Comprehensive Rheumatology Center

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23067 Ventura Blvd. Suite 200
Woodland Hills, CA 91364
818-598-0000
Fax: 818-598-0500

Welcome!

Thank you for choosing Comprehensive Rheumatology Center. We look forward to providing you with personalized and comprehensive rheumatology care.

For your convenience, this package includes new patient forms, which you can fill out in advance and bring with you to your first appointment. **Please arrive 15 minutes early** to allow our staff members to prepare your chart.

In case you have any questions please contact our office; one of our staff members will be happy to help. We are open Monday through Friday from 8:00AM – 5:00PM. Our office phone number is **818-598-0000**. For any medical records you would like to be faxed over to help your consultation please fax them to **818-598-0500** or email them to **admin@myrheumdocs.com.**

What to bring with you to your appointment:

1. Your ID
2. Your insurance card
3. A method of payment for your copay and deductible
4. New patient forms
5. Any labs, radiology reports, or other information pertinent to your consultation with us. If you would like to review these records during your visit, please bring a PRINTED copy with you or email or fax the documents to our office ahead of your appointment. We must have a copy of these documents in your chart and cannot review records on your phone. Please come prepared for your appointment as our office will not gather records on your behalf.
6. A list of all your medications

If you cannot make it to the appointment:

We will call you the day before your appointment to confirm your appointment. If you have already signed up with our portal, you will also receive a separate reminder email or text. We do understand that occasionally situations come up that are beyond your control. In those instances, we do request that you extend to us the courtesy of a 24-hour notice. We work very hard to accommodate all our patients' scheduling needs. Your courtesy allows us to continue to operate efficiently and use the time that was

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reserved for you to help other patients in need. It is our policy to charge a no-show fee if you repeatedly miss your consultation appointment.

Thank you again for choosing us to help enhance your health . We are delighted to have you be part of our family.

Sincerely,
All of us at Comprehensive Rheumatology Center

NOTICE OF PRIVACY PRACTICES

Comprehensive Rheumatology Center
23067 Ventura Blvd. #200, Woodland Hills, CA 91364
Effective Date: 11/11/2013

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.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **Treatment.** We use medical information about you to provide your medical care. We disclose medical information to others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. **Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us.

3. **Health Care Operations.** We may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law.
4. **Appointment Reminders**. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. **Sign In Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. **Notification and Communication with Family**. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. **New treatments**. We may contact you about new services or treatments we may offer in the office which may be of benefit to you.
8. **Sale of Health Information**. We will not sell your health information.
9. **Required by Law**. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities. In addition, may be required by law to disclose your health information:
    - To health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
    - In response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
10. **Public Health.** We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.
11. **Coroners**. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

12. **Organ or Tissue Donation**. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
13. **Proof of Immunization**. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agree to the disclosure on behalf of yourself or your dependent.
14. **Worker's Compensation**. We may disclose your health information as necessary to comply with worker's compensation laws (when applicable).
15. **Change of Ownership**. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
16. **Breach Notification**. In the case of a breach of unsecured protected health information, we will notify you as required by law.
17. **Psychotherapy Notes**. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: (1) your treatment, (2) to defend ourselves in case of a legal proceeding, (3) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, (4) to avert a serious threat to health or safety, or (5) to the coroner or medical examiner after you die.
18. **Research**. We may disclose your health information to researchers conducting research (if you are a research study participant), as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law.

3. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice.

After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

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Name: _____ Date of Birth: _____

Telephone: _____ Secondary Telephone: _____

Address:
_____
Street City Zip Code

**Email:_____

Pharmacy (Name, City, Telephone): _____

Specialty Pharmacy (If required by insurance): _____

Primary Physician: _____ Referring Physician:_____

Race: _____ Ethnicity: _____ Language: _____

Emergency Contact:

1) Name: _____ Telephone: _____

2) Name: _____ Telephone: _____

Please Note:** We request your email address only for our Online Patient Portal. With the patient portal you can view lab results and upcoming appointments. Also, schedule and change future appointments. The most important feature of our portal is you can send messages directly to the providers and staff. We do not send out ***SPAM emails.

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Medications:

_____

_____

_____

_____

Surgeries:

_____

_____

_____

_____

Allergies:

_____

_____

_____

_____

Past Medical Diagnosis: (example: High Blood Pressure, Asthma, Diabetes, ect.)

_____

_____

_____

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MEDICAL RECORDS RELEASE AUTHORIZATION FORM

PATIENT NAME _____

ADDRESS_____

TELEPHONE # _____

DOB _____

I authorize the custodian of the records of

_____
(Practice name and address)

to release the following information *(Please check all that apply)*

- All Records
- Consultation Notes
- Operative Reports
- Laboratory/Pathology
- Progress Notes
- Admission Notes

These records are for services provided on the following dates:

_____
Please send the records listed above to:

Name_____

Address_____

Phone_____Fax_____

Signature of Patient or Representative_____ Date_____

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Appointment Cancellation, No Show, and Late Arrival Policies

At Comprehensive Rheumatology Center we value you and the care that you are receiving. To continue better catering to your medical needs, as well as our other patients' needs, we are implementing an appointment cancellation and no-show policy.

Cancellation and No-Show:

We work very hard to accommodate all of our patients' scheduling needs, and short-notice cancellations take the opportunity of that visit away from another patient eagerly anticipating an appointment. We request that you please give our office at least 24 hours' notice in the event that you need to reschedule your appointment. If you do not provide us with a 24 hour notice, or if you do not show up for a scheduled appointment, you may be charged a **$50** "no-show" fee.

If you are unable to make it to **your consultation (____) visit** and do not give us at least a 24 hour cancellation notice, you will be charged a **$100** "No Show" fee. Consultation spots are reserved for a longer time frame and short notice cancellations take the opportunity from other patients

Frequent no-shows hinders our ability to properly care for you. A patient who is a no-show three times or more may not be rescheduled for future appointments and may be dismissed from the practice.

Late Arrival Policy:

If a patient is more than 15 minutes late to their appointment, the appointment may be canceled and need to be rescheduled. Alternatively, patients arriving late may be asked to wait to be seen until the provider has an opening in their schedule. If you have any questions regarding these policies, please let our staff know and we will be glad to speak with you in more detail.

I have read and understand the Comprehensive Rheumatology Center Cancellation and No-Show Policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

I _____ (print name) have read and received a copy of Comprehensive Rheumatology Center Cancellation Policy.

Patient Signature: _____ Date: _____

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Name: _____ **Date of Birth: _____**

Acknowledgement of Receipt of Notice of Privacy Practices: _____ (Initial)
(This notice describes how medical information about you may be used and disclosed and how you can get access to this information). I have received a copy of the Notice of Privacy practices.

Financial Responsibility: _____ (Initial)
I understand that I am liable/responsible for all charges, including but not limited to copayments and annual deductibles. If I am found to be ineligible under the terms of my health plan agreement, or if my insurance carrier deems the service as "non-covered services", I understand that I am liable for the charges for services rendered. I understand that payment is required within 30 days of receiving a bill from this office and that failure to pay may result in my account being placed in collection. **After 60 days of non payment I will incur up to $50 in late fees.**

I irrevocably assign to the doctor all payments for medical services rendered to myself or my dependents.
Returned checks: **A $35.00 charge will be applied to all returned checks for insufficient funds.**

Cancellation Policy: _____ (Initial)
I understand that my appointment is a time that is reserved for me. In case I am not able to make it to my appointment for any reason, I agree to notify the office immediately. **I understand that failure to cancel my appointment at least 24 hours before may result in a $50.00 fee.**

Review of Results Over the Phone: _____ (Initial)
Unless otherwise specified, results of laboratory studies, x-rays, and other diagnostic studies completed after my initial visit will not be discussed over the phone. This is to ensure that I am provided with thorough and complete care. Since rheumatologic diseases are often complex, interpretation of such studies are often not possible without a re- evaluation during the follow-up visit. A positive result may have serious implications and will require a full explanation of the disease and design of a treatment plan unique to me. In case of negative results, further investigation is needed to determine the cause of my symptoms given the negative findings. Should I choose not to have a follow up visit, I can get a copy of my results after signing a waiver.

Use of Scribe Services: _____ (Initial)
I understand that my provider may be assisted by a scribe during my visit to help document my medical encounter. This scribe may be physically present, virtual, or AI-powered. All scribing is conducted under my provider's direct supervision, and all documentation is reviewed and approved by my provider. Any AI tool used complies with HIPAA and applicable privacy laws.

Emergency contact:

Name: _____ Phone#: _____ Relationship: _____

Whom can we discuss your medical information with:

☐ No one ☐ Spouse ☐ Other family: _____ ☐ Other: _____

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable

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I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE.

_____ _____
Signature Date

_____
Name

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable

Telehealth (Televisit) Consent – California

Patient Name: _____ DOB: _____ Date: _____

I consent to receive medical care via telehealth, which may include audio and/or video communication with my healthcare provider.

I understand that telehealth has limitations compared to in-person care, including the inability to perform a full physical examination, and that there are potential risks to privacy and security despite reasonable safeguards.

Patient Acknowledgments

I understand and agree that:

- I may request an in-person visit at any time when feasible.
- My health information will be protected in accordance with applicable privacy laws, including HIPAA.
- Telehealth is not appropriate for emergency medical conditions. If I am experiencing a medical emergency, I will call 911 or go to the nearest emergency room.
- My identity may be verified at the start of the visit using personal identifying information.

Televisit Requirements

For safety, quality of care, and privacy, I agree to:

- Be in a private, quiet location
- Use a reliable internet connection
- Remain stationary (not driving or moving) during the visit
- Limit distractions and ensure no unauthorized individuals are present unless I provide consent

I understand that if these conditions are not met, the provider may stop the visit and require it to be rescheduled. In such cases, the appointment may be treated as a missed appointment, and a no-show fee may apply

Financial Responsibility

I understand that telehealth services will be billed to my insurance when applicable. I am responsible for any applicable copayments, deductibles, or non-covered services.

Right to Withdraw Consent

I understand that I may withdraw this consent at any time prior to or during the telehealth visit.

By signing below, I acknowledge that I have read and understand this consent form and agree to participate in telehealth services under the terms described above.

Patient/Guardian Signature: _____
Date: _____

Provider Signature: _____
Date: _____