GARBER FORBESS RHEUMATOLOGY – NEW PATIENT INFORMATION

DATE

THIS SECTION REFERS TO PATIENT ONLY

NAME	SEX ☐ MALE ☐ FEMALE	AGE	BIRTH DATE / /	MARITAL STATUS ☐ SINGLE ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ MARRIED
ADDRESS	SOC SEC NO			
CITY STATE ZIP	EMPLOYER NAME			
HOME PHONE ( )	WORK PHONE ( )	CELL PHONE ( )	ADDRESS	
DRIVERS LIC #	OCCUPATION	EMAIL ADDRESS	CITY STATE ZIP	
NAME OF SPOUSE	SPOUSE'S OCCUPATION		BIRTHDATE / /	

COMPLETE IF PERSON RESPONSIBLE FOR BILL IS OTHER THAN PATIENT

NAME	RELATION TO PATIENT	SOC SEC NO	OCCUPATION
ADDRESS		EMPLOYER	
CITY STATE ZIP		ADDRESS	
HOME PHONE ( )	WORK PHONE ( )	CITY STATE ZIP	

INSURANCE INFORMATION

PLEASE CHECK ALL THAT APPLY ☐ NO COVERAGE ☐ MEDICARE # _____ ☐ PRIVATE ☐ WORKER'S COMP

NAME OF INSURANCE COMPANY	NAME OF INSURANCE CO
ADDRESS	ADDRESS
NAME OF INSURED	NAME OF INSURED
GROUP NO/COMPANY NAME / PHONE ( )	GROUP NO/COMPANY NAME / PHONE ( )
POLICY/CERT NO / EFFECTIVE DATE / /	POLICY/CERT NO / EFFECTIVE DATE / /
PATIENT IS ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐ SPECIFY _____	PATIENT IS ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐ SPECIFY _____
DOES INSURANCE COVER ☐ OFFICE CARE ? ☐ HOSPITAL ?	DOES INSURANCE COVER ☐ OFFICE CARE ? ☐ HOSPITAL ?

OTHER INFORMATION

REFERRED BY / PHONE ( )		FAMILY PHYSICIAN / PHONE ( )	
DRUG ALLERGIES		PREFERRED PHARMACY	PHARMACY PHONE ( )GARBER FOR-
REASON FOR CONSULTATION		PHARMACY ADDRESS	

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE GARBER FORBESS RHEUMATOLOGY TO FURNISH INFORMATION CONCERNING MY ILLNESS AND TREATMENT TO INSURANCE CARRIERS AND I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BE MADE DIRECTLY TO GARBER FORBESS RHEUMATOLOGY, 8631 WEST THIRD STREET, SUITE 700E, LOS ANGELES, CALIFORNIA 90048. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED VALID AS AN ORIGINAL. I HAVE READ AND AGREE TO ABIDE BY GARBER FORBESS RHEUMATOLOGY'S SUBSPECIALTY PRACTICE POLICY, HER FEES AND PAYMENTS POLICY AND HER MEDICARE AND PRIVATE INSURANCE POLICY.

_____ _____ _____

(DATE) *(PRINT PATIENT'S NAME)* *(PATIENT'S SIGNATURE)*

GarberForbess
RHEUMATOLOGY

8631 West Third Street, Suite 700E
Los Angeles, California 90048
Telephone (310) 854-3539
Fax (310) 652-3914

OFFICE POLICY ACKNOWLEDGMENT

(Please Sign Below and Return to the Garber Forbess Rheumatology Staff)

Subspecialty Practice Policy

My practice is limited to the diagnosis and management of arthritis and related problems. This is where my expertise lies. Referrals come to me from all over the Southern California area, from all parts of the country and sometimes from outside of the United States. Referrals come from other doctors of all specialties, other patients, the Arthritis Foundation and from universities. I remain active in rheumatology through my general practice, and through teaching, lecturing, attending conferences, publishing, and participating in clinical research.

Your primary medical care should remain with your internist or family doctor. Because I limit my practice to rheumatology, I do not take care of colds, high blood pressure, chest pain, diabetes, or other general medical problems. If you do not have an internist or family doctor, I will be happy to refer you to an excellent primary care physician in your area.

Fees and Payments

We feel our fees are fair and reasonable in light of the quality of care we offer. If you have any questions about our fees, we would be happy to discuss them with you. Please pay for services rendered at the end of your appointment. If full payment is impossible because of an extreme financial hardship, then we expect that this was discussed at the time your appointment was made and a payment schedule arranged. However, please keep in mind that a payment schedule arrangement is reserved for those who are truly needy. At the end of each month, you will receive a statement delineating your outstanding charges.

Insurance Policy

Patients who carry medical insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. Insured patients are expected to take care of the required 20% (or other applicable percentage) of their fees as services are rendered. Cash patients are expected to pay for the services rendered in full, unless other arrangements are made in advance with the front office.

Even though an insurance claim is prepared and filed for you by this office, you will receive a statement each month if your account has a balance due. This office cannot accept responsibility for collection of your insurance claim or for negotiating a settlement on a disputed claim. You are responsible for payment of your account within the limits of our credit policy. Please contact your insurance company representative or medical plan carrier for a claim form. Fill in your part of the form (usually Part 1 or Part A). The form will be completed by this office when your visit has been completed, and it will be sent in to your insurance company. Your eventual reimbursement will be determined by your insurance carrier.

Medicare and Private Insurance

Regardless of whether you have Medicare or private insurance, and regardless of the nature of that plan, ***all patients are responsible for payment of fees directly to us***. As a courtesy and service to you, we will be happy to sign and complete the insurance form you supply at the time you pay your bill. We will also submit the form to your insurance company for you for your reimbursement. If you are entitled to Medicare benefits, we will submit the charges to Medicare for your reimbursement on forms that we have here in the office for that purpose. There will be a nominal fee for insurance paperwork to help defray our costs. Please remember that no insurance plan pays all costs and fees. Most plans include a deductible, and the amount of your reimbursement may be less than the amount of your bill.

Interest on Overdue Accounts

For those patients who are not on Medicare, we will automatically add an interest charge of one percent (1%) per month on amounts which are sixty days overdue. This applies as well to accounts where insurance claims are pending. We are not able to wait more than sixty days for payment from the insurance company, and at that time, we expect payment directly from the patient. Thank you for your cooperation.

I have received a copy of the above office policies of Garber Forbess Rheumatology, and I agree to abide by them.

_____
(Patient's Signature)

_____ _____
(Print Name) *(Date)*

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AGREEMENT TO PAY FOR MEDICAL SERVICES

I, the undersigned, am a member or subscriber ("Member") under a health insurance plan ("Health Plan"), or am a person legally responsible for the debts of such Member. I and/or Garber Forbess Rheumatology, a Health Plan network provider, have requested, or will during the course of treatment from time to time, that the Health Plan give its approval, authorization or certification for certain services rendered by Garber Forbess Rheumatology (the "Services").

Experience has shown that the Health Plan, for a variety of reasons may from time to time deny approval, authorization or certification of the Services. Among the reasons for such denial are limitations in the coverage under the Member's insurance plan, utilization review criteria of the Health Plan considering the Services to be elective and/or not medically necessary, among others. As a result, the Health Plan may, from time to time, not pay any benefits for the Services.

After discussing the matter with Garber Forbess Rheumatology, I have elected to have Garber Forbess Rheumatology render such Services at my own expense. I agree to pay the full amount of Garber Forbess Rheumatology's billed charges for the Services on an out-of-pocket basis. Also, I agree that Garber Forbess Rheumatology may bill and collect charges for the Services at Garber Forbess Rheumatology's own fee-for-service rates. Any Health Plan maximum that applies to medically necessary covered services will not apply and will not limit the amount that I may become obligated to pay for the Services.

I have read and understand this Agreement. By signing this Agreement, I know that I am creating a binding contract that is legally enforceable against me by Garber Forbess Rheumatology.

_____ _____

(Signed) *(Date this Agreement is Signed)*

_____ _____

(Print Name of Person Signing) *(Patient if Other than Person Signing)*

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Patient Consent for Use and Disclosure of Protected Health Information and Receipt of Notice of Privacy Practices

I hereby give my consent for Garber Forbess Rheumatology to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Garber Forbess Rheumatology's Notice of Privacy Practices provides a more complete description of such uses and disclosures. **I acknowledge that I have received a copy of Garber Forbess Rheumatology's Notice of Privacy Practices**.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Garber Forbess Rheumatology reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Garber Forbess Rheumatology Privacy Officer at 8631 West Third Street, Suite 700E Los Angeles, CA 90048.

With this consent, Garber Forbess Rheumatology may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Garber Forbess Rheumatology may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Garber Forbess Rheumatology may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Garber Forbess Rheumatology restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Garber Forbess Rheumatology's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Garber Forbess Rheumatology may decline to provide treatment to me.

_____
Signature of Patient

_____ _____
Print Patient's Name Date

GarberForbess
RHEUMATOLOGY

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Patient Authorization for Use and Disclosure of Protected Health Information

By signing this authorization, I authorize Garber Forbess Rheumatology to use and/or disclose certain protected health information (PHI) about me to the following:(1) outside treatment facilities, including their respective staffs, made in connection with my medical care, including other health care providers, clinical laboratories, physical therapy facilities, and x-ray and other imaging facilities; (2) pharmacies in connection with prescriptions for me; (3) other individuals who may assist in my care, such as spouses and other family members; and (4) insurance companies and other services relating to the billing and collection of payments relating to the services provided to me.

This authorization permits Garber Forbess Rheumatology to use and/or disclose such individually identifiable health information about me as Garber Forbess Rheumatology and its staff determines is reasonably necessary, except as set forth below:

_____

Specifically describe any information which is not to be used or disclosed.

The information to be used or disclosed is made at my request.

This authorization will not expire, unless I specifically revoke it in writing, except as set forth below:

_____

Specify expiration date or defined event.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Garber Forbess Rheumatology. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer as follows:

Garber Forbess Rheumatology
8631 West Third Street, Suite 700E
Los Angeles, CA 90048

_____
Signature of Patient

_____ _____
Print Patient's Name Date

Multi Dimensional Health Assessment Questionnaire (MDHAQ)

Date of birth: ☐☐ / ☐☐ / ☐☐☐☐ Last 4 digits of your social security number: ☐☐☐☐

Your Initials: ☐☐☐ Name: (Optional) _____

This questionnaire includes information not available from blood tests, X-rays, or any source other than you. Please try to answer each question, even if you do not think it is related to you at this time. There are no right or wrong answers. Please answer exactly as you think or feel. Thank you.

Today's Date: ☐☐ / ☐☐ / ☐☐☐☐

1 . Please check the ONE best answer for your abilities at this time.

Over the last week, were you able to:	Without Any Difficulty (0)	With Some Difficulty (1)	With Much Difficulty (2)	Unable To Do (3)
Dress yourself, including shoelaces and buttons?	☐	☐	☐	☐
Get in and out of bed?	☐	☐	☐	☐
Lift a full cup or glass to your mouth?	☐	☐	☐	☐
Walk outdoors on flat ground?	☐	☐	☐	☐
Wash and dry your entire body?	☐	☐	☐	☐
Bend down to pick up clothing from the floor?	☐	☐	☐	☐
Turn faucets on and off?	☐	☐	☐	☐
Get in and out of a car, bus, train, or airplane?	☐	☐	☐	☐
Walk two miles?	☐	☐	☐	☐
Participate in sports and games as you would like?	☐	☐	☐	☐
Get a good night's sleep?	☐	☐	☐	☐
Deal with feelings of anxiety or being nervous?	☐	☐	☐	☐
Deal with feelings of depression or feeling blue?	☐	☐	☐	☐

2. How much pain have you had because of your condition OVER THE LAST WEEK? Place an X in the box below that best describes the severity of your pain on a scale of 0-100.

NO PAIN 0 ○ ☐ ☐ ☐ ○ ☐ ☐ ☐ ○ ☐ ☐ ☐ ○ ☐ ☐ ☐ ○ ☐ ☐ ☐ ○ 100 PAIN AS BAD AS IT COULD BE

3. If you are stiff in the morning, about how long does the stiffness last? ☐ No stiffness ☐ Less than 15 min ☐ 15-30 min ☐ 30-45 min ☐ 45 min- 1 hr ☐ 1-2 hrs ☐ 2-4 hrs ☐ 4-8 hrs ☐ More than 8 hrs

4. How much of a problem has USUAL fatigue or tiredness been for you OVER THE LAST WEEK? Place an X in the box below that best describes the severity of your fatigue on a scale of 0-100.

FATIGUE IS NO PROBLEM 0 ○ ☐ ☐ ☐ ○ ☐ ☐ ☐ ○ ☐ ☐ ☐ ○ ☐ ☐ ☐ ○ ☐ ☐ ☐ ○ 100 FATIGUE IS A MAJOR PROBLEM

5. What is the main reason you are seeing a rheumatologist today? ☐ Not Sure

☐ Rheumatoid Arthritis ☐ Osteoarthritis ☐ Fibromyalgia ☐ Postive lab test ☐ Other _____
(please specify)

6. Considering all the ways in which your illness and health conditions may affect you at this time, please place an **X** in the box below to show how you are doing on a scale of 0-100.

	0																				100	
VERY WELL	○	☐	☐	☐	○	☐	☐	☐	○	☐	☐	☐	○	☐	☐	☐	○	☐	☐	☐	○	VERY POORLY

7. Please check if you have experienced any of the following over the last month:

- ☐ Fever
- ☐ Weight gain (>10 lbs)
- ☐ Weight loss (<10lbs)
- ☐ Feeling sickley
- ☐ Headache
- ☐ Unusual fatigue
- ☐ Swollen glands
- ☐ Loss of appetite
- ☐ Skin rash or hives
- ☐ Unusual bruising of bleeding
- ☐ Other skin problems
- ☐ Loss of hair
- ☐ Dry eyes
- ☐ Other eye problems
- ☐ Problems with hearing
- ☐ Ringing in ears
- ☐ Stuffy nose
- ☐ Sores in the mouth
- ☐ Dry mouth
- ☐ Problems with smell or taste
- ☐ Lump in your throat
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Pain in the chest
- ☐ Wheezing (asthma)
- ☐ Heart pounding (palpitations)
- ☐ Trouble swallowing
- ☐ Heartburn or stomach gas
- ☐ Stomach pain or cramps
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Dark or bloody stools
- ☐ Problems with urination
- ☐ Gynecological (female) problems
- ☐ Dizziness
- ☐ Losing your balance
- ☐ Muscle pain, aches, or cramps
- ☐ Muscle weakness
- ☐ Paralysis of arms or legs
- ☐ Numbness or tingling of arms or legs
- ☐ Fainting spells
- ☐ Swelling of hands
- ☐ Swelling of ankles
- ☐ Swelling in other joints
- ☐ Joint pain
- ☐ Back pain
- ☐ Neck pain
- ☐ Use of drugs not sold in stores
- ☐ Smoking cigarettes
- ☐ More than 2 alcoholic drinks per day
- ☐ Depression- feeling blue
- ☐ Anxiety- feeling nervous
- ☐ Problems with thinking
- ☐ Problems with memory
- ☐ Problems with sleeping
- ☐ Sexual problems
- ☐ Burning in sex organs
- ☐ Problems with social activities

8. Please place a check in the appropriate box to indicate the amount of pain you having today in each of the joint listed below.

LEFT Side Joints	None	Mild	Moderate	Severe
Fingers	☐	☐	☐	☐
Wrists	☐	☐	☐	☐
Elbow	☐	☐	☐	☐
Shoulder	☐	☐	☐	☐
Hip	☐	☐	☐	☐
Knee	☐	☐	☐	☐
Ankle	☐	☐	☐	☐
Toes	☐	☐	☐	☐

RIGHT Side Joints	None	Mild	Moderate	Severe
Fingers	☐	☐	☐	☐
Wrists	☐	☐	☐	☐
Elbow	☐	☐	☐	☐
Shoulder	☐	☐	☐	☐
Hip	☐	☐	☐	☐
Knee	☐	☐	☐	☐
Ankle	☐	☐	☐	☐
Toes	☐	☐	☐	☐

Draft