Jose A. Leon, MD

Zarmeena Ali, MD

Linda Back, NP

Rheumatology Consultants — of Alabama —

111 N 24th St Opelika, AL 36801

Phone: 334.704.8100

Fax: 866.538.3485

New Patient Intake Form

Today's Date: _____

Please complete the below information, to the best of your knowledge, and bring this form to your appointment.

NAME: _____ **BIRTHDATE** _____

ADDRESS: _____

PHONE: *HOME* ( ) _____ *WORK*: ( ) _____ *CELL*: ( ) _____

EMAIL ADDRESS: _____

Sex: _____ Race: _____ Ethnicity: _____ Social Security #: _____

Employer: _____ Occupation: _____

Retired: ☐ Yes ☐ No Disabled: ☐ Yes ☐ No Retirement Date: _____

Your Preferred Language: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name: _____ Birthdate: _____

Spouse's Social Security #: _____ Spouse's Cell Phone #: _____

Person To Contact In Case of Emergency: _____

Relationship To You: _____ Phone #: _____

Billing Information

Primary Insurance:

Name of Insurance: _____

Contract #: _____ Group Name: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder's Birthdate: _____

Relationship to Policy Holder: _____

Secondary Insurance:

Name of Insurance: _____

Contract #: _____ Group Name: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder's Birthdate: _____

Relationship to Policy Holder: _____

Local Pharmacy

Name / Address: _____

Pharmacy Phone # ( ) _____ Fax # ( ) _____

Mail Order Pharmacy

Name/City/State: _____

Pharmacy Phone # ( ) _____ Fax # ( ) _____

Drug Allergies: _____

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PLEASE LIST YOUR CURRENT MEDICATIONS:

NAME/DOSE/HOW IT'S TAKEN

1. _____
2. _____
3. _____
4. _____
5. _____

NAME/DOSE/HOW IT'S TAKEN

6. _____
7. _____
8. _____
9. _____
10. _____

PLEASE LIST MEDICATIONS YOU HAVE TRIED IN THE PAST FOR YOUR RHEUMATIC CONDITION(S):

NAME/DOSE/HOW IT'S TAKEN

1. _____
2. _____

NAME/DOSE/HOW IT'S TAKEN

3. _____
4. _____

PLEASE LIST ANY MEDICAL CONDITIONS YOU HAVE OR HAVE HAD PREVIOUSLY:

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

PLEASE LIST ANY PREVIOUS SURGERIES (and date):

1. _____
2. _____
3. _____
4. _____

HISTORY OF SMOKING AND ALCOHOL USE:

Do you currently drink alcohol? ☐ Yes ☐ No Did you previously drink alcohol? ☐ Yes ☐ No

Do you currently smoke tobacco? ☐ Yes ☐ No Did you previously smoke tobacco? ☐ Yes ☐ No

PLEASE INDICATE ANY FAMILY HISTORY OF ARTHRITIS OR RHEUMATIC DISEASE:

	Mother	Father	Sibling(s)
Rheumatoid Arthritis			
Gout			
Psoriasis			
Lupus			
Other: Please write in below			

_____

PLEASE LIST OTHER PHYSICIANS SEEING YOU CURRENTLY AND THEIR SPECIALTY:

_____

_____

_____

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Office Policies and Consents

Authorization to Release Information:

I authorize the release of medical information and records concerning my treatment to Medicare, Medigap, and/or other insurance companies and assign my claim for medical benefits to the Practice to the extent permitted under applicable law or insurance agreements. I agree to allow the Practice to request and release my medical records from the other physicians or medical institutions as it deems necessary for my medical care and I further authorize the release of my medical records by such parties for such purpose. I agree to allow the Practice to use my medical information and photography in an anonymous manner for the purpose of teaching or publication. I release the Practice from all legal responsibility or liability that may arise from above authorizations and agreements.

Appointment Reminder Policy:

I authorize this Practice and their agent to place appointment reminder phone calls or text messages to the phone I have listed on my patient form.

Consent to Treatment:

I authorize the physicians of the Practice, their associates, technical assistants, and other health care providers under their direction to provide diagnostic evaluation and treatment. I understand that no guarantee has or will be made to me regarding any possible result or cure based on my examination and/or treatment.

No Show and Cancellation Policy:

Patients who fail to show up to their scheduled appointment without 24-hour notification will be charged a $75.00 No-show & cancellation fee. New Patients will be charged a $100 No-Show fee. Patients are required to provide 24 hours' notice if they can't make their appointment. If a patient cancels within that time frame, they won't be charged. Patients who cancel their appointment with less than 24 hours' notice will be charged a $75.00 Cancellation fee.

Guest Policy:

To help us provide a safe, comfortable, and efficient environment for all patients, we kindly ask that you limit guests during your visit. Patients are permitted to have one guest accompany them into the exam room. Any additional guests are welcome to remain in the waiting area during the appointment. For patient safety and to maintain a controlled clinical environment, guests are not permitted in the infusion room during treatments. Only the patient receiving care may be present in this area.

Acknowledgement

By signing below, I acknowledge that I have received, read, and understand the office policies of Rheumatology Consultants of Alabama. I agree to comply with these policies and understand that failure to do so may impact my care.

Patient Name: _____

Patient Signature: _____ **Date:** _____

Multi-Dimensional Health Assessment Questionnaire (R808-NP2)

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** 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

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 of the joint areas listed below:

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

4. 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
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 (0-10): ☐

4.PTGL (0-10): ☐

RAPID 3 (0-30) ☐

Cat:
HS = >12
MS = 6.1-12
LS = 3.1-6
R = ≤3

Please turn to the other side

5. 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 of 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 as limber as you will be for the day.

7. How do you feel TODAY compared to ONE WEEK AGO? Please check (✓) **only one.**
Much **B**etter ☐ (1), **B**etter ☐ (2), the **S**ame ☐ (3), **W**orse ☐ (4), **M**uch **W**orse ☐ (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	FATIGUE IS A 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 work, 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 _____
Work Status: ☐ Full-time, ☐ Part-time, ☐ Disabled
☐ Homemaker, ☐ Self-Employed, ☐Retired,
☐ Seeking work, ☐ Other_____

Please circle the number of years of school you have completed:
1 2 3 4 5 6 7 8 9 10
11 12 13 14 15 16 17 18 19 20

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_____

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Zarmeena Ali, MD

Linda Back, NP

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PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND ABOUT HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE DATE: 04/01/2026

The policy of **Rheumatology Consultants of Alabama, PLLC** is to protect the confidentiality, integrity and security of the protected health and personal information of our patients and to prevent unauthorized access to, or the use or disclosure of such information. We are required by law to maintain the privacy of your health information and provide you with this notice of our duties and obligations. This policy applies to patients who are current or former patients of **Rheumatology Consultants of Alabama, PLLC**.

Individually identifiable health and personal information are any information obtained by **Rheumatology Consultants of Alabama, PLLC** in connection with providing healthcare treatment, obtaining payment and related health care operations. This relates to past, present or future information that **Rheumatology Consultants of Alabama, PLLC** receives from you as our patient.

Rheumatology Consultants of Alabama, PLLC collects personal information in order to learn about your medical history, medical conditions, render treatment and collect payment for our services. We gather this information from your patient forms, health questionnaires and other forms you will be asked to complete from time-to-time. In addition, we will assemble information based on our discussions and conversations with you, your personal representative, and your family members. Your healthcare plan or insurance carrier may provide information to our office.

We will use this information to provide caring and quality medical care to you. Examples include diagnosis, treatment, and communications such as follow up and appointment reminders, as well as treatment alternatives or other health-related benefits that may be of interest to you or your particular medical condition. As part of our standard treatment and healthcare operations, we may share information with a facility such as a hospital, laboratory, diagnostic service, or healthcare provider to efficiently coordinate your treatment plan. We will obtain your written authorization before using your information for marketing purposes. For contracted insurers, your information will be used for claims management and to obtain payment from your insurance carrier. We will exchange paper and electronic data with your insurance carrier for activities such as eligibility, benefit and coverage determinations, precertification, utilization review and related activities. For worker's compensation, information about a work-related condition can be exchanged with the employer.

Your information is maintained in our office in our computer system. We also maintain information about you in your medical chart. **Rheumatology Consultants of Alabama, PLLC** limits the access to your protected health information to those employees and business associates

who need to know that information. With some limitations, you have the right to inspect, amend, copy and receive an accounting of disclosures of your medical and billing records.

We do not disclose personal information to third parties unless one of the following exceptions applies:

- We will receive an explicit authorization from you to release individually identifiable information. This authorization must be in writing and give exact details regarding to whom the disclosure applies, the nature of the data to be released, the applicable dates and signed by the patient (or guardian). You may revoke this authorization by providing a written statement to **Privacy Officer**, **Rheumatology Consultants of Alabama, PLLC**, **111 N 24th St Opelika, AL 36801**.
- Federal, state or other applicable law requires us to share protected information or records. Your information may be disclosed to a health agency for purposes such as licensure, certification, audits, investigations and inspections. As required for law enforcement purposes or in response to a valid subpoena or court order, your information may be disclosed. Other disclosures could be required by law for military duty, national security activities or for coroners or funeral director to carry out their duties.
- We are obligated to abide by the terms of this notice. We will obtain a signed, written authorization from you for permission to use and disclose your information for reasons not described in this Notice of Privacy Practices. The authorization will have an expiration date and a description of the purpose or the event you are authorizing. You will be provided with a copy of the signed authorization. You have the right to revoke the authorization in writing, at any time, and mail to **Privacy Officer**, **Rheumatology Consultants of Alabama, PLLC**, **111 N 24th St Opelika, AL 36801**.

We will notify you in the event you are affected by an unsecured breach of information. We reserve the right to change the terms of this Notice of Privacy Practice and to make new notice provisions effective for all health information that we maintain. The revised notice will be made available on our website/portal and any new notices will be distributed to you upon your return to the practice.

With some exceptions, you have right to inspect, review or obtain a copy of your health information. This request must be in writing and there may be a reasonable charge to provide you with a copy of your information. You also have the right to request your records be amended, to request special accommodations and restrictions of your health information, including to your health plan, and to receive an accounting of the disclosures of your information. You have the right to request to receive communications of your information in a special manner or location. Rheumatology Consultants of Alabama, PLLC is not obligated to agree to a requested restriction unless the disclosure to your health plan is for payment or health care operations and is not otherwise required by law and it pertains solely to a health care item or service has paid the health care provider/entity in full. We must receive a written request from you to administer these rights. Please ask to speak to the Privacy Officer or Office Manager for further information or to begin the process to exercise any of these rights.

If you have a complaint about the management of your health information or believe your privacy rights have been violated, please contact our Privacy/Security Officer at (334-704-8100) or you may file a complaint in writing to our Privacy Officer, **Rheumatology Consultants of Alabama, PLLC**, **111 N 24th St Opelika, AL 36801**. You have the right to file a complaint with our office and the Office for Civil Rights (OCR) and there will be no retaliation for filing a complaint with either entity.

Other optional uses of PHI:

- ❑ Your medical information may be reviewed by our medical staff for possible inclusion and referral in research studies. You will be contacted prior the use of your information in a research study. You will be required to sign and complete a written authorization. The authorization will have an expiration date and a description of the purpose or the event you are authorizing. You have the right to revoke the authorization in writing and then mail to the Privacy Officer at **Rheumatology Consultants of Alabama, PLLC**, **111 N 24th St Opelika, AL 36801**, or this may be done at our office. You will be provided with a copy of the signed authorization.
- ❑ In order to coordinate your care or service your account, **Rheumatology Consultants of Alabama, PLLC** and our agents may contact you by telephone at any telephone number you provide, including wireless telephone numbers, which could result in charges. **Rheumatology Consultants of Alabama, PLLC** may also contact you by sending text messages or emails, using any e-mail address you provide. Methods of contacting may include prerecorded or artificial voice messages and/or use of automatic dialing devices, as applicable.

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Acknowledgement of Receipt of Notice of Privacy Practices with Restrictions

Patient Name: _____ Patient Date of Birth: _____

I have been presented with a copy of Rheumatology Consultants of Alabama, PLLC's Notice of Privacy Practices, detailing how the above-named patient's information may be used and disclosed as permitted under federal and state law.

In the event of a medical emergency or if I am otherwise unavailable, I hereby allow Rheumatology Consultants of Alabama, PLLC to discuss billing, appointments, treatment, diagnosis, test results, and other protected health information regarding the above-named patient with the following persons who are involved with the patient's health care and/or payment related to the patient's health care:

Name	**Relationship**	**Contact #**

Contact Methods:

May we leave information on your answering machine at home?	Yes	No
May we leave information on your voicemail at work?	Yes	No
May we leave information on your cell phone?	Yes	No

I understand the contents of the Notice of Privacy Practices, and I request the following restriction(s) concerning the use and/or disclosure of my personal medical information (*include type of information covered and the parties who should not receive the information*):

_____

_____

_____

I understand that Rheumatology Consultants of Alabama, PLLC will carefully consider my request, but is not obligated to accept the request unless the request is to restrict the disclosure of information to a health plan for purposes of carrying out payment or other health care operations and the information pertains solely to a health care item or service for which Rheumatology Consultants of Alabama, PLLC has been paid in full other than by the health plan.

The request stated herein ☐ **does or** ☐ **does not** restrict the disclosure of information to a health plan for purposes of carrying out payment or other health care operations with the information pertaining solely to a health care item or service for which Rheumatology Consultants of Alabama, PLLC has been paid in full other than by the plan

My signature below is acknowledgment that I have received a copy of Rheumatology Consultants of Alabama, PLLC 's Notice of Privacy Practices and that I agree to the conditions stated in the Notice of Privacy Practices and contained in this form.

_____

Printed Name of Patient

_____ _____

Signature of Patient Date

_____ _____

Printed Name of Parent/Patient's Representative (If Applicable) Signature of Parent/Patient's Representative (If Applicable)