



## RHEUMATOLOGY CENTER OF SAN DIEGO

9850 Genesee Ave, Ste 780, La Jolla, CA 92037 • 215 S Hickory St, Ste 114, Escondido, CA 92025 • 320 Santa Fe Dr, Suite 212, Encinitas CA 92024

Tel (858) 336-2810 • Fax (949) 798-7990

Dear Patient,

Thank you for choosing Rheumatology Center of San Diego for your medical needs. We are located in the XIMED building on the campus of Scripps Memorial Hospital in La Jolla, Scripps Encinitas and in downtown Escondido.

Our goal is to make your experience in our office as pleasant as possible. To help minimize your waiting time, we have included the patient forms necessary for your first visit. Please complete the forms and bring them along with you **insurance card** and a **picture ID** to your appointment. Please let us know if you have a secondary insurance and provide that insurance card. **We will also need the date of birth and SSN of the primary policy holder.**

Our billing department will be happy to bill your insurance for you. If you are uncertain as to whether or not we are contracted with your insurance, you should contact your insurance company **prior to your visit**. If you need a referral please contact your primary care provider. This referral needs to be authorized by your insurance company **PRIOR** to your appointment. We are contracted with Tricare Prime, and SCMG HMO (**Graybill patients only**).

If you have any questions or need to reschedule your appointment, please do not hesitate to contact our office at (858) 336-2810.

We look forward to seeing you.

Tania L. Rivera, M.D.

Rheumatology Center of San Diego



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PATIENT INFORMATION

Date of Appointment: \_\_\_\_\_ Birth Place: \_\_\_\_\_

Patient's Legal Name: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Telephone Home# (\_\_\_\_) \_\_\_\_\_ Mobile# (\_\_\_\_) \_\_\_\_\_ SS#: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_ Race: \_\_\_\_\_ Ethnicity:  Hispanic  Non-Hispanic

Marital Status:  Single  Married  Divorced  Widowed  Legally Separated

Patient's Occupation: \_\_\_\_\_ Patient's Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone#: \_\_\_\_\_

How did you find us?  Physician Referral  Family or Friend  Internet  Insurance  Other

Name of the person making the referral: \_\_\_\_\_

Primary Policy Holder (Name): \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

MEDICAL INFORMATION

Main reason for your visit today: \_\_\_\_\_

Primary Care Physician Name/Location : \_\_\_\_\_ PCP's Phone #: \_\_\_\_\_

Pharmacy Name/Location: \_\_\_\_\_ Pharmacy ZIP CODE: \_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_

Past Medical History: Please be as specific as possible

- Cataracts COPD/Emphysema Hernia Epilepsy Hypothyroidism
Allergic rhinitis Cirrhosis Kidney disease Stroke Anemia
Hypertension Acid reflux (GERD) STDs Bipolar Cancer
Heart disease Heartburn Dermatitis Depression HIV
Asthma Hepatitis Psoriasis Diabetes Tuberculosis



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Past Medical and Family History Do you (or a family member) have any of these conditions?

Table with 6 columns: Condition, Yourself, Relative, Condition, Yourself, Relative. Rows include Arthritis, Osteoarthritis, Gout, Childhood arthritis, Psoriasis, Lupus or SLE, Rheumatoid arthritis, Ankylosing Spondylitis, Osteoporosis, Fibromyalgia.

Other significant illness (please list): \_\_\_\_\_

Major Surgeries and Hospitalizations (Reason, Date and Name of the Hospital): \_\_\_\_\_

Have you ever broken a bone as an adult? [ ] Yes [ ] No Please explain: \_\_\_\_\_

Have you been tested for Hepatitis B or C? [ ] Yes [ ] No Date and Result: \_\_\_\_\_

Have you been tested for TB (Tuberculosis)? [ ] Yes [ ] No Date and Result: \_\_\_\_\_

Female Patient: Are you pregnant? \_\_\_\_\_ Planning to become pregnant? \_\_\_\_\_

Have you ever been pregnant? [ ] Yes [ ] No How many times? \_\_\_\_\_ Any miscarriages? \_\_\_\_\_

Allergies (Name of the Medication and Reaction): (THIS IS IMPORTANT)

Social History: Do you drink alcohol? [ ] Yes [ ] No How frequent? \_\_\_\_\_

Do you smoke? [ ] Yes [ ] No How long have you smoked for? \_\_\_\_\_ Cig a day? \_\_\_\_ Trying to quit? [ ] Yes [ ] No

Did you use to smoke (daily)? [ ] Yes [ ] No When did you quit smoking? How long did you smoke for?

Do you use recreational drugs? [ ] Yes [ ] No Have you ever had a blood transfusion? [ ] Yes [ ] No

How do you wish to be contacted? [ ] Email [ ] Phone May we leave messages on your voicemail? [ ] Yes [ ] No



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**Current Medications:** (List any medication you are taking, including vitamins, aspirin and supplements). Use an additional sheet if needed.

| Name | Current dose (strength and number of pills) | When did you start taking it? | Did the medicine help? |
|------|---|-------------------------------|------------------------|
|      |   |                               |                        |
|      |   |                               |                        |
|      |   |                               |                        |
|      |   |                               |                        |
|      |   |                               |                        |
|      |   |                               |                        |
|      |   |                               |                        |
|      |   |                               |                        |

Have you participated in any clinical trials for new medications?  Yes  No If yes, list: \_\_\_\_\_

Natural or Alternative Therapies (chiropractic, magnets, acupuncture, over-the-counter preparations, etc): \_\_\_\_\_

**Systems Review:** Are any of the following problems affecting you **TODAY**? Please check

|                  |  |                     |  |                         |  |                       |  |
|------------------|--|---------------------|--|-------------------------|--|-----------------------|--|
| Weight change    |  | Cough               |  | Problems with urination |  | Color changes fingers |  |
| Fatigue/Weakness |  | Shortness of breath |  | Joint pain              |  | Headaches             |  |
| Fever            |  | Nausea/Vomiting     |  | Joint swelling          |  | Dizziness             |  |
| Eye problem      |  | Jaundice            |  | Rashes                  |  | Memory loss           |  |
| Ear problem      |  | Change in bowel mov |  | Sun sensitive (allergy) |  | Anxiety/depression    |  |
| Chest pain       |  | Abdominal pain      |  | Hair loss               |  | Other                 |  |

On the scale below, circle a number which best describes your situation (**most of the time**): You function....

1      2      3      4      5      6      7      8      9      10

VERY WELL
VERY POORLY



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FINANCIAL POLICY

**Insurance Billing:** We are participating with various insurance plans; we suggest that you always verify with your insurance carrier that you are covered for services at our center. We will bill your insurance for services provided, however, it is our policy to collect all co-pays, and deductibles and out of pocket expenses **at the time of your visit**. A fee of \$10 (ten dollars) may be assessed on any portion of the above not paid at the time of the visit.

**HMO plans:** You are responsible for obtaining referrals from primary care physician prior to the appointment. You are also advised to inform our office that you have obtained the referral. In case of failure to obtain referral **you will be responsible for the full payment** for your doctor’s visit. We are contracted with **Tricare Prime** and **SCMG HMO**.

**Private Pay Patients :** For new patients a minimum of **\$180** (one hundred and eighty dollars) is expected upon check in (for estimate of services, please call our office or email [billing@rheumSD.com](mailto:billing@rheumSD.com)). Follow-up visits; must be prepared to pay **\$120** (one hundred and twenty dollars) at the time services are rendered.

**Secondary Insurance Plans:** If you have a secondary insurance plan that we are not a participating provider for; you will be given a receipt to assist you in filing your secondary claim.

**Collection Amount:** If we find it necessary to send an account to a collection agency, you will be assessed a Collection Recovery Fee of \$40 (forty dollars) in addition. You will be responsible for any fees assessed by the collection agency (i.e. attorney’s fees, court costs, and collection agency fees). Accounts unpaid past 30 days will be assessed a Monthly Billing Fee of 1% per month, 12% annually.

**Returned Checks:** These are assessed a fee of \$40 (forty dollars), and must be paid in cash, money order or by credit card within 15 days of receipt of our notice. Future amounts could be paid by cash, money order, or credit card.

**Phone calls:** You will be charged for telephone conversations with the doctor that are longer than 2 minutes. It will be \$50 (fifty dollars) to \$250 (two hundred and fifty dollars) depending on the length of the conversation.

MISSED APPOINTMENT OR SHORT NOTICE CANCELLATION POLICY

I understand the above Financial Policy. I also understand that Rheumatology Center of San Diego, PC has a policy that requires a notice of at least 24 hours to cancel an appointment. If I do not give the required notice **or** if I miss an appointment I will be charged a fee of \$50 (fifty dollars) for follow up visits, and \$60 (sixty dollars) for new visits. Additionally if I do not show to three appointments I may be discharged from the practice. I also understand that **medical insurance does not pay for missed appointments** and that I will be billed these charges personally.

\_\_\_\_\_  
Patient’s Signature and Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name (if Signed on Behalf of Patient)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date



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Tania L Rivera, MD

# Electronic Communications Disclosure

Effective Date: October 24, 2013

Please read this Electronic Communications Disclosure ("eCommunications Disclosure") thoroughly - It contains important information about your legal rights.

### (1) Your Legal Rights

Certain laws and regulations require us to provide specific information to you in writing, which means you have a right to receive that information on paper. We may provide such information to you electronically if we first present this eCommunications Disclosure and obtain your consent to receive the information electronically. At times, we may still send you paper communications, but as a basic proposition we need to know that you are willing to receive communications electronically by e-mail that we may otherwise be required to provide on paper or in person, and that you have the hardware and software needed to access to this information (and note that in Section No. 3 below, we explain ways to obtain selected disclosures or other information on paper even after you have consented to this eCommunications Disclosure).

### (2) Types of Electronic Communications You Will Receive

You understand and agree that we may provide to you in electronic format only, by posting the information on the website where you access your accounts, through e-mail (if applicable and if you have provided a valid e-mail address), or other electronic means, agreements, disclosures, notices, and other information and communications regarding your personal health information, services, your relationship with us, and/or other programs, products or services that are or may be in the future made available to you (collectively, "Communications"). Such Communications may include, but are not limited to: This eCommunications Disclosure and any updates; The access to our website or other electronic services, all updates to these agreements and all disclosures, notices and other communications regarding transactions you make through our website or our other electronic services;

Any notice of the addition of new terms and conditions or the deletion or amendment of existing terms and conditions applicable to accounts, products or services you obtain from us; Our Privacy Policy and other privacy statements or notices (by posting such notices on our website);

### (3) Setting Your Electronic Communications Preferences

After you consent to this eCommunications Disclosure, you will still be able to set your preferences to receive certain categories of Communications in (1) both electronic and paper format; (2) electronic format only; or (3) paper format only.

### (4) Types of Communications You Will Receive in Paper

This eCommunications Disclosure does not apply to any communications that we determine, in our sole discretion, that we are required to deliver in paper form under applicable law or that you should receive in paper rather than electronic form. Such communications shall be mailed to the primary address we show for you in our records or otherwise delivered as required by law or the governing agreement. You are responsible for providing us with a valid e-mail address to accept delivery of Communications. To print or download Communications you must have a printer connected to your device or sufficient hard-drive or other storage space to store the Communications.



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### (5) How to Withdraw Your Consent to this eCommunications Disclosure

Subject to applicable law, you may withdraw your consent to this eCommunications Disclosure by calling our office. You will not be charged a fee for withdrawal of your consent.

### (6) Obtaining Copies of Electronic Communications.

You may print or make a copy of Communications by using the "Print" button (or otherwise using your printing functionality) or saving a copy - do this when you first review the Communications. Upon request, we will provide you with a paper copy of any Communications provided electronically by us to you pursuant to this eCommunications Disclosure, provided we receive your request within 12 months after the date the Communication was first made available to you electronically. You may request a paper copy of these Communications by calling us.

### (7) Updating Your Contact Information

In the event that your e-mail address or other contact information is changed, you must notify us of such changes immediately.

If you fail to update or change an incorrect or invalid e-mail address or other contact information, you understand and agree that any Communications shall nevertheless be deemed to have been provided to you if they were made available to you in electronic form on our websites, e-mailed to the e-mail address we have for you in our records, or delivered through other electronic means.

### (8) Retain Copies for Your Records

We recommend that you print or download a copy of this eCommunications Disclosure, the applicable service agreement and all other Communications to retain for your permanent records; if you have not already placed a copy of our Privacy Policy in your records, you can obtain another copy of our privacy policy.

**Please be advised that confidential information entered may not be secure and may be viewed by strangers without your or our knowledge or permission while in transit over the Internet.**

I hereby acknowledge that I received a copy of Rheumatology Center of San Diego PC's Electronic Communications Disclosure, and I agree with the terms.

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

(PRINT) Name: \_\_\_\_\_

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



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## Acknowledgement of Receipt of Notice of Privacy Practices

Privacy Office can be reached at (858) 336-2810

I hereby acknowledge that I received a copy of Rheumatology Center of San Diego PC's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be **available in the reception area**, and that I will be offered a revised copy at my next appointment if the Notice of Privacy Practices has been amended. **An updated copy can also be found at our website <http://www.rheumSD.com>**

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

(PRINT) Name of the Patient: \_\_\_\_\_

Responsible party:

Self / Patient's Signature: \_\_\_\_\_

Other/ Responsible Party Signature: \_\_\_\_\_

Responsible Party's name (PRINT): \_\_\_\_\_

Telephone number: \_\_\_\_\_

Please indicate your relationship to the patient:

- Parent or guardian of a minor patient
- Guardian or conservator of incompetent patient
- Beneficiary or personal representative of deceased patient





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RELEASE OF MEDICAL RECORDS

Today's date: \_\_\_\_\_

I (**your name**), \_\_\_\_\_ request and give my permission to release my Medical Record as indicated below from the following Medical Facility: (**name of doctor or medical facility we will be obtaining records from**) \_\_\_\_\_

\_\_\_\_\_ to Rheumatology Center of San Diego PC at the above address.

- Most recent lab results AND any immune system lab results, regardless of the date
- Diagnostic testing reports, including X-Rays, MRI, CT of spine and joints, Bone Density (DEXA scan), EMG reports or biopsies
- Progress report from patient's last visit
- Other: \_\_\_\_\_

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
DOB