Arthritis & Rheumatic Disease Center, Inc.
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24331 El Toro Road Suite 380
Laguna Woods, CA 92637

NEW PATIENT REGISTRATION

Welcome to our practice! Please take a moment to complete <u>all</u> pages of this form.

Today's Date:

Name:			Home Phone:
Address:			Work Phone:
			Mobile Phone:
City:		State:	Zip:
Date of Birth:	Driver's Lic #:		SS#:
e-mail:	Name of Primary Doctor:		
How did you hear about us? ❑ Referred by M.D. ❑ Word-of-mouth ❑ Web page ❑ Other internet ❑ Insurance ❑ Other:			

Guarantor Information (if other than patient)

Name:		Relationship:	SS#:
Home Phone:	Mobile Phone:		Date of Birth:
Occupation:	Employer:		
Home Address:			
City:		State:	Zip:

Is your visit related to a job injury? ❑ Yes ❑ No *if **Yes** please complete the following:*

Date of Injury:	Claim #:	Insurer:	
Adjuster's Name:		Phone:	

Insurance Information

Primary Insurance Company

Name of Insurance Co:			
Address:			
City:		State:	Zip:
Phone:	ID#:	Group/Policy#:	
Name of Policy Holder:		Relationship to Patient:	
Policy Holder's Date of Birth:			

Secondary Insurance Company

Name of Insurance Co:			
Address:			
City:		State:	Zip:
Phone:	ID#:	Group/Policy#:	
Name of Policy Holder:		Relationship to Patient:	
Policy Holder's Date of Birth:			

Assignment of Insurance Benefits, Authorization to Pay Benefits and Release of Information to Insurance Companies

Please Initial the Following and Sign at Bottom:

_____ I hereby authorize payment to **Arthritis & Rheumatic Disease Center, Inc. (ARDC, Inc.)** all benefits now due or becoming due under my group policy and I hereby direct my insurance carrier to pay such benefits to ARDC, Inc.

_____ I authorize said assignee to release information to the insurance carrier related to these services rendered in order to ensure the settlement of claims.

_____ I understand that in the event that my insurance coverage is not effective, I will be billed and held financially responsible for all services rendered.

MEDICARE PATIENTS CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

_____ I request that payment of authorized Medicare benefits be made either to me or on my behalf to **ARDC, Inc.** for any services rendered to me. I authorize any holder of medical information about me to release to the Healthcare Financing Administration and its agents any information needed to determine the benefits payable for related services. I understand that my signature directs that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the HCFA-1500 claim form or elsewhere, my signature authorizes release of the information to the insurer or agency shown.

I have read the above and understand my possible financial responsibility to ARDC, Inc., and hereby affix my signature as acknowledgment of this understanding.

_____ _____

Signature (Patient, Parent or Guardian) Date

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California.

800-633-2322 www.mbc.ca.gov

Consent to Access Prescription History

Our office uses a computerized medical record that allows us to electronically send prescriptions directly to pharmacies. Our system allows us to access a list of prescriptions filled by our patients within the past 2 years. Reviewing this list helps to assure patient safety and avoid duplication of prescriptions. It also alerts us to possible drug interactions with medications which may be prescribed by others. Please select one of the following options and sign below:

- ❑ **YES.** I grant **ARDC, Inc.** and staff permission to access my prescription history from external sources.
- ❑ **NO.** I do not wish to grant **ARDC, Inc.** and staff permission to access my prescription history from external sources.

_____ _____ _____

Printed Patient Name Patient Signature Date

Message Authorization

You may leave appointment reminders on:

- ❑ My home phone number
- ❑ My mobile phone number
- ❑ With a member of my household
- ❑ None of the above

You have my authorization to leave test results on:

- ❑ My home phone number
- ❑ My mobile phone number
- ❑ With a member of my household
- ❑ None of the above

_____ _____ _____

Printed Patient Name Patient Signature Date

Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that **ARDC, Inc.** and staff may disclose certain aspects of my health information to a family member, close personal friend or other caregiver because such a person may be involved with my health care or payment related to my health care. It is understood that we will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I understand that I am not required to list anyone and that I may change this list at any time in writing.

I authorize disclosure of my health information to the following persons:

Name	Relationship	Phone

_____ _____ _____

Printed Patient Name Patient Signature Date

Medical History

Have you ever had any of the following medical problems?

❑ prolonged bleeding	❑ AIDS or HIV	❑ bleeding ulcer
❑ cancer	❑ coughing up/spitting up blood	❑ diabetes
❑ emphysema	❑ excessive bruising	❑ stomach ulcers
❑ heart disease	❑ high blood pressure	❑ intestinal or rectal bleeding
❑ stroke or TIA	❑ thyroid gland problems	❑ unexplained weight loss
❑ tuberculosis	❑ glaucoma	❑ bowel disease
❑ hepatitis	❑ blood clots or phlebitis	

List all serious illnesses you have had. Include all hospitalizations and surgeries, including outpatient procedures. Enter diagnosis and year of the illness and/or surgery:

Do you have any serious or chronic medical conditions for which you see a doctor regularly (for example, diabetes, heart disease, emphysema, etc.)? Please list:

If arthritis or any other rheumatic diseases or osteoporosis run in your family, please list here. (Include type of arthritis):

If female:
pregnancies: _____ # live births: _____ If post-menopausal, have you taken estrogens? ❑ Yes ❑ No

Please list any medications you are now taking. Include dose. Include non-prescription drugs, herbs and vitamins:

Are you sensitive or allergic to any medications? If so, please list:

Are you a: ❑ Current smoker (Packs per day: _____) ❑ Former smoker Non-smoker
If 'current smoker', are you: ❑ Ready to quit ❑ Thinking about quitting ❑ Not ready to quit

Do you drink alcohol-containing beverages? ❑ Yes ❑ No
If yes, how many drinks do you have in a typical day? _____ ❑ I do not drink daily
Do you ever have more than 6 drinks on one occasion? ❑ Never ❑Rarely ❑ Monthly ❑ Weekly ❑ Daily

Office Financial Policy

Our office strives to provide the best possible care for our patients. Advising you of our office policies in advance allows for improved communication to achieve the best possible physician-patient relationship. Please review this policy carefully and if you have any questions, do not hesitate to ask a member of our staff. Thank you.

- Upon arrival, please sign in at the front desk. If this is you first visit, or if your insurance has changed since your last visit, please present your insurance card(s).
- Federal law requires that our office review and document photo ID for our patients. A driver's license is usually used for this purpose. Photo ID also helps to ensure patient safety by verifying that all records, medications, etc. are associated with the correct person.
- You are responsible for any and all copayments, deductibles and coinsurance as specified by your insurance plan.
- Copayments are due at the time of service.
- Patient balances are billed immediately upon receipt of your insurance plans explanation of benefits. Your remittance is due within 30 calendar days of receipt of your bill.
- Accounts with balances over 90 days past due may be turned over to a collection agency.
- If your account is in bad debt or is assigned to a collection agency, no future routine appointments will be scheduled until the balance is paid in full.
- A $25 fee will be charged for any checks returned for insufficient funds, stop payment, etc., plus any bank fees incurred.
- A $25 missed appointment fee will be assessed for any patient failing to appear for a scheduled appointment without prior notice, or cancelling an appointment with less than 24 hours' notice. Exceptions will be made for illness and family emergency, at the discretion of the medical practice. Second instances are subject to a $50 charge; repeated absentees may be subject to dismissal from the practice.
- We charge $1 per page for the copying of medical records.

I have read and understand the above Office Financial Policy and agreed to comply and accept the responsibility for any payment that becomes due as outlined above.

_____ _____ _____

Printed Patient Name Patient Signature Date

NOTICE OF PRIVACY PRACTICES

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

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

We are legally required to protect the privacy of your health information. We call this information "protected health information" (PHI), and it includes information that can be used to identify you that we have created or received about your past, present or future health condition, the provision of health care to you, or the payment for this health care. We must provide you with this notice about our privacy practices that explains how, when and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish that purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will probably change this notice and post a new notice in the main reception area. You can also request a copy of this notice from any member of our staff.

III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below, we described the different categories abuses and disclosures.

A. Uses and Disclosures Which Do Not Require Your Authorization

1. **For treatment.** We may disclosure PHI to hospitals, physicians, nurses, and other health care personnel will provide you with Healthcare Services or are involved in your care. For example, we may share information with another physician involved in your care.
2. **To obtain payment for treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment services provided to you. For example, we may provide portions of your PHI to your health plan to get paid for the health care services we provided to you.
3. **For healthcare operations.** We may disclosure PHI in order to operate this practice. For example, we may use your PHI in order to evaluate the quality of healthcare services that you received or to evaluate the performance of the healthcare professionals who provided health care to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we are complying with the laws that affect us.
4. **When the disclosure is required by Federal, state or local law, judicial or administrative proceedings, or law-enforcement.** For example, we make disclosures when the law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence, or when ordered in a judicial or administrative proceeding.
5. **For public health activities.** For example, we reported information about various diseases to government officials in charge of collecting that information and we provide coroners, medical examiners, and funeral directors necessary information relating to an individual's death.
6. **For health oversight activities.** For example, we will provide information to assist the government when it conducts an investigation or

inspection of a healthcare provider organization.

7. **For research purposes.** In certain circumstances, we may provide PHI in order to conduct medical research.
8. **To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
9. **For specific government functions.** We may disclose PHI of military personnel and veterans in certain situations and we may disclose PHI for national security purposes or conducting intelligence operations**.**
10. **For Worker's Compensation purposes.** We may provide PHI in order to comply with Worker's Compensation laws.
11. **Appointment reminders and health related benefits or services.** We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other healthcare services or benefits we offer.

B. Use and Disclose Where You Have the Opportunity to Object

1. Disclosure to family, friends, or others. We may provide your PHI to a family member, friend or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.

C. All Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we have not taken any action relying on the authorization).

D. Incidental Uses and Disclosures. Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a byproduct of an otherwise permitted use or disclosure. However, such incidental uses or disclosures are permitted only to the extent that we have applied reasonable safeguards and did not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient that might be overheard by office personnel not involved in the patient's care would be permitted.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that we limit how we use and disclose your PHI. We will consider your request, but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

B. **The Right to Choose How We Send PHI to You.** You have the right to ask that we send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, fax instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.

C. **The Right to See and Get Copies of Your PHI.** In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we do not have your PHI, but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your request. If we do, we will tell you in writing, our reasons for the denial and explaining your right to have the denial reviewed.

If you request copies of your PHI, we will charge you $1 for each page. Instead of providing the PHI you requested, we may provide you with the summary or explanation of the PHI as long as you agreed to that and to the cost in advance.

D. **The Right to Get a List of the Disclosures We Have Made.** You have the right to get a list of instances in which we have disclosure PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or healthcare operations, directly to you or to your

family. The list also will not include uses or disclosures made for national security purposes, to corrections or law-enforcement personnel, or before January 1, 2006.

We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last 7 years (beginning January 1, 2006) unless you requested a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide a list to you at no charge, but if you make more than one request in the same year, we will charge you $25 for each additional request.

E. **The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI, or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. We will respond within 60 days of receiving your request in writing. You must provide the request and your reason for the request in writing. We may deny a request in writing if the PHI is (i) correct and complete (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explaining your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

V. **HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES**.

If you think that we may have violated your privacy rights, or you disagree with the decision we made about access to your PHI, you may file a complaint with our office manager. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave., SW; Room 615F; Washington, DC 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. **PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES**. If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact our office manager.

VII. **EFFECTIVE DATE OF THIS NOTICE**

This notice went into effect on December 1, 2012.

ARDC, Inc. Patient Registration Form
Revised May, 2016