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 of paperwork.

Lewes Office:
20268 Plantations Road
20268 Plantations Road is about a mile from the “5-Points” light going into Lewes. Go through the light at Happy Harry’s and Windsor’s Flowers. Our office is the third building from the light on the right side across from Bayside Health.

Millville Office:
609 North Atlantic Avenue
From Route 1 South - Turn right onto Route 26 West. Follow Route 26 past Millville Pet Stop and look for Millville Medical Suites which will be to your right.
From Route 26 East - Follow past 84 Lumbar 1/2 miles or so looking for Millville Medical Suites which will be on your left.

Millford Office:
907 N. Dupont Highway, Suite 102
South bound side of Rt. 113 in Airpark Plaza where Subway is located.
Across from Wawa.

(All information is strictly confidential)
NEW PATIENT REGISTRATION

Name: ____________________________ Middle ____________________________ Last ____________________________
Address: ____________________________

Zip Code ____________________________ City ____________________________ State ____________________________
Phone: Home ____________________________ Work ____________________________ E-mail: ____________________________
Birth Date: __________ SS#: ____________________________ Sex: __________ Ethnicity: ____________________________
Employer: ____________________________ Business Phone: ____________________________
Guarantor/Spouse/Parent: ____________________________ Relationship: ____________________________
Address: ____________________________ DOB: ____________________________
SS#: ____________________________ Emergency Contact: ____________________________ Phone: ____________________________
Pharmacy: ____________________________ Phone: ____________________________ Location: ____________________________

If you do not have your insurance card(s) with you, you will be billed.

Credit Card type: ____________________________ Number: ____________________________ Expiration date: __________
Name on card: ____________________________
Primary Care Physician: ____________________________ Phone #: ____________________________
Address: ____________________________
Referring Physician: ____________________________ Phone #: ____________________________
Address: ____________________________

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

Do you have a living will?   ___ Yes   ___ No

PATIENT RELEASE: I, the undersigned have insurance coverage and assign directly to Rheumatology Consultants of Delaware, 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 Rheumatology Consultants of Delaware on my behalf for any services furnished me by physical 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
**FAMILY HISTORY: Fill in health information about your family**

<table>
<thead>
<tr>
<th>RELATION</th>
<th>AGE</th>
<th>STATE OF HEALTH</th>
<th>AGE AT DEATH</th>
<th>CAUSE OF DEATH</th>
<th>Check (✓) if your blood relative had any of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Arthritis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Asthma, Hay Fever</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Cancer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YEAR</th>
<th>HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HAVE YOU EVER HAD A BONE DENSITY SCAN?</th>
<th>Y</th>
<th>N</th>
<th>WHEN?</th>
<th>WHERE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever had a blood transfusion?</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes, please give approximate dates:

<table>
<thead>
<tr>
<th>Diagnoses or Illness (diabetes, thyroid, etc)</th>
<th>DATE</th>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HEALTH HABITS: Check (✓) which substances you use and describe how much you use.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caffeine</td>
</tr>
<tr>
<td>Tobacco</td>
</tr>
<tr>
<td>Drugs</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CURRENT MEDICATIONS</th>
<th>OCCcupATIONAL CONCERNS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICATION</td>
<td>DOSE (MG)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Check (✓) if your work exposes you to the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress</td>
</tr>
<tr>
<td>Hazardous substances</td>
</tr>
<tr>
<td>Heavy lifting</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Your occupation:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

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: ___________________________
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
- Depression - feeling blue
- Dry eyes
- Diarrhea
- Anxiety - feeling nervous
- Other eye problems
- Dark or bloody stools
- Problems with thinking
- Sores in the mouth
- Losing your balance
- Problems with memory
- Dry mouth
- Muscle pain, aches, or cramps
- Burning in sex organs
- Problems with smell or taste
- Muscle weakness
- Problems with social activities
- Other problems
- Vomiting
- Smoking cigarettes
- Loss of hair
- Constipation
- Depression - feeling blue
- Dry eyes
- Diarrhea
- Anxiety - feeling nervous
- Other eye problems
- Dark or bloody stools
- Problems with thinking
- Sores in the mouth
- Losing your balance
- Problems with memory
- Dry mouth
- Muscle pain, aches, or cramps
- Burning in sex organs
- Problems with smell or taste
- Other problems

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 □ 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 Medical emergency or stay overnight in hospital
    □ No □ Yes A fall, broken bone, or other accident or trauma
    □ No □ Yes An important new symptom or medical problem
    □ No □ Yes Side effect(s) of any medication or drug
    □ No □ Yes Smoke cigarettes regularly

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 ___________________

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

Date: _____________________ Signature ___________________
Narcotics Policy

We are not a pain management practice, we are a Rheumatology practice. We treat conditions that cause pain. Treatment would include non-narcotic medications, physical therapy, aqua therapy and lifestyle modifications. Low dose narcotics could be used as a last resort and for a limited time. A pain contract would be required and random urine drug screenings will be performed. Patients will be required to be seen every 1 to 2 months. Patients requiring higher doses of narcotics would be referred to pain management.
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. There are no right or wrong answers. 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:

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

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 | 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. 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:

<table>
<thead>
<tr>
<th>Joint Area</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. LEFT FINGERS</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>b. LEFT WRIST</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>c. LEFT ELBOW</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>d. LEFT SHOULDER</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>e. LEFT HIP</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>f. LEFT KNEE</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>g. LEFT ANKLE</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>h. LEFT TOES</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>i. NECK</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>j. RIGHT FINGERS</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>k. RIGHT WRIST</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>l. RIGHT ELBOW</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>m. RIGHT SHOULDER</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>n. RIGHT HIP</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>o. RIGHT KNEE</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>p. RIGHT ANKLE</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>q. RIGHT TOES</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>r. BACK</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

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 | 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 | POORLY

Please turn to the other side

Copyright: Health Report Services, Telephone 615-479-5303, E-mail tedpincus@gmail.com
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)
- Shortness of breath
- Numbness or tingling in arms or legs
- Weight loss (>10 lbs)
- Wheezing
- Fainting spells
- Feeling sickly
- Pain in the chest
- Swelling of hands
- Headaches
- Heart pounding (palpitations)
- Swelling of ankles
- Unusual fatigue
- Trouble swallowing
- Swelling in other joints
- Swollen glands
- Heartburn or stomach gas
- Joint pain
- Loss of appetite
- Stomach pain or cramps
- Use of drugs not sold in stores
- Skin rash or hives
- Constipation
- More than 2 alcoholic drinks per day
- Headaches
- Diarrhea
- Depression - feeling blue
- Unusual bruising or bleeding
- Nausea
- Anxiety - feeling nervous
- Other skin problems
- Vomiting
- Problems with thinking
- Other eye problems
- Constipation
- Problems with memory
- Prostate problems
- Gynecological (female) problems
- Problems with smell or taste
- Gastrointestinal (problems)
- Problems with social activities
- Problems with hearing
- Dizziness
- Problems with eating
- Stuffy nose
- Losing your balance
- Sexual problems
- Sores in the mouth
- Muscle weakness
- Problems with sleeping
- Dry mouth
- Muscle pain, aches, or cramps
- Burning in sex organs
- Problems with the mouth
- Problems with the legs
- Problems with the eyes
- Problems with the bones
- Problems with the blood
- Problems with the skin
- Problems with the bones
- Problems with the liver
- Problems with the lungs
- Problems with the brain
- Problems with the heart
- Problems with the intestines
- Problems with the stomach

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

5. ROS:

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 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
   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 □ Homemaker, □ Self Employed, □ Retired □ Seeking work, □ Other
□ 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 write your weight: ______ lbs.  height: ______ inches

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

I hereby authorize all insurance payments to be paid directly to Delaware Arthritis, under the terms of my insurance policy with respect to services provided for myself and/or my dependants.

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 an collection agency fees, postage and an 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, postange 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 authorize 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
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 email 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 email address is 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 email address, please check here: ________________
Patient Policies

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Services Offered:

Patient Evaluation   •   Infusion Services   •   Clinical Trials   •   Electrical Stimulation   •   Bone Densitometry

MISSION:

To provide state-of-the-art care to all our patients and to restore them to their optimal level of wellness.

These policies have been drafted to give you the best and most timely response and treatment to your health needs.

1. AT YOUR VISIT

Please make every effort to get your paper referrals, if your insurance requires one.

If you arrive without your referral, we will need to reschedule your appointment.

We are asking patients to bring a WRITTEN LIST or ACTUAL MEDICATION BOTTLES for all office visits. Please bring your pharmacy’s telephone number as well.

Remember to bring your insurance cards and 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.

2. MEDICATION REFILL POLICY

Please allow 2 workdays for non-narcotic prescriptions.

Please allow 3 - 5 workdays for narcotic prescription refills.

Narcotic prescriptions must be picked up at our business during regular office hours.

No prescription will be mailed unless otherwise stated by your doctor.
3. PRESCRIPTION HOTLINE: (302) 644-4156

This is a 24-hour refill hotline. Our staff will pick up calls during the next workday, Monday through Thursday. All messages left on Friday will be taken care of on Monday.

The information we will need on your message is as follows:

- Patient’s Name
- Name of medication (please spell it).
- Strength (dosage).
- Directions (how you take it).
- Quantity
- Name of physician who ordered it.
- Name and telephone of pharmacy.

4. PHONE CALL FORMAT

We will be instituting a “triage phone call format”. This means the reception staff will be asking all callers if a call is:

A. **Emergency Call**  Example: Chest pain, difficulty breathing.

B. **Urgent Call**  Example: Prolonged pain, sick more than 3 days.

C. **Non-urgent Call**  Example: all other concerns.

Non-urgent calls will be returned between 4:00 and 5:00 pm that day, if possible. If, for some reason it is not possible, the call will be returned the following workday.

5. AFTER HOURS PHONE CALLS

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.
6. LABORATORY/X-RAY RESULTS

Normal test (lab, x-ray, etc.) values will not be called to you.

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

7. MEDICAL RECORD COPYING

Please allow 7 workdays for charts to be copied unless otherwise stated by your physician. A charge, according to the number of pages may be applied.

8. APPOINTMENTS

If you are unable to keep your appointment, we now require a 24-hour notice. There will be a charge of $25.00 for “no shows”/missed appointments.

If you are more than 15 minutes late for an appointment, we will make every effort to accommodate you. If this is not possible, we will need to reschedule your appointment for another date and time.

9. INSURANCE REFERRALS

Please allow our staff 3 - 5 workdays to obtain referrals/authorizations from your insurance company.

Please have the following information ready for our reception staff:

• Date of appointment

• Name of doctor and phone number

• Reason for appointment

The co-pay is collected at the time of your visit.
It is a privilege to serve you and your families. We would like to thank you for the anticipated cooperation with these policies.

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