ARTHRITIS

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Kelly Fanto, M.D.
Jennifer Rahn PA-C
Jennifer Willey FNP

302-644-2633

If I have not obtained authorization or a referral from my primary care physician or have not used the designated facility required by my insurance company, I, the undersigned patient or guarantor, release **DELAWARE ARTHRITIS** and all affiliated physicians, from any and all responsibility for charges or office visits, x-rays, laboratory work or any other diagnostic testing or procedures.

Signature _____ Date _____

IF YOUR INSURANCE REQUIRES AUTHORIZATION/REFERRAL, YOU MUST HAVE IT AT THE TIME OF YOUR VISIT OR YOU WILL BE RESPONSIBLE FOR THE CHARGE.

Insurance Information

Primary Insurance

Insurance Company Name: Subscriber: Relationship:

Street Address: City: State: Zip:

ID Number: Group Number:

Secondary Insurance

Insurance Company Name: Subscriber: Relationship:

Street Address: City: State: Zip:

ID Number: Group Number:

PATIENT RELEASE: I, THE UNDERSIGNED HAVE INSURANCE COVERAGE AND ASSIGN DIRECTLY TO DELAWARE ARTHRITIS, ALL MEDICAL BENEFITS. I AUTHORIZE RELEASE OF MEDICAL INFORMATION TO INSURANCE COMPANIES AND OTHER PHYSICIANS AS IS NECESSARY FOR FILING MEDICAL CLAIMS OR FOR CONSULTATIONS. I AUTHORIZE PAYMENT OF MEDICAL CLAIMS TO THE PROVIDER. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS.

SIGNATURE DATE

Patient, Parent or Guarantor

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE TO DELAWARE ARTHRITIS ON MY BEHALF FOR ANY SERVICES FURNISHED ME BY PHYSICIAN OR SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

SIGNATURE DATE

Patient, Parent or Guarantor

Multi-Dimensional Health Assessment Questionnaire (R808-NR2)

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. Try to complete as much as you can yourself, but if you need help, please ask. <u>There are no right or wrong answers</u>. Please answer exactly as you think or feel. Thank you.

1. 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	_____ 1.1	_____ 2.2	_____ 3.3
l. Deal with feelings of anxiety or being nervous?	_____ 0	_____ 1.1	_____ 2.2	_____ 3.3
m. Deal with feelings of depression or feeling blue?	_____ 0	_____ 1.1	_____ 2.2	_____ 3.3

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 ○ PAIN AS BAD AS IT COULD BE
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

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

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
a. <u>LEFT FINGERS</u>	☐ 0	☐ 1	☐ 2	☐ 3	j. <u>RIGHT FINGERS</u>	☐ 0	☐ 1	☐ 2	☐ 3
b. <u>LEFT WRIST</u>	☐ 0	☐ 1	☐ 2	☐ 3	k. <u>RIGHT WRIST</u>	☐ 0	☐ 1	☐ 2	☐ 3
c. <u>LEFT ELBOW</u>	☐ 0	☐ 1	☐ 2	☐ 3	l. <u>RIGHT ELBOW</u>	☐ 0	☐ 1	☐ 2	☐ 3
d. <u>LEFT SHOULDER</u>	☐ 0	☐ 1	☐ 2	☐ 3	m. <u>RIGHT SHOULDER</u>	☐ 0	☐ 1	☐ 2	☐ 3
e. <u>LEFT HIP</u>	☐ 0	☐ 1	☐ 2	☐ 3	n. <u>RIGHT HIP</u>	☐ 0	☐ 1	☐ 2	☐ 3
f. <u>LEFT KNEE</u>	☐ 0	☐ 1	☐ 2	☐ 3	o. <u>RIGHT KNEE</u>	☐ 0	☐ 1	☐ 2	☐ 3
g. <u>LEFT ANKLE</u>	☐ 0	☐ 1	☐ 2	☐ 3	p. <u>RIGHT ANKLE</u>	☐ 0	☐ 1	☐ 2	☐ 3
h. <u>LEFT TOES</u>	☐ 0	☐ 1	☐ 2	☐ 3	q. <u>RIGHT TOES</u>	☐ 0	☐ 1	☐ 2	☐ 3
i. <u>NECK</u>	☐ 0	☐ 1	☐ 2	☐ 3	r. <u>BACK</u>	☐ 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:

VERY WELL ○ VERY POORLY
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

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1.a-j FN (0-10)

1=0.3 16=5.3
2=0.7 17=5.7
3=1.0 18=6.0
4=1.3 19=6.3
5=1.7 20=6.7
6=2.0 21=7.0
7=2.3 22=7.3
8=2.7 23=7.7
9=3.0 24=8.0
10=3.3 25=8.3
11=3.7 26=8.7
12=4.0 27=9.0
13=4.3 28=9.3
14=4.7 29.9.7
15=5.0 30=10

2.PN (1-10)

4.PTGL (1-10)

RAPID3 (1-10)

Cat:

HS => 12

MS = 6.1-12

LS = 3.1-6

R = ≤3

Please turn to the other side

1. Please check (✓) if you have experienced any of the following over the last month:

___ Fever	___ Lump in your throat	___ Paralysis of arms or legs
___ Weight gain (>10 lbs)	___ Cough	___ Numbness or tingling in arms or legs
___ Weight loss (>10 lbs)	___ Shortness of breath	___ Fainting spells
___ Feeling sickly	___ Wheezing	___ Swelling of hands
___ Headaches	___ Pain in the chest	___ Swelling of ankles
___ Unusual fatigue	___ Heart pounding (palpitations)	___ Swelling in other joints
___ Swollen glands	___ Trouble swallowing	___ Joint pain
___ Loss of appetite	___ Heartburn or stomach gas	___ Back pain
___ Skin rash or hives	___ Stomach pain or cramps	___ Neck pain
___ Unusual bruising or bleeding	___ Nausea	___ Use of drugs not sold in stores
___ Other skin problems	___ Vomiting	___ Smoking cigarettes
___ Loss of hair	___ Constipation	___ More than 2 alcoholic drinks per day
___ Dry eyes	___ Diarrhea	___ Depression - feeling blue
___ Other eye problems	___ Dark or bloody stools	___ Anxiety - feeling nervous
___ Problems with hearing	___ Problems with urination	___ Problems with thinking
___ Ringing in the ears	___ Gynecological (female) problems	___ Problems with memory
___ Stuffy nose	___ Dizziness	___ Problems with sleeping
___ Sores in the mouth	___ Losing your balance	___ Sexual problems
___ Dry mouth	___ Muscle pain, aches, or cramps	___ Burning in sex organs
___ Problems with smell or taste	___ Muscle weakness	___ Problems with social activities

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5. ROS: ☐

Please check (✓) here if you have had none of the above over the last month: .

---

6. When you awakened in the morning OVER THE LAST WEEK, did you feel stiff? ☐ No ☐ Yes
If "No," please go to Item 7. **If "Yes," please indicate the number of minutes____ , or hours ____** until you are limber as you will be for the day.

7. How do you feel TODAY compared to ONE WEEK AGO? Please check (✓) only one.
Much Better ☐(1), Better ☐(2), the Same ☐(3), Worse ☐(4), Much Worse ☐(5) than one week ago.

8. How often do you exercise aerobically (sweating, increased heart rate, shortness of breath) **for at least one half hour** (30 minutes)**? Please check ( ) only one.**
☐3 or more times a week (3) ☐1-2 times per month (1)
☐1-2 times per week (2) ☐Do not exercise regularly (0) ☐Cannot exercise due to disability/handicap (9)

9. How much of a problem has UNUSUAL fatigue or tiredness been for you over the past week?
FATIGUE IS ○ FATIGUE IS A
NO PROBLEM 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 MAJOR PROBLEM

10. Over the last 6 months have you had: [Please check ( )]

☐No ☐Yes An operation or new illness	☐No ☐Yes Change(s) of arthritis or other medication
☐No ☐Yes Medical emergency or stay overnight in hospital	☐No ☐Yes Change(s) of address
☐No ☐Yes A fall, broken bone, or other accident or trauma	☐No ☐Yes Change(s) of marital status
☐No ☐Yes An important new symptom or medical problem	☐No ☐Yes Change job or work duties, quit job, retired
☐No ☐Yes Side effect(s) of any medication or drug	☐No ☐Yes Change of medical insurance, Medicare, etc.
☐No ☐Yes Smoke cigarettes regularly	☐No ☐Yes Change of primary care or other doctor

Please explain any "Yes" answer below, or indicate any other health matter that affects you:

SEX: ☐ Female, ☐ Male **ETHNIC GROUP**: ☐ Asian, ☐ Black, ☐ Hispanic, ☐ White, ☐ Other
Your Occupation _____ **Please circle the number of years of school you have completed:**
Work Status: ☐ Full-time, ☐ Part-Time, ☐ Disabled 1 2 3 4 5 6 7 8 9 10
☐ Homemaker, ☐ Self Employed, ☐ Retired 11 12 13 14 15 16 17 18 19 20
☐ Seeking work, ☐ Other **Please write your weight: _____ lbs. height: _____ inches**

Your Name _____ **Date of Birth** _____ **Today's Date** _____

 Thank you for completing this questionnaire to help keep track of your medical care. R808nP2

FOR OFFICE USE ONLY: I have reviewed the questionnaire responses.
Date: _____ Signature _____

Last Name _____ First Name _____ DOB _____

Authorization to Pay Insurance Benefits

I hereby authorize all insurance payment be made directly to Delaware Arthritis, under the terms of my insurance policy with respect to services provided for myself and/or my dependents. _____

I understand that I am financially responsible for any balance of charges not covered by my insurance including deductibles, copayments and co-insurances.
I understand that my copayment is due at the time of my visit. If not paid at this time there will be a $5.00 administrative fee applied to my account each month until paid in full.
If a budget agreement is made with Delaware Arthritis, it will require a financial agreement signed by myself and the billing department and according to this agreement all balances must be paid in full within 4 months or my account will be sent to collections and will include any collection agency fees, postage and any other associated fee; I will also be dismissed from Delaware Arthritis until my account is paid in full. _____

I understand that if no payment is made within 3 months of when the insurance payment is received, my account will be sent to collections and will include any collection agency fees, postage and any other associated fees; I will also be dismissed from Delaware Arthritis until my account is paid in full. _____

I understand that if I cancel the same day of my appointment (under 24 hours), or do not show up for my appointment, a NO SHOW FEE of $25.00 will be charged to my account and are subject to Delaware Arthritis' financial policies. _____

Authorization to Release Medical Information
I authorization Delaware Arthritis to release any medical information to my Primary Care Physician, Insurance Company and/or other Medical Professional. _____

Consent for Treatment
I give my consent to Delaware Arthritis, its staff and related associates to provide services considered necessary and proper for my diagnosis.
My signature below indicates consent to all of the above.

Signature: _____ Date: _____
Signature must be a parent or guardian if patient is under 18 years of age

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Narcotics Policy and Patient Consent and Disclosure of Protected Health Information

Patient Name: _____ **DOB:** _____

We are not a pain management practice. We are a Rheumatology practice. We treat conditions that cause pain. Treatment may include non-narcotic medications, physical therapy, aqua therapy and lifestyle modifications. Low dose narcotics may be used as a last resort for a limited time. A pain contract will be required and updated frequently. Random urine toxin screens will also be performed. Patients will be required to be screened every 1-2 months. Patients requiring higher doses of narcotics will be referred to pain management.

Patient Initials: _____ **Today's Date:** _____

I hereby give my consent for Delaware Arthritis to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by Delaware Arthritis describes uses and discloses more completely).
With this consent, Delaware Arthritis may call my home or other alternative location and leave a message on voicemail, answering machine, or with a person in reference to any items that assist the practice in carrying out TPO. Such items include, but are not limited to, appointment reminders, insurance items, test results and patient statements.
I have been offered a written copy of the Notice of Privacy Practices of Delaware Arthritis prior to signing this consent. Delaware Arthritis reserves the right to revise its Notice of Privacy Practices at any time. I can request a copy of Privacy Practices at any time to check the updates.
I have the right to request in writing that Delaware Arthritis restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Delaware Arthritis may decline to provide treatment to me.

Patient Initials: _____ **Today's Date:** _____

I also give my consent to disclose my health information to the following:

_____ **Relationship** _____ **Phone Number** _____
_____ **Relationship** _____ **Phone Number** _____

Internal use only
If patient or representative refuses to sign the Patient Consent for Use and Disclosure of Protected Health Information, please document date and time the notice was presented to patient and sign below
Presented on (date and time) _____ By (name and title) _____

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ARTHRITIS

Consent for E-Mail Communication

This consent gives Delaware Arthritis and/or any staff permission to contact you via e-mail. In order to receive access to your electronic medical records, an invitation will be sent by our office titled Follow My Health. You will be prompted to create a user name and password in order to gain access. On occasion any staff member may need to contact you regarding non-urgent issues such as normal lab results, appointments and office updates. E-mail should not be used for any urgent health issues. We will respond to your non-urgent e-mail within 24-48 hours. Please call our office for any health concerns. While our e-mail is secure and confidential, we cannot guarantee the same for your e-mail service. Please check with your e-mail provider with any questions or concerns regarding privacy and confidentiality. Any e-mail communication will be considered a part of your medical record.

Your e-mail address: _____

If this e-mail address belongs to a member of your family or a caregiver, please indicate that person's name and relationship: _____

Printed name: _____

Signature: _____

Date: _____

Date of birth: _____

If you do not want to share your e-mail address, please check here:_____