SOUTH CHARLOTTE RHEUMATOLOGY

Medical History

Patient Information:

Last Name	First Name	Date of Birth
Reason for Visit	Allergies	**O Allergy list attached**
Preferred Pharmacy	Pharmacy Telephone	Pharmacy Address

Please list the physicians who care for you now or have cared for you in the past (including previous rheumatologists):

1.	3.
2.	4.

Please list your current medications, vitamins and supplements: **O Medication list attached**

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Please list medications you have been prescribed by a rheumatologist previously:

1.	3.
2.	4.

Please list any diseases, illnesses, or surgeries you have now or have had previously: **O Medical History attached**

1.
2.
3.
4.
5.

Please indicate the history of arthritis or rheumatic disease in your family:

	Mother	Father	Sibling	Grandparent	Other (please specify)
Arthritis (unknown type)	O	O	O	O	O
Rheumatoid Arthritis	O	O	O	O	O
Psoriatic Arthritis	O	O	O	O	O
Osteoarthritis	O	O	O	O	O
Osteoporosis	O	O	O	O	O
Lupus	O	O	O	O	O
Psoriasis	O	O	O	O	O
Gout	O	O	O	O	O
Other Autoimmune Condition	O	O	O	O	O

Social History:

Tobacco: O YES O NO O Current Smoker ___packs/day or week O Former Smoker Year quit _____ O Never	**Alcohol: O YES O NO** (circle one: wine / beer / spirits) O Daily O Frequent (1-5/week) O Casual (<1/week) O None	**Exercise: O YES O NO** O Vigorous How often? _____ O Low intensity How often? _____ O Cannot exercise due to health problems
Occupation: _____ O Full-time O Retired O Disabled O Part-time O Homemaker O Self-Employed O Student O Other: _____		**Highest Level of Education:** _____ **Household Members:** O Spouse/Significant Other O Children (ages: _____) O Other _____

Immunizations: Please list only the most recent date you received each immunization:

Influenza:	Pneumonia:	COVID-19:

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

Constitutional
O Chills
O Fatigue
O Fever
O Night sweats
O Weight gain (_____lbs)
O Weight loss (_____lbs)

HEENT
O Vision changes
O Vision loss
O Blurred vision
O Dental cares
O Double vision
O Dry mouth
O Dry eyes
O Nose bleeds
O Eye pain
O Facial pain
O Hearing loss
O Hoarseness
O Jaw pain
O Nasal drainage
O Nasal sores
O Oral ulcers
O Red eye
O Sinusitis
O Sore throat
O Ringing in ears

Respiratory
O Cough
O Frequent URI
O Coughing up blood
O Difficulty breathing when lying down
O Difficulty breathing at night
O Pain when taking deep breath
O Shortness of breath
O Wheezing

Cardiovascular
O Chest pain
O Leg cramping
O Leg swelling
O Palpitation
O Episodes of finger discoloration with cold exposure
O Chest pain
O Fast heart beat
O Blood clots
O Varicose veins

Gastrointestinal
O Abdominal cramping
O Abdominal pain
O Bloating
O Blood in stools
O Constipation
O Diarrhea
O Difficulty swallowing
O Getting full quickly after eating
O Heartburn
O Hemorrhoids
O Loss of appetite
O Nausea
O Vomiting

Genitourinary
O Painful urination
O Rash in genital area
O Genital ulcers
O Hematuria
O Erectile dysfunction
O Kidney stones
O Frequent urination at night
O Pelvic pain
O Frequent urination
O Recurrent UTI
O Scrotum/testicular pain
O Urinary incontinence

Metabolic/Endocrine
O Cold intolerance
O Hair loss
O Heat intolerance
O Increased hair growth
O Hot flashes
O Polydipsia (increased thirst)

Neurological
O Confusion/disorientation
O Dizziness
O Extremity numbness
O Extremity weakness
O Gait disturbance
O Headache
O Memory loss
O Seizures
O Syncope (fainting)
O Tingling
O Tremors

Psychiatric
O Anxiety
O Depression
O Emotional instability
O Hallucinations
O Insomnia
O Suicidal thoughts

Immunologic
O Allergic rhinitis
O Frequent infections
O Food allergies

Integumentary
O Acne
O Hives
O Itching
O Nail changes
O Rash with sun exposure
O Psoriasis
O Rash
O Scalp pain
O Skin lesion

Musculoskeletal
O Back pain
O Height loss (_____in.)
O Joint pain
O Joint swelling
O Low back pain
O Morning stiffness
O Muscle cramping
O Muscle weakness
O Muscular wasting
O Muscle pain
O Neck pain
O Neck stiffness

Hematologic/Lymph
O Easy bleeding
O Easy bruising
O Swollen lymph glands

SOUTH CHARLOTTE RHEUMATOLOGY

RAPID 3: Routine Assessment of Patient Index Data

The RAPID3 includes a subset of core variables found in the Multidimensional HAQ (MD-HAQ). Page 1 of the MD-HAQ, shown here, includes an assessment of physical function (section 1), a patient global assessment (PGA) for pain (section 2), and a PGA for global health (section 3). RAPID3 scores are quickly tallied by adding subsets of the MD-HAQ as follows:

1. PLEASE CHECK THE **ONE** BEST ANSWER FOR YOUR ABILITIES AT THIS TIME:

OVER THE LAST WEEK, WERE YOU ABLE TO:	WITHOUT **ANY** DIFFICULTY	WITH **SOME** DIFFICULTY	WITH **MUCH** DIFFICULTY	**UNABLE** TO DO
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

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 (0-10):

3. PTGE (0-10):

RAPID3 (0-30):

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**

O O O O O O O O O O O O O O O O O O O O O

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. 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 — **VERY POORLY**

O O O O O O O O O O O O O O O O O O O O O

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

CONVERSION TABLE:
Near Remission (NR): 1=0.3; 2=0.7; 3=1.0
Low Severity (LS): 4=1.3; 5=1.7; 6=2.0
Moderate Severity (MS): 7=2.3; 8=2.7; 9:3.0; 10=3.3; 11=3.7; 12=4.0
High Severity (HS): 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=10.0

HOW TO CALCULATE RAPID3 SCORES

1. Ask the patient to complete questions 1, 2, and 3 while in the waiting room prior to his/her visit.
2. For question 1, add up the scores in questions a-j only (questions k-m have been found to be informative, but are not scored formally). Use the formula in the box on the right to calculate the formal score (0-10). For example, a patient whose answers total 19 would score a 6.3. Enter this score as an evaluation of the patient's functional status (FN).
3. For question 2, enter the raw score (0-10) in the box on the right as an evaluation of the patient's pain tolerance (PN).
4. For question 3, enter the raw score (0-10) in the box on the right as an evaluation of the patient's global estimate (PTGE).
5. Add the total score (0-30) from questions 1, 2, and 3 and enter them as the patient's RAPID3 cumulative score. Use the final conversion table to simplify the patient's weighted RAPID3 score. For example, a patient who scores 11 on the cumulative RAPID3 scale would score a weighted 3.7. A patient who scores between 0-1.0 is defined as near remission (NR).; 1.3-2.0 as low severity (LS); 2.3-4.0 as moderate severity (MS); and 4.3-10.0 as high severity (HS).

SOUTH CHARLOTTE RHEUMATOLOGY

Patient Registration

Patient Information

Patient Last Name	First Name	Middle Initial	Date of Birth	Sex
Mailing Address		City	State	Zip Code
Primary Telephone	Other Telephone	Email Address		
Primary Language	Ethnicity (White, Asian, Black, Hispanic, or Other):		Birth Country (if other than USA):	

How did you hear about us?

- O My referring Doctor recommended you
- O You were recommended by one of your patients (Name:)
- O Online Research (Circle: Google/Other (if other, where?)

Emergency Contact Information

Last Name	First Name	Relationship to Patient	Primary Telephone	Legal Guardian? Yes No

Responsible Party If Other Than Patient

Last Name	First Name	Relationship to Patient	Primary Telephone	
Street Address		City	State	Zip Code

Medical Insurance Policy Holder

- O **Check here if you have provided us your insurance card(s)**
- O **Check here if you do not have medical insurance**

Primary Insurance Company	Policy Holder Last Name	Policy Holder First Name	
Relationship to Patient	Subscriber ID	Group Number	Date of Birth

Secondary Insurance Company	Policy Holder Last Name	Policy Holder First Name	
Relationship to Patient	Subscriber ID	Group Number	Date of Birth

Assignment of Benefits / Consent for Treatment

I do hereby assign all medical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I acknowledge receipt of the Financial Policy and I understand that I am responsible for all charges not paid by insurance. I authorize this practice to release all information necessary to secure payment. I hereby voluntarily consent to treatment at this office and authorize such treatments, examinations, medications, and diagnostic procedures (including, but not limited to the use of lab and radiographic studies) as ordered by attending providers. I hereby voluntarily consent to the taking of photographic images for treatment purposes only (wound care progression, documentation of rashes, etc.) as ordered by the attending providers.

Signature of Patient / Legal Guardian	Date

South Charlotte Rheumatology
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

We are committed to protect the privacy of your personal health information (PHI). This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. You will be notified of any breach of unsecured PHI. We will follow the terms outlined in this Notice. We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- Providing a copy of the new Notice in our office or by mail, upon request.
- Posting the revised Notice on our website.

Uses and Disclosures of Your PHI

The law permits or requires us to use or disclose your PHI for various reasons, which we explain in this Notice. We have included some examples, but we have not listed every permissible use or disclosure. When using or disclosing PHI or requesting your PHI from another source, we will make reasonable efforts to limit our use, disclosure, or request about your PHI to the minimum we need to accomplish our intended purpose.

Uses and Disclosures for Treatment, Payment or Health Care Operations

- **Treatment.** We may use or disclose your PHI and share it with other professionals who are treating you, including doctors, nurses, technicians, medical students, or hospital personnel involved in your care. For example, we might disclose information about your overall health condition with physicians who are treating you for a specific injury or condition.
- **Payment.** We may use and disclose your PHI to bill and get payment from health plans or others. For example, we share your PHI with your health insurance plan so it will pay for the services you receive.
- **Health Care Operations.** We may use and disclose your PHI to run our practice and improve your care. For example, we may use your PHI to manage the services you receive or to monitor the quality of our health care services.

Other Uses and Disclosures of Your PHI

We may share your information in other ways, usually for public health or research purposes or to contribute to the public good. For example, these other uses and disclosures may involve:

- **Our Business Associates.** We may use and disclose your PHI to our business associates that perform services on our behalf, such as auditing, legal, or transcription. The law requires our business associates and their subcontractors to protect your PHI in the same way we do. We also contractually require these parties to use and disclose your PHI only as permitted and to appropriately safeguard your PHI.
- **Health Information Exchanges.** We participate in health information exchanges (HIEs), which support electronic information sharing among members for treatment, payment, and health care operations purposes. Individuals may opt-out of HIEs. We will use reasonable efforts to limit the sharing of PHI in these electronic sharing activities for individuals who have opted out. If you would like to opt out, please contact us.
- **Legal Compliance.** For example, we will share your PHI if the Department of Health and Human Services requires it when investigating our compliance with privacy laws.
- **Public Health and Safety Activities.** For example, we may share your PHI to report injuries, births, and deaths; prevent disease; report adverse reactions to medications or medical device product defects; report suspected child neglect or abuse or domestic violence; or avert a serious threat to public health or safety.

- **Responding to Legal Actions.** For example, we may share your PHI to respond to a court or administrative order or subpoena; discovery request; or another lawful process.
- **Research.** For example, we may share your PHI for some types of health research that do not require your authorization, such as if an institutional review board (IRB) has waived the written authorization requirement [because the disclosure only involves minimal privacy risks].
- **Medical Examiners or Funeral Directors.** For example, we may share PHI with coroners, medical examiners, or funeral directors when an individual dies.
- **Organ or Tissue Donation.** For example, we may share your PHI to arrange an authorized organ or tissue donation from you or a transplant for you.
- **Workers' Compensation.** We may use and disclose your PHI for workers' compensation claims; health oversight activities by federal or state agencies; law enforcement purposes or with a law enforcement official; or specialized government functions, such as military and veterans' activities, national security and intelligence, presidential protective services or medical suitability.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, please contact us and we will make a reasonable effort to follow your instructions. You have both the right and choice to tell us whether to:

- Share information such as your PHI, general condition, or location, with friends or family members, or other persons involved in your care.
- Share information in a disaster relief situation, such as to a relief organization to assist with locating or notifying your family, close friends or others involved in your care.

We may share your information if we believe it is in your best interest, according to our best judgment, and:

- If you are unable to tell us your preference, for example, if you are unconscious.
- When needed to lessen a serious and imminent threat to health or safety.

Your Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing.

Inspect and obtain a copy of your protected health information. You may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested, we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost-based fee for a copy of the records.

Request Additional Restrictions. You have the right to ask us to limit what we use or share about your PHI. You can contact us and request us not to use or share certain PHI for treatment, payment, or operations or with certain persons involved in your care. For these requests:

- we are not required to agree;
- we may say "no" if it would affect your care; but
- We will not agree to disclose information to a health plan for purposes of payment or health care operations if the requested restriction concerns a health care item or service for which you or another person, other than the health plan, paid in full out-of-pocket, unless otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations. We will agree to reasonable requests. We may also request an alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

Make Amendments. You may ask us to correct or amend PHI that we maintain about you that you think is incorrect or inaccurate. For these requests:

- You must submit requests in writing, specify the inaccurate or incorrect PHI and provide a reason that supports your request.

- We will generally decide to grant or deny your request within 60 days. If we cannot act within 60 days, we will give you a reason for the delay in writing and include when you can expect us to complete our decision.
- We may deny your request for an amendment if you ask us to amend PHI that is not part of our record, that we did not create, that is not part of a designated record set, or that is accurate and complete.

Request an Accounting of Disclosures. This right applies to disclosures for purposes other than treatment, payment, or healthcare operations. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12-month period, you may be charged a reasonable fee.

Additional Privacy Rights

You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency we will give you this Notice as soon as possible. You have a right to receive notification of any breach of your protected health information.

Complaints

You have the right to complain if you feel we have violated your rights. We will not retaliate against you for filing a complaint. You may either file a complaint:

- directly with us by contacting the office. **All complaints must be submitted in writing.**
- with the Office for Civil Rights at the US Department of Health and Human Services (HHS). Send a letter to U.S. HHS at 200 Independence Ave., S.W., Washington, D.C. 20201; call 1-800-368-1019; or visit www.hhs.gov/ocr/privacy/hipaa/complaints/.

Acknowledgment of Receipt
"NOTICE OF PRIVACY PRACTICES"

I acknowledge that I have received a copy of the **"Notice of Privacy Practices"** for protected health information on the date set forth below:

Date of Receipt	Patient Date of Birth
Print Patient Name	Print Name of Authorized Personal Representative
Patient Signature	Signature of Authorized Personal Representative (Please indicate Relationship to Patient)

----------FOR USE BY PRACTICE PERSONNEL ONLY----------

(Complete only if patient acknowledgement is **not** obtained)

An Acknowledgement of Receipt of Notice of Privacy Practices was not received because:

O Patient refused to sign Acknowledgment

O Unable to gain signed Acknowledgment due to communication / language or another barrier

O Patient was unable to sign Acknowledgment due to emergency treatment situation

O Other (*please indicate reason)*: _____

SOUTH CHARLOTTE RHEUMATOLOGY

Patient Authorization for Use of Disclosure of Protected Health Information

This information is used to facilitate our communications with you as we strive to provide you with excellent service.

Patient Information *(Please print clearly):*

Last Name	First Name	Middle Initial	Date of Birth (Month/Day/Year)

Mailing address: Check if same as registration form ☐	Social Security Number or Last four of your SSN:
Preferred Phone Number **Can we Leave a Voicemail: YES ☐ NO ☐	Other Phone Number if applicable **Can we Leave a Voicemail: YES ☐ NO ☐

***If South Charlotte Rheumatology cannot reach you at the telephone number listed above, may we leave a message regarding appointments or lab results.*

I authorize South Charlotte Rheumatology to disclose Protected Health Information to the following persons:

- **Spouse**

  Name: _____ Phone Number: _____

- **Child(ren)**

  Name: _____ Phone Number: _____

  Name: _____ Phone Number: _____

- **Other**

  Name: _____ Phone Number: _____

Information to be disclosed:

o All Medical Information o Laboratory Results o All Billing / Account Information

Authorization Statement:

I understand that Protected Health Information (PHI) used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my revocation to the South Charlotte Rheumatology location where I received care. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that South Charlotte Rheumatology cannot require me to sign this authorization as a condition of treatment unless the provision of health care by South Charlotte Rheumatology is solely for the purpose of creating PHI for disclosure to a third party legally authorized to receive such information. I understand that I will be given a copy of this authorization.

Print Patient Name or Name of Legal Guardian/Personal Representative	Signature of Patient or Legal Guardian/Personal Representative
Date (Month/Day/Year)	Indicate relationship to Patient

SOUTH CHARLOTTE RHEUMATOLOGY

Financial Policy

We thank you for choosing South Charlotte Rheumatology as your healthcare provider. Please read this policy before your visit and let us know if you have questions.

Arriving for Your Visit

We ask that every new patient arrives 15 minutes prior to their scheduled appointment time. Should the patient arrive more than 15 minutes late to your appointment, we will try our best to accommodate if the schedule allows - but might need to reschedule to a different time or date. If the patient does not arrive for their appointment, or if they cancel within 24 hours of the appointment, they will be subject to a $25 charge for return visits, or a $50 charge for new patient visits, which will be applied to their account. We reserve the right to discharge patients who arrive late, cancel within 24 hours of their visit, and/or no show for their appointments three times within a 12-month period.

Insurance and Billing

We are pleased to bill the primary and secondary health care plans on the patient's behalf. The patient is ultimately responsible for any co-pay or co-insurance related to the deductible at check-in for the appointment, as well as any remaining balance after insurance payments. We accept most insurance policies, but it is the patient's responsibility to verify that we are an in-network provider. As the owner of the insurance policy, the patient is solely responsible for coverage policies under the plan and the accuracy of information on file.

Insurance Errors

If the insurance company denied or processed a claim in error, please call us immediately. If the insurance company requests additional information from the patient, it is important to comply with their requests in a timely manner. If insurance does not pay a claim within 60 days of submission, the outstanding balance will be billed to the patient and becomes the patient's responsibility. Any overpayment will be applied as a credit on the account and the patient may decide to use the credit at their next visit or opt to receive a refund check.

Paying Your Bill

For convenience, we accept multiple forms of payment, including personal check, money order, credit card, debit card, and cash. Payment is accepted by phone, online, in person, and by mail. For any lab services performed at our office, Quest Diagnostics will bill patients directly for any outstanding out-of-pocket balances. Please contact Quest Diagnostics directly to discuss your lab bill at 866-MYQUEST (866-697-8378).

Credit Cards on File

Should there be a balance after 30 days or if a payment plan is established, an HSA and/or credit card must be kept on file. We do not have access to patients' credit-debit/HSA/bank information. Private financial information is stored and encrypted by a certified company that is compliant with all federal privacy laws, as well as the Payment Card Industry Data Security Standards (PCI DSS).

Ability to Pay

Account balances should be paid in full by the statement due date. If there are extenuating circumstances that limit the ability to pay the account balance and have exhausted other resources, please contact our Billing Office to discuss a payment plan option. Holds may be placed on accounts without payment arrangements and future appointments may not be scheduled until past balances are fulfilled. Failed attempts to contact patients about their unpaid balances to establish payment arrangements may lead to collections and/or discharge from the practice.

Accounts in Default

We will attempt to bill and collect from patients who are responsible for all or part of the cost of services performed at our office. After 90 days, if a payment has not been made, or a payment plan has not been established, we may initiate pre-collections by sending a pre-collections notice. If we fail to collect or arrange payment from the patient, the patient may receive a final notice to pay. If the balance is not paid after the final notice, a certified letter discharging the patient from the practice will be sent, and the account referred to a collections agency.

Signature of Patient / Legal Guardian	Date

SOUTH CHARLOTTE RHEUMATOLOGY

Prescription Refill Policy

Most of the time, we will provide you with enough medication to last until your next follow-up appointment. Please indicate if you need a 30-day or 90-day supply at your visit, and to which pharmacy your medication should be sent to.

- You may request a refill by calling the office and speaking with the medical assistant. Please leave a detailed message with your full name, date of birth, and medication information; please note that all requests require a 24-hour notice, and we will handle all refill requests submitted after hours, during weekends, and holidays the next business day.

- If we receive a refill request from your pharmacy, we may contact you to verify if you need it before approving the refill.

- You must have a follow-up appointment on file to continue refilling your medications and must have had a visit with the doctor within the previous 12 months.

- Refills of certain medications may require blood work or other requirements prior to fulfilling the refill request.

Signature of Patient / Legal Guardian	Date