

AppRheumatology

Contact Us

Phone & Fax

Phone: (828) 386-2300

Fax: (828) 386-2301

Hours

Monday - Thursday: 8:00 a.m. - 5:00 p.m.

Friday: 8:00 a.m. - 12:00 p.m.

Location

2146 Blowing Rock Road

Boone, NC 28607



Thank you for choosing AppRheumatology as your healthcare provider. We look forward to seeing you at your appointment.

This new patient information packet includes directions to our office and contact information for your records. Also enclosed is the paperwork that you will need for your upcoming appointment. Please complete the paperwork enclosed and bring it to your appointment. Our Billing & Insurance Information, Notice of Privacy Practices and Patient Bill of Rights & Responsibilities are available online at unhealthappalachian.org.

At AppRheumatology we treat the whole person, not just the illness. Our services focus on diagnosis and treatment of rheumatic diseases including arthritis, autoimmune diseases and osteoporosis. Our rheumatologist develops a personalized treatment plan for each patient based on medical history, family history, physical exam, test results and the patient's symptoms to improve quality of life.

Common conditions that we help with include ankylosing spondylitis (AS), gout, lupus, osteoarthritis (OS), psoriatic arthritis (PsA), rheumatoid arthritis (RA), scleroderma and sjogren's syndrome. Our team is dedicated to treating rheumatic diseases by focusing on safe and effective ways to help you manage your disease. We work with you to find ways to relieve pain, control your disease, prevent joint damage, and maximize your quality of life. Telehealth appointments are also available.

A physician referral is required.

New Patient Checklist

For your first appointment, please arrive 15 minutes early and bring the following:

- Insurance Card
- Pharmacy Information
- Medical Records
- Payment
- Current Medications/Prescription Bottles
- Questions for doctor
- Photo ID
- Completed forms from this packet

_____ has an appointment with

_____ Mon. Tues. Wed. Thurs. Fri.

_____ date _____ a.m./p.m.

To reschedule your appointment, please call (828) 386-2300.

UNC
HEALTH®
Appalachian

unhealthappalachian.org

HDF9217 02/17/25



Patient Name	_____
Date of Birth	_____
MRN	_____
CSN	_____
Please Fill in or Affix a Patient Label	

Patient Registration Form (ARMA)

Form #11332

Patient Name: First _____ M/I _____ Last _____

Date of Birth: ___/___/___ **Gender:** Male Female **Social Security #:** ___-___-___

Marital Status: Married Single Divorced Separated Widowed Life Partner

Mailing Address: Street- _____

City- _____ State- _____ Zip Code- _____

Primary Phone #: _____ Cell Home

Secondary Phone #: _____ Cell Home

Work Phone #: _____ **Employer/Occupation:** _____

E-mail: _____

Emergency Contact: _____ **Relationship to patient:** _____ **Ph #:** _____

I consent to Appalachian Regional Medical Associates (“ARMA”) or its representatives: calling my phone and leaving a message texting me (message and data rates may apply) e-mailing me about balances due, financial assistance, appointments, pre-registration, lab results, and other healthcare information. Methods of contact may include pre-recorded voice messages and the use of automatic dialing services.

What is your ethnicity? Hispanic or Latino Not Hispanic or Latino

Select one or more races to indicate what you consider yourself to be: Asian White

American Indian or Alaskan Native Black or African American

Native Hawaiian or other Pacific Islander Other: _____

Preferred language? English Spanish Other: _____

How did you hear about us?

Billboards Doctor Friends/Family Magazine Newspaper Social Media Radio TV

ARHS Website Other _____

If patient is a minor please print Guardian Name:

First: _____ M/I: _____ Last: _____

If patient has a guarantor (someone else responsible for the bill) please provide information below:

Patient’s relationship to Guarantor: _____

Guarantor’s Name: First: _____ M/I: _____ Last: _____

Mailing Address: Street- _____

City- _____ State- _____ Zip- _____

Date of Birth: ___/___/___ Social Security #: ___-___-___ Phone #: _____

Employer: _____ Employer Phone #: _____

Signature of Patient/ Legal Representative ▶		Date: Time:
Name of Patient/ Legal Representative (Please Print) ▶	Relationship of Legal Representative ▶	

Patient Name	_____
Date of Birth	_____
MRN	_____
CSN	_____
Please Fill in or Affix a Patient Label	

Patient History Survey-App Rheumatology
Form #11677

Name: _____ Date: _____

Who is your regular physician? _____

Chief Complaint (briefly state reason for seeing us): _____

How long have you had this problem? _____

Medications: (Please include both prescription medicines and over the counter medications such as those for headache, bowels, etc. as well as any herbal therapies, vitamins or injections):

Currently Taking (name, dose)	Taken within the past 6 months
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.

Drug Allergies (rash, fever, wheezing or other reaction):

Drug:	Reaction:	Year Occurred:

Surgeries:	Date (approx.)	Surgeon	City
Appendectomy:			
Hysterectomy:			
Tonsillectomy:			
Other: _____			

INJURIES (BROKEN BONES, ACCIDENTS):

Patient Name	_____
Date of Birth	_____
MRN	_____
CSN	_____
Please Fill in or Affix a Patient Label	

Recent Hospitalizations (within last three years):

Date (approx.) Reason:

Sleep Schedule: Retire: _____ Arise: _____

Childhood Diseases:

Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____
Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____
Have you ever had a blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____		

Have you or any of your relatives had any of these diseases? If so, please list your relationship to the person with the disease:

	Self	Relative		Self	Relative
Gout			High Blood Pressure		
Lupus			Fibromyalgia		
Rheumatoid Arthritis			Diabetes		
Osteoarthritis			Tuberculosis		
Psoriasis			Kidney Disease		
Epilepsy/Seizure			Kidney Stone		
Migraine			Thyroid Disease		
Cancer (kind?)			Osteoporosis		
Heart Disease			Other (specify)		

Social History: Marital Status: _____ Birth date: _____

Where were you born? _____ Education: High School _____

College/ Professional School: _____ Degree _____

Occupation (current): _____

Children:

Name	Age	Health Status

Have you traveled outside the Southeast in the past 3 years? _____

If so, when and where? _____

Patient Name	_____
Date of Birth	_____
MRN	_____
CSN	_____
Please Fill in or Affix a Patient Label	

Rheumatic Systems Review:

	Yes	No	Comments
Ever been told you have gout?			
Ever had tender joints?			
Any swollen joints?			
Any hot or red joints?			
Any nodules or lumps about any joints?			
Any prolonged morning stiffness?			
Any jaw pain with chewing?			
Any sudden change in vision?			
Any scalp tenderness?			
Any unusual headaches?			
Any muscle pain?			
Any difficulty with climbing stairs?			
Difficulty using arms?			
Trouble thinking?			
Persistent sadness or irritability?			
Have you been told that you snore?			
Any trouble with swallowing?			
Any thickness or tightening of skin?			
Do your fingers blanch or turn white on exposure to cold?			
Does sun exposure give you fever, rash or make you ill?			
Any large loss of scalp hair lately?			
Is your mouth persistently dry?			
Any persistent sandy or gritty sensation in your eyes?			
Have you ever had a blood clot?			
Do you have recurrent ulcers/sores of the mouth or genitals?			
Any episode(s) of painful/bloodshot eyes?			
Any problem with heel pain?			
Ever had bloody diarrhea?			
Any hot flashes / flushing or nightsweats?			
Any tick bites?			

Patient Name	_____
Date of Birth	_____
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CSN	_____
Please Fill in or Affix a Patient Label	

<i>Rheumatic Systems Review Continued</i>	Yes	No	Comments
Have you ever had pleurisy (hurting when you take a deep breath)?			
Have you had hepatitis?			
Do you have frequent back pain?			
Have you ever had a TB skin test?			
Have you ever had psoriasis?			
Do you smoke?			
Do you drink alcohol?			
Do you exercise regularly?			
Women: Regular menstrual periods?			
Menopause? If so, at what age?			
Using birth control pills?			
Ever had a miscarriage?			
Men: History of penile discharge?			
Penile rash or ulcers?			
Patients with Rheumatoid Arthritis:			
Have you taken:			
Plaquenil?			
Azulfidine			
Methotrexate (Rheumatrex)?			
Imuran (Azathioprine)?			
Leflunomide (Aava)?			
Remicade?			
Back pain patients only:			
Did your back pain begin shortly after an injury?			
Did your back pain begin suddenly?			
Has your back pain ever persisted for more than three months?			
Has your back been especially stiff in the morning?			
Is your back pain better relieved by rest or by exercise?			
At what age did your back pain begin?			

Patient Name	_____
Date of Birth	_____
MRN	_____
CSN	_____
Please Fill in or Affix a Patient Label	

Patient Evaluation-AppRheumatology
Form #11671

Patient Name: _____ DOB: ___/___/___ Date: ___/___/___

Instructions: This brief form provides a record of your health status today. Please try and answer each question even if you've already answered a similar question before. There are no right or wrong answers – just answer exactly as you think or feel.

1. Please check (✓) the ONE best answer for your abilities at this time:

Over the last week, were you able to:	Without	With	With	Unable To Do	For Office Use Only
	Any Difficulty	Some Difficulty	Much Difficulty		
a. Dress yourself, including tying shoelaces and doing buttons?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	1.a-j FH (0-10): <hr/> 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. PH (0-10): <hr/> 4. PTGL (0-10): <hr/> RAPID 3 (0-30): <hr/>
b. Get in and out of bed?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
c. Lift a full cup or glass to your mouth?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
d. Walk outdoors on flat ground?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
e. Wash and dry your entire body?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
f. Bend down to pick up clothing from the floor?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
g. Turn regular faucets on and off?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
h. Get in and out of a car, bus, train, or airplane?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
i. Walk two miles or three kilometer, if you wish?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
j. Participate in recreational activities and sports as you would like, if you wish?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
k. Get a good night's sleep?	<input type="checkbox"/> 0	<input type="checkbox"/> 1.1	<input type="checkbox"/> 2.2	<input type="checkbox"/> 3.3	
l. Deal with feelings of anxiety or being nervous?	<input type="checkbox"/> 0	<input type="checkbox"/> 1.1	<input type="checkbox"/> 2.2	<input type="checkbox"/> 3.3	
m. Deal with feelings of depression or feeling blue?	<input type="checkbox"/> 0	<input type="checkbox"/> 1.1	<input type="checkbox"/> 2.2	<input type="checkbox"/> 3.3	

2. How much pain have you had because of your condition **over the past week**? Please indicate how severe your pain has been on a scale of 1 to 10:

3. How much of a problem has **unusual** fatigue or tiredness been for you **over the past week** on a scale of 1 to 10?

4. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing on a scale of 1 to 10: _____

Pharmacy: _____ Date: _____

GENERAL CONSENT FOR TREATMENT (PAGE 1 of 2)

HIM #129s

I understand that the University of North Carolina Health Care System (UNC Health) is an integrated health system made up of various entities as reflected at www.unchealthcare.org/documentapplicability (each referred to in this form as a “UNC Health affiliate” or collectively as “UNC Health affiliates”). **This consent will be effective for 1 year after the date I sign it at any UNC Health affiliate of which I am a patient; however, this consent will not expire for services, claims processing or collection activities for admissions or visits occurring while this consent was in effect.**

Consent for Treatment/Care

I consent to treatment and care by UNC Health affiliates and by their physicians and health care providers, including those who are located at sites other than the one at which I am present and who provide treatment and care through electronic communications/telemedicine. I also consent to treatment and care by physicians and health care providers who are not employees or agents of UNC Health affiliates (including but not limited to physicians and providers in the specialties of emergency medicine, anesthesia, surgery, pathology, psychiatry, obstetrics and gynecology, radiology, oncology, cardiology, neurology, pediatrics and internal medicine) but are authorized by UNC Health affiliates to provide treatment and care to me as a patient of the UNC Health affiliate, and who provide services to the UNC Health affiliates’ patients in accordance with their professional judgment (collectively, “Independent Providers”). I understand that my treatment and care may include routine care, such as immunizations, and a variety of other medical services depending on my condition, such as laboratory testing. I can receive a list of services and care that I have received from UNC Health affiliates. I understand that my care team at UNC Health affiliates may include resident physicians and students or other trainees. I am aware that the practice of medicine (including surgery) is not an exact science, and no one has made any guarantees about the results of my treatments, examinations, or procedures.

Consent for Use and Release of Information

I give permission to UNC Health affiliates – including their treating and referring providers and other staff members – to release any information about me, my health, the health services provided to me, or payment for my health services as permitted by law. For more detailed information about the way my information may be used or released, I can read UNC Health’s *Notice of Privacy Practices*.

I give permission to UNC Health affiliates and their employees, agents, and contractors to take photographs or make videos of me for permissible treatment, payment, health care operations, education and for research purposes where either I have given consent or an Institutional Review Board has approved as long as such recordings are consistent with policies and laws that protect my rights.

Consent for Use Within UNC Health

I further give permission to UNC Health affiliates and their treating providers and other staff members to disclose to each other any of my sensitive information necessary for my treatment, including information related to behavioral and/or mental health (including records of my treatment by a facility whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, developmentally disabled, or substance abusers, as defined by N.C.G.S. Chapter 122C, Articles 1 and 3), drugs and alcohol (including records of a provider that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing.

Financial Responsibility

I understand and agree that physician charges for medical and related professional services performed or supervised by a physician will be billed separately from hospital charges. I understand that my actual charges may be different from charge estimates given to me. I also understand that an insurance company may not pay the full amount of my charges, and I may be responsible (as a patient, spouse, guardian, or the parent of a minor child) for the amount not paid. If I do not have health insurance or have not provided current or accurate insurance information, I am responsible for payment of all charges. If I have overpaid any of my accounts with a particular UNC Health affiliate, I agree that the overpayment may be applied to pay any outstanding charges on any of my accounts with other UNC Health affiliates. I designate UNC Health as my authorized representative with respect to any health or liability insurance policy or any group health plan, fund or program applicable to me, and I authorize UNC Health to exercise on my behalf any grievance, claim or appeal rights, including external review rights, I may have under any such health or liability insurance policy or group health plan, fund or program.

Medicare/Medicaid/Insurance Certification, Assignment & Payment Request

I have been informed that Medicare will only pay for services that it determines to be reasonable and necessary under section 1862(a)(1) of the Medicare Law. I certify that the information given by me or by my authorized representative in applying for payment for my health care under the Medicare or Medicaid programs is correct. I request that payment of authorized benefits be made to the appropriate UNC Health affiliate on my behalf. I authorize UNC Health affiliates to bill directly and assign the right to



* S D C O N A U T *

all health and liability insurance benefits otherwise payable to me, and I authorize direct payment to the appropriate UNC Health affiliate.

Social Security Number

I have given my social security number voluntarily. UNC Health affiliates may use it for accurate identification, filing insurance claims, billing and collections, and compliance with federal and state laws.

Wireless Telephone Number and Electronic Mail

UNC Health affiliates, Independent Providers (as defined above), and/or any of their respective agents, representatives, or business associates (including their billing service providers or debt collectors), may contact me by electronic mail or telephone (including phone calls, prerecorded messages using automated technology, or text messages) at any electronic mail address or number contained in my UNC Health affiliate's or my Independent Provider's records, including wireless telephone numbers, for the purposes of communicating with me about my health care, requesting information about patient satisfaction, servicing my account, and/or collecting amounts due. I also understand that UNC physician researchers or members of their research team may also contact me via phone or electronic mail to determine my interest in participating in human subjects research. I consent to receive electronic mail, text messages, phone calls, and prerecorded messages using automated technology from UNC Health Care affiliates, Independent Providers, and/or any of their respective agents, representatives or business associates, including their billing service providers or debt collectors. I understand that consent to receive electronic mail, text messages, phone calls, and prerecorded messages using automated technology is not required to receive health care services. I understand that if I wish to revoke consent to receive communications from UNC Health affiliates via phone calls, text messages, prerecorded messages using automated technology, or electronic mail, I may do so by following the instructions in the communication regarding opt-out, if any, or by calling UNC Health Customer Service at (888) 996-2767. If I wish to revoke consent to receive communications from an Independent Provider via phone calls, text messages, prerecorded messages using automated technology, or electronic mail, I may do so by following the instructions in the communication regarding opt-out, if any, or by contacting the Independent Provider directly.

Personal Property

Unless I am a resident of a skilled nursing facility, I understand that UNC Health affiliates do not assume responsibility for my personal belongings that I keep in my possession, and I release UNC Health affiliates from all liability for the loss or theft of, or damage to, such belongings.

I UNDERSTAND THAT I MAY WITHDRAW THIS CONSENT IN WRITING. MY WITHDRAWAL WILL NOT BE EFFECTIVE FOR ACTIONS ALREADY TAKEN BY ANY UNC HEALTH CARE AFFILIATE, OR IN PROGRESS.

I AUTHORIZE UNC HEALTH CARE AFFILIATES TO RELEASE ALL RECORDS REQUIRED TO ACT ON THESE REQUESTS. I HAVE READ AND UNDERSTAND THIS FORM, BEEN OFFERED A COPY, AND I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS FORM.

DATE: _____ TIME: _____
PATIENT SIGNATURE (or Authorized Representative)

PRINTED NAME

RELATIONSHIP, if not patient: _____

GUARANTOR OF PAYMENT: This line may be signed by someone who wishes to agree to be responsible for payment *other than*: 1) the patient, 2) the patient's spouse, or 3) a minor patient's parent.

By signing as guarantor below, I agree to pay all charges of any UNC Health Care affiliate not paid, **even if I am otherwise not legally obligated to pay.**

DATE: _____ TIME: _____
GUARANTOR OF PAYMENT SIGNATURE

PRINTED NAME



Patient Name _____
Date of Birth _____

Limited Release of Information to Family/Friends for Physician Clinics
HIM# 1315s

I give my permission to my physician practice that is part of the UNC Health Care System to share certain personal health information about me with the individuals listed below. These individuals will only be given information about me that is related to their involvement in my care or payment for my care.¹ I understand that I am not required to complete this form in order to obtain health care.

Name: _____ Phone Number: _____

Relationship: _____ Talk to this person about (*check each box that applies*):

Any non-sensitive² information regarding my health care or payment for my health care.

OR

Only these things:

My appointments – scheduling & reminders	My test results
My after visit summary (AVS)	My bills
Other:	

Name: _____ Phone Number: _____

Relationship: _____ Talk to this person about (*check each box that applies*):

Any non-sensitive² information regarding my health care or payment for my health care.

OR

Only these things:

My appointments – scheduling & reminders	My test results
My after visit summary (AVS)	My bills
Other:	

If I change my mind about the people or the contact information I have listed in this form, I will complete a new form with such changes.

DATE: _____ TIME: _____

PATIENT SIGNATURE (or Authorized Representative)

PRINTED NAME & RELATIONSHIP (if not patient): _____

¹ This form is not a substitute for a health care power of attorney or other formal designation of an individual authorized to make health care decisions for you if you are not able. If an individual listed above is your guardian or agent (under a power of attorney), or is otherwise authorized by law to act on your behalf, your health care provider may share as much of your personal health information with that person as the law permits.

This form is not a substitute for a valid HIPAA compliant written authorization when it is required to release copies of medical and billing records or information.

² Non-sensitive information excludes mental health, alcohol and substance abuse, HIV and other communicable diseases, and genetic testing. **This form is not considered sufficient authorization to release sensitive information.**

