RHEUMATOLOGY CENTER OF SAN DIEGO

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 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**, Mercy Physicians Medical Group, Scripps Health Plans, and **SCMG HMO** (**Graybill and Inland North patients only**). We are not contracted with Aetna or Meritain (as of November 2024).

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 (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:_______________________

____

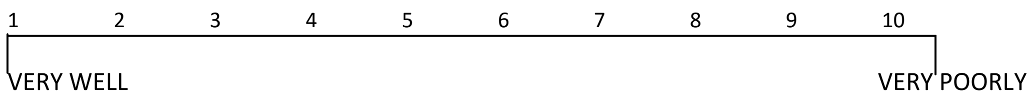
Natural or Alternative Therapies (chiropractic, magnets, acupuncture, over-the-counter preparations, etc): ________

____

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….



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PATIENT FINANCIAL AGREEMENT

1. ____ (initial) **Co Payments:** Your insurance company requires us to **collect co-payments 48h prior your appointment.** Due to State and Federal laws, co-payments will not be waived. Returned checks: a fee of $40 (forty dollars) will be assessed, and must be paid in cash, money order or by credit card within 15 days of receipt of our notice.
2. ____ (initial) **Claims Submissions:** As a courtesy we will bill your insurance.
   a. A quote of benefits is not a guarantee of payment. We will submit your claims and assist you until the claim is resolved. Payment from your insurance company is usually expected within 45 days. After 45 days**, we may look to you for full payment**.
   b. You are responsible for all non-covered services according to your insurance's guidelines.
   c. If we received notification that you are not eligible for coverage or we are not contracted with your insurance, **you will responsible for all charges** incurred and payment is due upon receipt of the bill.
   d. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request in a timely manner. If you have an HMO plan you are responsible for obtaining <u>referrals from primary care physician prior to the appointment</u>.
   e. You are responsible to provide a copy of your most recent insurance cards for all applicable health plans.
   f. Accounts that are more than 90 days past due will be referred to a collection agency. You will be assessed a Collection Recovery Fee of $40 (forty dollars) in addition to your outstanding balance. You will be responsible for any fees assessed by the collection agency (i.e. attorney's fees, court costs, and collection agency fees). There is also a Monthly Billing Fee of 1% per month, 12% annually.
3. ____ (initial) **Ancillary Services:** Laboratory and radiology procedures will be billed separately by an outside provider. Please contact them directly should you have any questions regarding your bill.
4. ____ (initial) Missed appointments**: If you cancel an appointment less than 48 hours prior to the scheduled time or do not show up for your appointment, you will be billed a cancellation/no show fee of $50 (fifty dollars).** Additionally, if I do not show to three appointments you may be discharged from the practice. **Medical insurance plans do not cover missed appointments.**

Private Pay Patients : For new patients **$260** (two hundred and sixty dollars) is expected upon check in. Follow-up visits; must be prepared to pay **$160** (one hundred and sixty dollars) at the time services are rendered.

Please confirm your appointment within 48 hrs. Your appointment may be cancelled if you do not confirm within 48 hours of your scheduled time.

Patient's Signature and Printed Name ____________________ Date ____________

____________________ ____________ ____________

Printed Name (if Signed on Behalf of Patient) Relationship Date

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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.

(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.

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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 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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NOTICE AND ACKNOWLEDGMENT OF RECEIPT AND UNDERSTANDING

NOTICE TO PATIENTS

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

To check up on a license or to file a complaint, go to

www.mbc.ca.gov,

email: licensecheck@mbc.ca.gov,

or call (800) 633-2322.

______________________	______________________
Date	Patient's Name (Type or Print)
	______________________
	Patient's Signature
______________________	______________________
Date	Patient Representative's Name and Relationship (Type or Print)
	______________________
	Patient's Representative's Signature

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OPEN PAYMENTS DATABASE NOTICE

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

openpaymentsdata.cms.gov

____________________	____________________
Date	Patient's Name (Type or Print)
	____________________
	Patient's Signature
____________________	____________________
Date	Patient Representative's Name and Relationship (Type or Print)
	____________________
	Patient's Representative's Signature

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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

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