RHEUMATOLOGY CENTER OF SAN DIEGO

9850 Genesee Ave, Ste 850, La Jolla, CA 92037 • 16516 Bernardo Center Dr, Suite 220, San Diego, CA 92128

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, and in Rancho Bernardo at Clock Tower Office Plaza.

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**, Brand New Day, XIMED IPA and **SCMG HMO** (**Graybill and Inland North 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?

	Yourself	Relative		Yourself	Relative
Arthritis			Lupus or SLE		
Osteoarthritis			Rheumatoid arthritis		
Gout			Ankylosing Spondylitis		
Childhood arthritis			Osteoporosis		
Psoriasis			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: DO YOU HAVE ANY ALLERGIES? ☐ Yes ☐ No (Name of the Medication and Reaction):

_____

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.

Private Pay Patients: For new patients a minimum of **$220** (two hundred and twenty dollars) is expected upon check in (for estimate of services, please call our office or email billing@rheumsd.com). Follow-up visits; must be prepared to pay **$140** (one hundred and fourty 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 www.rcsandiego.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 conservtor of incompentent 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

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CONSENT TO RETRIEVE MEDICATION HISTORY

Name: _____

Date of Birth: _____

We can now view medication history retrieved from Surescripts for every patient. We must obtain your consent before viewing this information.

Surescripts understands the importance of respecting the privacy and confidentiality of personal health information. Surescripts gives healthcare providers secure, electronic access to prescription information that can save their patients' lives and reduce the cost of healthcare for all. Available during emergencies or routine care, the Surescripts network is used by authorized prescribers nationwide to exchange health information and prescribe without paper. Surescripts handles personal health information in connection with activities undertaken to fulfill this mission.

Disclaimer: Certain information may not be available or accurate in this report, including items that the patient asked not be disclosed due to patient privacy concerns, over-the-counter medications, low cost prescriptions, prescriptions paid for by the patient or non-participating sources, or errors in insurance claims information. The provider should independently verify medication history with the patient.

_____ _____

Signature Date

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Card on File: Authorization Form

Information to be completed by cardholder:

The undersigned agrees and authorizes medical practice to save the credit card indicated below on file. The use of this form is optional and for your convenience.

Medical Practice: Rheumatology Center of San Diego PC

Patient's Name: _____

Name as it Appears

on the Credit Card: _____

Type of Credit Card: ☐ MasterCard ☐ Visa ☐ Discover ☐ Amex

Last 4 Digits of Card: ☐☐☐☐

Expiration Date: _____

I, _____ authorize the above medical practice to process the above credit card as "Card on File". I understand this authorization will remain in effect until the expiration of the credit card account. Patient may also revoke this form by submitting a written request to the medical practice.

_____ _____

Cardholder's Signature Date