

# ARTHRITIS SPECIALISTS, LTD.

**Peter Coutlakis, M.D.  
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1401 Johnston Willis Dr., Suite 1200, North Chesterfield, Va 23235  
804.323.1401 • Fax: 804.323.1878

**James P. Brodeur, M.D., F.A.C.P.  
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8201 Atlee Road, Suite B, Mechanicsville, Va 23116  
804.730.5222 • Fax: 804.730.5225

Dear \_\_\_\_\_ :

You have an appointment scheduled with Dr. \_\_\_\_\_

on \_\_\_\_\_ at \_\_\_\_\_. Please arrive at \_\_\_\_\_

so we may complete your registration in time for the visit. It is very important that you confirm this appointment two business days before the scheduled appointment by dialing our office at 804-323-1401 option 1. Call on \_\_\_\_\_ by 12:00 noon, failure to do so will result in the cancellation of this appointment. If we are unable to contact you, your appointment will be automatically cancelled and filled with another patient.

We have enclosed paperwork that must be completed ahead of time and brought with you to the appointment along with your insurance cards, a picture identification card or driver's license, and copay if applicable. The appointment will last at least an hour as the doctor will obtain a medical history and a physical exam.

**If your insurance plan changes from when you originally made this appointment, please notify us to make sure we accept the new insurance plan.** Please remember that if your insurance requires a referral then it is the patient's responsibility to make sure that we receive the referral by the time of the visit or you may be asked to reschedule. Please note that if you are a Medicare patient, you must fill out the section titled "Lifetime Form" with your name as the beneficiary, with your signature and the date.

**We also ask that you have all of your doctors' offices send a copy of all lab, office visit notes, and radiology results from the past year to fax number 804-323-5016 as soon as possible. We do not need any radiology films or discs, just the written report.**

Our office is located in the Atrium wing of Johnston Willis Hospital on the first floor in Suite 1200.

**If you need to call the office the morning of your appointment due to illness, needing directions or are running late and you are calling before 8:30am, please call 804-323-1401 extension 302.**

Arthritis Specialists, Ltd.

**You may now go visit our website at: [www.arthritisspecialistsltd.com](http://www.arthritisspecialistsltd.com)**

Directions to Arthritis Specialists, Ltd. Johnston Willis Office

**From Goochland and points West:**

Travel east on I-64

Take 288 South

Cross the James River and exit onto Midlothian Turnpike East

Travel on Midlothian Turnpike to Johnston Willis Drive

Turn left onto Johnston Willis Drive

Follow the signs to the Atrium which is to the right of the Emergency Room

Our office is located on the 1<sup>st</sup> floor of the Atrium, Suite 1200 beside the information desk

**From the West End: (Follow directions below or use 288 directions above)**

Travel South on Parham Road

Cross the Willey Bridge, Parham Road then becomes Chippenham Parkway

Take Huguenot Road exit and turn right

Travel down Huguenot Road to Midlothian Turnpike

Turn left on Midlothian Turnpike

Turn left on Johnston Willis Drive

Follow the signs to the Atrium which is to the right of the Emergency Room

Our office is located on the 1<sup>st</sup> floor of the Atrium, Suite 1200 beside the information desk

**From North side and the Fan:**

Travel South on I-95 and follow signs to Powhite Parkway South

Travel across the James River and through the toll plaza

Exit onto Midlothian Turnpike West towards Midlothian

Travel about 3 miles and turn right onto Johnston Willis Drive

Follow the signs to the Atrium which is to the right of the Emergency Room

Our office is located on the 1<sup>st</sup> floor of the Atrium, Suite 1200 beside the information desk

**From the South:**

Travel North on I-95

Exit on Chippenham Parkway North

Travel on Chippenham North to Midlothian Turnpike

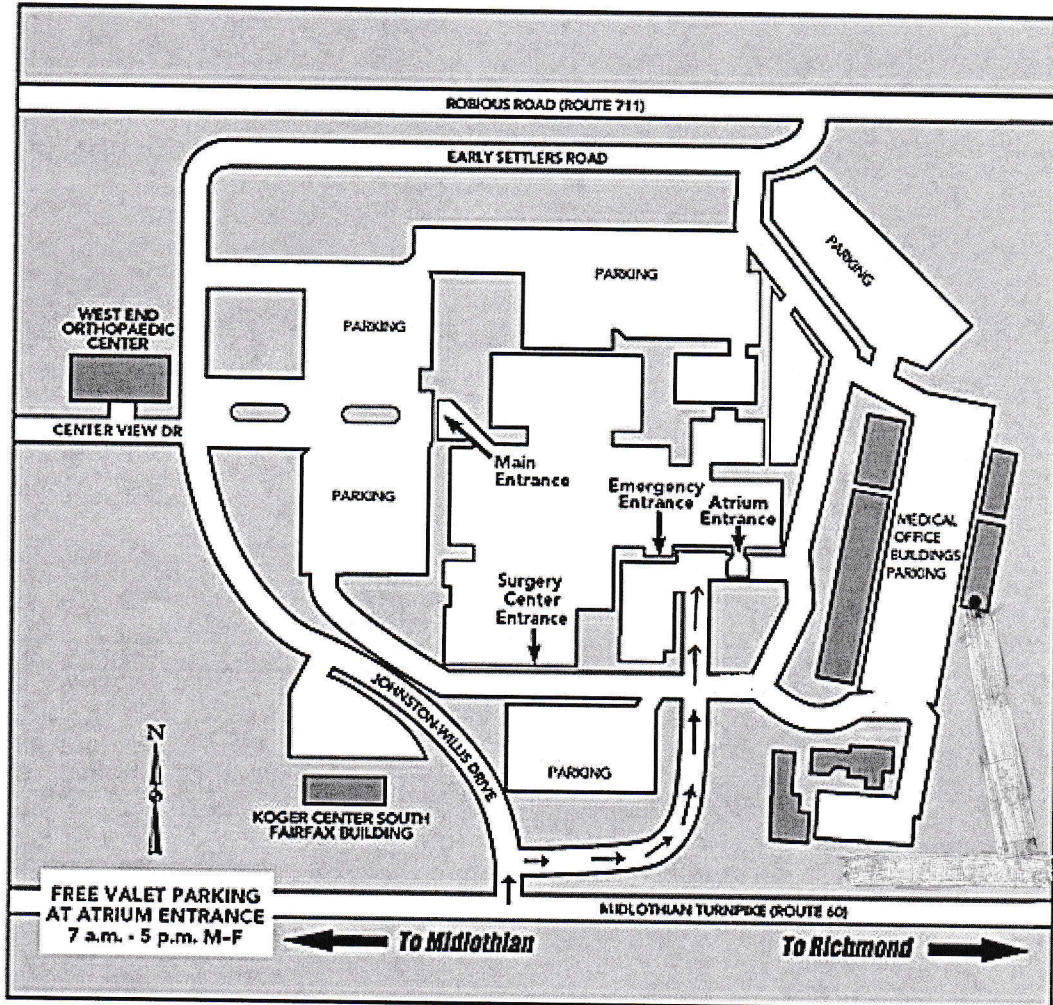
Exit on Midlothian Turnpike West

Travel about 4 miles and turn right onto Johnston Willis Drive

Follow the signs to the Atrium which is to the right of the Emergency Room

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**Our office is located in the Atrium wing of the  
Johnston Willis Hospital on the first floor  
in Suite 1200.**

# ARTHRITIS SPECIALISTS, LTD.

## Patient Registration

FULL NAME					S.S. NUMBER	
ADDRESS				CITY		STATE AND ZIP
BIRTH DATE	AGE	SEX	MARITAL STATUS	PRIMARY PHONE		SECONDARY PHONE
LANGUAGE		RACE			ETHNIC GROUP	

EMPLOYER	OCCUPATION
ADDRESS	BUSINESS PHONE

EMERGENCY CONTACT	PHONE
ADDRESS (IF DIFFERENT FROM ABOVE)	

FAMILY PHYSICIAN (IF ANY)	LOCATION	PHONE
REFERRING PHYSICIAN (IF ANY)	LOCATION	PHONE

### Insurance Information (Name of Insurance Companies)

PRIMARY	SECONDARY	TERTIARY
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### PATIENT AUTHORIZATION

I hereby authorize the release of medical information to my physician(s) or my insurance company.  
In order to help us provide you with the best services possible, we have adopted the following billing policy:

I understand that I am responsible for payment of my bill in full, regardless of what my insurance pays.

In the event that the responsible party defaults on payment to this office for professional services rendered within the preceding 60 days, the responsible party agrees to pay to Arthritis Specialists, Ltd. expenses incurred in effecting collection of this account, including attorney's fees equal to 33 1/3% of the balance due, as well as applicable court costs. These sums are expressly recognized to be in addition to the balance on the account at the time it is placed for collection.

Arthritis Specialists, Ltd. requires at least 24 hours notice for all appointment cancellations. If you are unable to provide 24 hours notice, you will be billed a \$25.00 charge for your scheduled appointment time.

I request that the physicians and staff of Arthritis Specialists, Ltd. have any and all access to my electronic medical records for the purpose of providing me medical care.

I give my permission for physicians and staff of Arthritis Specialists, Ltd. to leave voice mails on my home phone or work phone.

By supplying my home phone number, mobile phone number, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s) to notify me of pending appointments.

Patient agrees that the physicians of Arthritis Specialists, Ltd. are specialists in Rheumatology and are not in any way practicing as *Primary Care Physicians* or *General Internal Medicine Physicians* for the patient. Furthermore, patient represents that he or she has a *Primary Care Physician* who serves him or her for general medical problems, both routine and emergency in nature.

Your signature below attests to your understanding and willingness to comply with the above policy. Thank you for your cooperation.  
In the event one of Arthritis Specialists, Ltd.'s employees is exposed to your blood or body fluids, you consent to have your blood drawn to test for blood borne pathogens.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

### LIFETIME FORM

Beneficiary Name: \_\_\_\_\_ Health Insurance #: \_\_\_\_\_

I request that payment under the Medicare Insurance Program be made either to me or on my behalf to Arthritis Specialists, Ltd. for any services furnished by that physician/provider.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services.

Beneficiary Signature: \_\_\_\_\_ Date \_\_\_\_\_



# Arthritis Specialists, Ltd.

Name \_\_\_\_\_ Date \_\_\_\_\_ DOB \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

**Past Medical History**

\_\_\_ *No Known Medical History*

___ Anxiety	___ Arthritis	___ Asthma
___ Back Pain	___ Cancer	___ Chronic Renal Insufficiency
___ Clots in Legs	___ Clots in Lungs	___ Congestive Heart Failure
___ COPD	___ Crohn's Disease	___ Depression
___ Diabetes (Type I)	___ Diabetes (Type II)	___ Fibromyalgia
___ Gout	___ Glaucoma	___ Heart Attack
___ Heart Disease	___ Heart Disease – Angina	___ Hepatitis
___ High Cholesterol	___ Hypertension	___ Intestinal Bleeding
___ Kidney Stones	___ Lupus	___ Migraine Headache
___ Osteoarthritis	___ Osteopenia	___ Osteoporosis
___ Peptic Ulcer Disease	___ Prostate Trouble	___ Reflux Heart Burn
___ Rheumatoid Arthritis	___ Seizures	___ Sjogren's
___ Strep Throat (Recent)	___ Tension Headache	___ Ulcerative Colitis
___ Underactive Thyroid	___ Urinary Tract Infection	
Other:(not listed above) _____		

**Surgical History/Operations** (Please include date if possible) \_\_\_ *No Known Surgical History*

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**Review of Systems** (please mark the symptoms that you have on a regular basis)

**Constitutional Symptoms**

- Recent Weight Gain
- Amount (lbs.) \_\_\_\_\_
- Recent Weight Loss
- Amount (lbs.) \_\_\_\_\_
- Fatigue
- Weakness
- Night Sweats
- Fever
- Hours of Sleep Per Night \_\_\_\_\_
- Chills

**HEENT**

- Dry Mouth/Dry Eyes
- Blurred Vision
- Loss of Vision
- Mouth Ulcers
- Pain or Redness of the Eyes
- Tender Scalp
- Jaw Pain while Chewing Food

**Pulmonary**

- Coughing
- Wheezing
- Sputum Production
- Shortness of Breath
- Chest Pain with Deep Breath
- Coughing Up Blood

**Musculoskeletal**

- Morning Stiffness
- How long \_\_\_\_\_
- Joint Pain
- Joint Swelling
- Neck Pain
- Back Pain
- Muscle Pain or Tenderness
- Muscle Nodules
- Deformities of the Joints
- Other \_\_\_\_\_

**Hematologic/Lymphatic**

- Swollen Glands
- Clots in Lungs or Legs
- Anemia
- Excess Bleeding

**Skin**

- Rash
- Psoriasis
- Tightening of the Skin
- Nodules
- Sensitivity to Sunlight
- Easy Bruising
- Nail Changes or Pits
- Loss of Hair All Over or Spots
- Facial Rash

**Cardiovascular**

- Raynaud's
- Fingers White, Purple, Blue in Cold
- Shortness of Breath while Lying Flat
- Heart Pounding
- Chest pain/Angina
- Heart Murmurs
- Swollen Legs or Feet
- Wake at Night to Sit Up and Catch Breath

**Gastrointestinal**

- Heartburn
- Trouble Swallowing
- Nausea
- Stomach Pain
- Diarrhea
- Constipation
- Blood in Stool
- Black/Tarry Stools
- Hepatitis
- Yellow Skin/Eyes

**Neurological System**

- Epilepsy/Seizures
- Muscle Weakness
- Headaches
- Dizziness
- Fainting
- Muscle Spasms
- Loss of Coordination
- Fainting Spells
- Numbness/Tingling Arms/Legs

**Psychiatric**

- Anxiety
- Depression
- Suicidal Thoughts

**Genitourinary**

- Burning while Urinating
- Urinating Frequently
- Kidney Stones
- Blood in Urine
- Night time Urination
- Prostate Troubles
- Miscarriages (Number: \_\_\_)
- Flank Pain

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_





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Dear Patient,

The appointment that you have made with our physician is a one hour consultation that has been set aside for you and you only.

At this time the physician will take an extended history from you and perform an extensive exam and evaluation.

If for some reason you cannot keep this appointment, you must call our office two business days in advance to cancel or reschedule. In not doing so, we will not be able to schedule another appointment for you until we have a \$200.00 deposit to hold your appointment. After receiving your deposit, our office will call you and schedule the next available appointment.

We will refund this money back to you if you keep your appointment and gladly file any insurance that is applicable. If you do not keep your second appointment, the deposit is non-refundable.

Sincerely,

The Physicians & Staff of Arthritis Specialists, Ltd.