Southern Oregon Rheumatology Clinic

David Chamberland, MD, FACR
Dominik G. Sokalski, MD, FACR
Zhijie Zhou, MD, FACR
Giorgos Loizidis, MD, RhMSUS™

To our patients:

As you know, the cost of medical care is rising at an alarming rate, which is disturbing to all of us. Part of this rise is due to the increasing cost of sending statements to patients. It is threatening to increase our costs and the fees you pay for our medical services. To help keep down the cost of billing; we would like to explain our office policy:

> Uninsured patients receive a 25% discount for services paid in full at time of service. Otherwise, a minimum payment of 25% of balance due paid at time of service and monthly payments of 25% of balance due per month on account balance greater than $100. Account balances of $100 or less require minimum payment of $25 per month.

In the event of an overpayment on your account, a refund will automatically be issued on all balances greater than $10.00. If you feel you have a refund due to you for less than $10.00 please notify the business office.

If your insurance is a managed care plan, we are required to obtain an authorization from your primary care provider, your family physician or nurse practitioner, before we can see you. This would allow us to see you during a specific time period and for a specified number of visits. ***It is extremely important that we know this information before your appointment.*** If we do not have an authorization at the time of your visit, you may be asked to sign a waiver that makes you responsible for services performed on that day. If you do not wish to sign a waiver, your appointment will be rescheduled.

We understand that it is a burden for many of our patients to bill their insurance(s) so we will provide this service for you. For us to bill your insurance, we ask that you provide us with current insurance information. Please bring all of your insurance cards to the office with you and notify us whenever there are changes in your coverage. If you would rather bill your insurance company yourself, AND we are not providers with the company, please let us know. **We are not contracted with, nor do our providers treat patients with workers compensation, motor vehicle claims, TriWest Health Alliance, or VA insurance.**

Please complete and return the following documents either by mail (2 weeks in advance; an envelope has been included for your convenience), by fax at 541-773-7089, or bring them with you to your appointment:

- Registration Form
- Health History
- HIPAA Consent (This form is a government regulation that authorizes us to use and share your health information with other health facilities to carry out your treatment plan and must be signed before we can participate in your health care)
- Medical/Billing Release
- Collection Policy

Please bring a detailed list of ALL medications or bring all of your medications in their original containers to your first appointment, including non-prescription medications, vitamins or mineral supplements. You may want to bring a pair of shorts to change into for your exam.

1365 Poplar Drive, Medford, OR 97504-5207
Phone: (541)773-2233 / Fax: (541)773-7089

Southern Oregon Rheumatology Clinic

David Chamberland, MD
Dominik G. Sokalski, MD
Zhijie Zhou, MD
Giorgos Loizidis, MD

Registration and Patient Information

(The following information is very important to your health. Please take the time to fully and accurately complete this form.)

Patient Name_____ Gender: ☐ Male ☐ Female ☐ Non-Gender
Last, First, Middle

Social Sec #_____ Marital Status: S D M W O Date of Birth: _____

Mailing Address_____ City_____ State_____ Zip_____

Home Phone: ( )_____ Cell ( )_____ Street Address (if different) _____

Message Authorization: If you have an answering machine or voicemail, may we leave a message? Yes / No

Please select one or more of the following races:

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Latino or Hispanic

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other _____ ☐ Decline

Preferred Language: English / Spanish Alternate Communication Preference to Phone: Mail / Email

Email Address: _____

Employer_____ Occupation_____

Work Address_____ Work Phone ( )_____

Who referred you to our office?_____ Family Dr/NP _____

Name of spouse/parent/guardian_____ Address_____

Employer_____ Work Phone ( )_____

*__Emergency contact__ _____ Phone ( )_____

Do we have permission to release medical or billing information to the Emergency contact listed above? Yes / No

PRIMARY INSURANCE

(Patient's own insurance policy or spouse's if not employed)

Name of Insurance_____ ID#_____ Group # _____

Subscribers Name_____ Subscriber's Social Security # _____

Relationship to Patient_____ Subscriber's Birth Date _____

Address (if different from patient)_____ Phone ( )_____

Subscribers Employer_____ Work Phone ( )_____

SECONDARY INSURANCE

*(Are you covered by additional insurance? **If yes**, complete this section)*

Name of Insurance_____ ID#_____ Group # _____

Subscribers Name_____ Subscriber's Social Security # _____

Relationship to Patient_____ Subscriber's Birth Date _____

Address (if different from patient)_____ Phone ( ) _____

Subscribers Employer_____ Work Phone ( )_____

***Is this visit related to a work injury?** No Yes If yes, see / call receptionist

***Is this related to a car accident?** No Yes If yes, see / call receptionist

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits directly to my healthcare provider who accepts assignment.
I understand that I am financially responsible for all charges whether or not paid by insurance.
I attest the above information is true and correct to the best of my knowledge.

_____ _____ _____
Responsible Party Signature Relationship to patient Date

Southern Oregon Rheumatology Clinic

David Chamberland, MD, FACR
Dominik G. Sokalski, MD, FACR
Zhijie Zhou, MD, FACR
Giorgos Loizidis, MD, RhMSUS™

COLLECTION POLICY
PROMISE TO PAY – Installment Note

I promise to pay Southern Oregon Rheumatology Clinic.

1. **Collection policy:** Co-pays are due at time of service. If unable to pay all other estimated charges at time of service, a 25% down payment and minimum monthly payments of 25% are due by the end of each month. Account balances of $100 or less require a minimum payment of $25 per month.

2. **Uninsured Policy:** Payment made in full at time of service will receive a 25% discount. If unable to pay in full, 25% down and minimum monthly payments of 25% are due by end of each month.

3. **24 hour cancellation policy:** If you are a "No-Show" for your appointment, you will be charged $45. This policy is in place out of respect for our physicians and their patients. Cancellation without 24 hours notice is difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule. By initialing you acknowledge you have read and understand the cancellation policy as described above. **Initial here:** _____

4. Auto-payment is available for Visa/MasterCard and Discover. Inquire with our business office.

5. Financial hardship is available. A patient must complete hardship paperwork and supply a copy of their previous year's tax return before any changes can be made to the collection policy.

Waiver of Responsibility:

Some out-of-state BlueCross plans do not cover services rendered in Oregon. You can choose to pay at the time of service to receive the above discount, or we can bill your insurance and you will not be eligible for a discount if your insurance denies coverage.

TriWest Health Alliance or **VA Insurance**: We are not contracted with TriWest or the VA and do not accept this insurance. By initialing below, you are certifying that you:

1. Do not have this insurance; or
2. You are aware of our policy and you are responsible for billing and obtaining your own authorizations. **Initial here:** _____

This policy is subject to change at the Rheumatology Clinic's discretion.

Printed Patient Name (Last, First, MI)	Patient Signature (or person authorized by law)
Permanent Street Address	Date Signed
City, State, Zip	SORC Staff Signature

CC: Chart/Patient

1365 Poplar Drive, Medford, OR 97504-5207
Main Office: (541)773-2233
Business Office (541)245-6012

Southern Oregon Rheumatology Clinic

David Chamberland, MD, FACR
Dominik G. Sokalski, MD, FACR
Zhijie Zhou, MD, FACR
Giorgos Loizidis, MD, RhMSUS™

HIPAA CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

(This is not a records release form)

I authorize **Dr. Chamberland** **Dr. Sokalski** **Dr. Zhou** **Dr. Loizidis** (circle one)

to use and disclose the health and medical information of _____
(Patient's legal name)

for the purposes of **Treatment, Payment** and other **Health Care Operations**.

- **Treatment** includes activities performed by a physician, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician.
- **Payment** includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, precertification and preauthorization.
- **Health Care Operations** include the necessary administrative and business functions of our office.

You may review our "**Notice of Privacy Practices**" for additional information about the uses and disclosures of information described in this consent prior to signing this consent. Please verify that you have **received or declined a copy of our Notice** by initialing here: _____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may also change. A summary of the Notice will be posted in the lobby of our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right to revoke this consent, provided that I do so in writing, except to the extent that either: Dr. Chamberland, Dr. Sokalski, Dr. Zhou or Dr. Loizidis has already used or disclosed the information in reliance on this consent.

_____ _____ (or)
Date Signature of patient

_____ _____
Date Signature of person authorized by law

1365 Poplar Drive, Medford, OR 97504-5207
Main Office (541)773-2233
Business Office (541)245-6012

Southern Oregon Rheumatology Clinic

David Chamberland, MD, FACR
Dominik G. Sokalski, MD, FACR
Zhijie Zhou, MD, FACR
Giorgos Loizidis, MD, RhMSUS™

Release of Information – Medical and Billing

(Optional)

Our physician's and staff make every effort to protect your health care information.

It is the practice of Rheumatology Clinic, LLC to address you by your name when calling you to the back office. If this is not acceptable to you please advise the receptionist or clinical staff and indicate how you would like to be addressed.

Others involved in healthcare:
If you have someone in your life, other than yourself, that you would like the physician or billing department staff to discuss treatment and or billing issues, please complete the following information.

Examples of people who may need information are:

- Spouse
- Caregiver
- Legal Guardian
- People who provide transportation for you

1. _____ _____ _____
Name | Phone Number | Relationship

2. _____ _____ _____
Name | Phone Number | Relationship

3. _____ _____ _____
Name | Phone Number | Relationship

This authorization is valid to disclose the following information to the above listed person(s). If you list more than one person please specify which information you are giving authorization to release per person.

• **Medical**	**1. ☐ Yes ☐ No**	**2. ☐ Yes ☐ No**	**3. ☐ Yes ☐ No**
• **Billing Information**	**1. ☐ Yes ☐ No**	**2. ☐ Yes ☐ No**	**3. ☐ Yes ☐ No**

This information is valid until revoked by the patient.

_____ _____
Print Patient Name | Patient Signature Date

_____
SORC Staff Signature Date

1365 Poplar Drive, Medford, OR 97504-5207
Main Office: (541)773-2233
Business Office: (541)245-6012

RHEUMATOLOGY CLINIC

New Patient Questionnaire

(Please complete both sides of this form)

Name: _____ **Date:** _____

Personal History

Birthplace: _____ Date of Birth: _____

Nationality: _____ Religious Affiliation: _____

Marital / Relationship Status: _____

Employment Status / Occupation: _____

Exercise: _____ Hobbies: _____

Average Per Day: Alcohol (type): _____ Recreational Drug Use: _____

Tobacco: _____ Tea / Coffee: _____

Medications Taken Regularly

(include prescription and over-the-counter)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medication Allergies: _____

_____ _____

_____ _____

Immunizations

Pneumovax (pneumonia)..... ❑ Yes ❑ No Year: _____

Hepatitis A..... ❑ Yes ❑ No Year: _____

Hepatitis B ..... ❑ Yes ❑ No Year: _____

Tetanus..... ❑ Yes ❑ No Year: _____

Polio..... ❑ Yes ❑ No Year: _____

Small Pox ..... ❑ Yes ❑ No Year: _____

Other: _____ Year: _____

X-rays / Procedures

Chest x-ray ..... Year of Last Test: _____

Mammogram ..... Year of Last Test: _____

Colonoscopy..... Year of Last Test: _____

Bone Density Scan..... Year of Last Test: _____

Prostate Exam (Men)..... Year of Last Test: _____

TB Skin Test (PPD)..... Year of Last Test: _____

Other: _____ Year of Last Test: _____

Other: _____ Year of Last Test: _____

Family History

	Present age, or age at death	If living, health (good, fair, poor); If deceased, cause of death
Father		
Mother		
Brothers / Sisters		
1.		
2.		
3.		
4.		
5.		

Is there any family history (in parents, siblings or children) of any of the following:

Arthritis	❑ No	❑ Yes	Who: _____
Lupus	❑ No	❑ Yes	Who: _____
Scleroderma	❑ No	❑ Yes	Who: _____
Muscle Disease	❑ No	❑ Yes	Who: _____
Psoriasis	❑ No	❑ Yes	Who: _____
Crohn's Disease or Ulcerative Colitis	❑ No	❑ Yes	Who: _____
Multiple Sclerosis	❑ No	❑ Yes	Who: _____
Cancer	❑ No	❑ Yes	Who: _____
Blood Disorders	❑ No	❑ Yes	Who: _____

Review of Systems

Do you have, or have you had in the past three months, any of the following (please check those you have experienced):

General
❑ Fever (over 100 degrees)
❑ Weight loss
❑ Night sweats
❑ Loss of energy
❑ Change in lymph nodes
❑ Snoring
❑ Trouble sleeping

Ears
❑ Ringing
❑ Loss of hearing

Eyes
❑ Trouble seeing
❑ Red or inflamed eyes
❑ Eye pain

Nose and Mouth
❑ Nose bleeds
❑ Mouth sores (ulcers, canker sores)
❑ Sinus pain
❑ Nasal congestion
❑ Nose bleeds

Neck
❑ Goiter
❑ Difficulty swallowing

Breasts
❑ Discharge from nipples
❑ Lumps

Cardiovascular
❑ Chest pain
❑ Difficulty breathing
❑ Leg swelling
❑ Palpitations

Pulmonary
❑ Wheezing
❑ Cough
❑ Pain with breathing
❑ Cough up blood

Digestive
❑ Loss of appetite
❑ Heartburn
❑ Nausea or vomiting
❑ Abdominal pain
❑ Constipation

Genitourinary
❑ Burning on urination
❑ Bloody urine or discharge
❑ Difficulty urinating
❑ Urination at night, # of times_____
❑ Sexually transmitted diseases

Brain and Nerves and Muscles
❑ Seizures or epilepsy
❑ Dizziness
❑ Blackouts
❑ Weakness
❑ Stroke
❑ Headaches
❑ Depression
❑ Numbness
❑ Muscle pain

Blood
❑ Easy bruising
❑ Excessive bleeding

Skin
❑ Rashes
❑ Fingers changing color

Your Past Medical History

Please check those you have had:

❑ Polio
❑ Valley Fever
❑ Exposure to TB
❑ Tuberculosis
❑ Pneumonia
❑ Pleurisy
❑ Hepatitis / Liver Disease
❑ Bladder Infections
❑ Kidney Disease
❑ Hay Fever
❑ Asthma
❑ Emphysema
❑ Back Trouble
❑ High Blood Pressure
❑ Heart Disease
❑ Stroke
❑ Anemia
❑ Bleeding Tendency
❑ Ulcer (stomach or intestine)
❑ Cancer
❑ Blood Transfusion
❑ Thyroid Disease
❑ Diabetes
❑ Mental Health Problem
❑ Epilepsy / Seizures
❑ Osteoporosis

Operations (Check if Yes)

❑ Tonsils ..... Year: _____
❑ Appendix ..... Year: _____
❑ Gallbladder ..... Year: _____
❑ Stomach ..... Year: _____
❑ Breast ..... Year: _____
❑ Uterus and/or Ovary ..... Year: _____
❑ Prostate ..... Year: _____
❑ Hernia ..... Year: _____
❑ Thyroid ..... Year: _____
❑ Varicose Veins ..... Year: _____
❑ Hemorrhoid ..... Year: _____
❑ Heart ..... Year: _____
❑ Spine (back or neck) ..... Year: _____
❑ Joint Replacement ..... Year: _____
❑ Other (please list): _____

Injuries or Accidents

❑ Head ..... Year: _____
❑ Broken Bones ..... Year: _____
❑ Other (please list): _____

Any work-related injuries (please list): _____

Patient Name: _____ Patient Signature: _____ Date: _____

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.

YOUR RIGHTS: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

You have the right to:

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way about your medical information (for example, home or office phone) or to send your medical information to a different address.
- We will say, "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or healthcare item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared (disclosed) your health information, for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and healthcare operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

You can file a complaint with us if you feel we have violated your rights by contacting our Practice Manager.

- To file a complaint with our organization, please submit your request in writing to: Practice Manager | 1365 Poplar Drive, Medford, OR 97504 | Phone: 541-773-2233 | Email: 4drrheum@sorheum.com
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, SW, Washington, D.C. 20201, calling 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/
- We will not retaliate against you for filing a complaint.

YOUR CHOICES: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, contact us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference - for example, if you are unconscious, we may share your information if we believe it is in your best interest to do so. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these following cases, we **never** share your information unless you give us written permission:

- Marketing purposes
- Sale of your protected health information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again. We will honor your request to not contact you again.

OUR USES AND DISCLOSURES

We typically use or share your health information in the following ways:

- **Treatment**
  We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
- **Run our organization**
  We can use and share your health information to run our practice, improve your care, and contact you when necessary.
  Example: We use health information about you to manage your treatment and services.
- **Bill for your services**
  We can use and share your health information to bill and get payment from health plans or other entities.
  Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Research

- We can use or share your information for health research.

Comply with the Law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information:

- www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

If you have any questions about this notice, please contact:

SORC Medical Records Department
1365 Poplar Drive, Medford, OR 97504
Phone: (541)773- 2233