SOCAL ARTHRITIS

A. AL HARASH, MD, FACR

PERSONAL INFORMATION

Full Name : _____

Date Of Birth : _____/_____/_____ Gender : ☐ Male ☐ Female

Address : _____

Phone Number : _____ E-Mail : _____

Emergency Contact Name : _____ Emergency Contact Number : _____

CARE TEAM INFORMATION

Primary Doctor Name : _____ Primary Doctor Number : _____

Primary Doctor Address : _____

Pharmacy/Address : _____

CONSENT TO RECEIVE MEDICAL CARE

I hereby authorize SoCal Arthritis Inc. and any employee working under the direction of the physician to provide medical care for me.

This medical care may include services and supplies related to my health and may include but is not limited to preventive, diagnostic, therapeutic, rehabilitative, maintenance, counseling, assessment, or review of physical or mental status/function of the body.

This is a HIPAA compliant clinic. All communication pertaining to patient care including interpersonal, print, telephonic, or electronic is conducted via HIPAA compliant services.

This consent includes contact and discussion with other health care professionals for care and treatment.

_____

Signature Date

909-342-7892
909-342-7891
13768 Roswell Ave, Ste 100, Chino, CA 91710
27403 Ynez Road, Ste 108, Temecula, CA 92591
socalarthritis@gmail.com
www.socalarthritis.com

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HEALTH HISTORY

Reason For Visit : _____

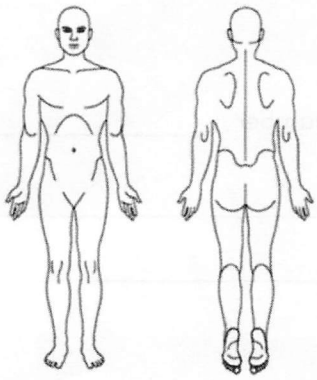
Describe Current Symptoms : _____

Date Symptoms Began : _____ Date Treatment Began : _____

Previous Treatments : _____

**Include physical therapy, surgery, and injections. Medical history will be taken at a later time.*

Mark all locations where you are currently experiencing pain on the figures below :



Provide brief description of pain areas indicated in the figures :

_____

_____

_____

_____

_____

Are you allergic to any medications? : ☐ YES ☐ NO

If yes, please list with description of reaction : _____

_____

Do you consume alcoholic beverages? : ☐ YES ☐ NO Average Quantity : _____

Do you consume any tobacco or nicotine products? : ☐ YES ☐ NO Average Quantity : _____

Any family history of autoimmune disorders? : ☐ YES ☐ NO

If yes, please provide a background : _____

_____

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SYMPTOM CHECKLIST *check all that apply

Constitutional:
- ☐ Recent weight gain/loss LBs:_____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever

Eyes:
- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or Blurred vision
- ☐ Dryness
- ☐ Feels like something in eyes
- ☐ Itching eyes

Ears/Nose/Throat:
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Sores in mouth
- ☐ Dry mouth
- ☐ Difficulty swallowing

Cardiovascular:
- ☐ Chest Pain
- ☐ Irregular heart beat
- ☐ High blood pressure
- ☐ Shortness of breath
- ☐ Swollen legs or feet

Respiratory:
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing
- ☐ Asthma

Genitourinary:
- ☐ Difficult urination
- ☐ Pain/burning urination
- ☐ Blood in urine
- ☐ Cloudy, "smoky" urine

Gastrointestinal:
- ☐ Nausea
- ☐ Vomiting blood
- ☐ Stomach pain relieved by food or milk
- ☐ Jaundice
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stool
- ☐ Heartburn

Musculoskeletal:
- ☐ Morning stiffness
  How long does this last?
  _____
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint swelling
  List affected joints:
  _____
  _____
  _____

Neurological:
- ☐ Headaches
- ☐ Dizziness
- ☐ Muscle spasm
- ☐ Sensitivity or pain in hands and/or feet
- ☐ Memory loss
- ☐ Night sweats

Integumentary (skin):
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun Sensitivity
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes in hands or feet in the cold

Hematologic/lymphatic:
- ☐ Swollen glands
- ☐ Tender glands
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Transfusion
  Date:_____
- ☐ Frequent Infections
  Describe: _____
  _____
  _____

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty staying asleep

For women only:

Number of pregnancies:
_____

Number or miscarriages:
_____

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CLINIC DISCLOSURES

- **Dr. Al Harash is a specialist and cannot provide primary care services.** We advise all of our patients to establish with a primary care physician. We are happy to make recommendations upon request.
- **Any outgoing correspondence (i.e. letters to employers, forms for special accommodations including DMV forms) can be completed by our office for a $40 fee.** Only forms or letters pertaining to the doctor's visit care plan will be completed.
- **Disability forms, worker's compensation, or legal matters of any kind, unless mandated by a government institution, should be completed by your primary care provider.** Patients may log in to Patient Passport for copies of medical records in electronic format, free of charge.
- **Prior authorization may be required by your insurance for new medications or biologics.** This may delay when your medications will be available to you. Standard prior authorizations may take 5 to 7 business days.

CANCELLATION POLICY

- **Please call at least 24 hours prior to your scheduled appointment if you need to cancel or reschedule.** If you are attempting to contact us outside our business hours, please leave a detailed message. ***Failure to do so will result in a $25 "no-show" charge.**
- **Failure to attend 2 appointments without attempted contact will result in a transfer of care.** A "no-show" is defined as a missed appointment with no attempt to notify our office. We understand urgent circumstances may arise, please notify us as soon as possible.
- **We allow a maximum of 15-minute grace period from your scheduled appointment time.** If you are experiencing delays, please call our office to confirm that we are able to accommodate your expected arrival time. We may have to reschedule your appointment if you are more than 15 minutes late.

FINANCIAL POLICY

- **All copays and deductibles will be collected at the time of your visit and must be paid in full prior to seeing the doctor.** Your in-office cost will be determined by your current benefits provided by your insurance.
- **Any outstanding balances or unpaid bills will be collected in-office.** A detailed ledger will be provided. If you would like to dispute the charge or need further clarification on the reason for the bill, it is the patient's responsibility to contact their insurance.
- **We require all patients to keep a card on file.** Our office utilizes 'Square' to collect payments and store card information on file. This information is protected under the California Consumer Privacy Act (CCPA). Your information will not be accessible to our staff and remain secure through 'Square'. This has become standard practice for many offices and will be enforced with no exception. **We will only use the card on file to charge cancellation fees, form-completion fees, copays, or telehealth visits. We will always notify you prior to any charge being issued.**
- **Unpaid bills over 60 days overdue will be sent to collections.** Please contact our office if you are in the process of disputing a bill with your insurance or would like to discuss a payment schedule. All balances must be paid prior to your scheduled return appointment.

Please sign and date to verify you have read the policies above :

_____

Signature Date

SOCAL ARTHRITIS

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Financial Policy, Billing Procedures, Card on File Policy

Insurance & Billing Procedures:

SoCal Arthritis Inc ("the practice") is participating with Medicare and many commercial insurances. If you have coverage with Medicare and/or one of the commercial insurance carriers that we participate in, we will file your claim directly to your insurance carrier or Medicare for reimbursement. The practice's participation with insurance carriers is subject to change without notice.

As a courtesy, the practice will contact your insurance carrier to verify your benefits and/or necessary authorizations prior to your visit. Please be aware, this is only "a QUOTE of Benefits/Authorizations." The practice cannot guarantee that your insurance carrier will provide us accurate or complete information regarding in or out of network status, reimbursement, or verify that definite eligibility of benefits. Payment of benefits are subject to all terms, conditions, and exclusions of the member's contract at the time of service. In the event that YOUR INSURANCE PROVIDER DOES NOT COVER services rendered for any reason, YOU WILL STILL REMAIN RESPONSIBLE TO PAY FOR ALL SERVICES RENDERED.

If your insurance carrier requires you to have a referral from your PCP, it is your responsibility to ensure that the referral information and referral number is received by this office from your PCP prior to your visit.

We accept all major credit cards, FSA/HSA cards, Apple Pay, Google Pay, electronic check, cash, personal checks. Payment IN FULL of all estimated out-of-pocket expenses (co-pays, deductible, co-insurance, etc.) is REQUIRED AT THE TIME OF SERVICE AT CHECK-IN. Please come prepared to make payment of these amounts. Your insurance policy is a contract between you and your insurance carrier. The ultimate responsibility for payment of services rendered rests with you, the patient or guarantor. There is a $30 declined transaction/returned check fee for every declined transaction/returned check.

If we are not in your insurance network or if you have no insurance, we will expect payment in full at the time of service. All pricing is subject to change without notice, thus please contact our office for our current fee schedule prior to all visits so that you are prepared to make payment in full of these amounts.

SoCal Arthritis Inc. DOES NOT DO WORKER'S COMPENSATION cases and DOES NOT FILL OUT DISABILITY FORMS of any kind.

Card On File & Autopay - A Better Billing Experience for You:

We have implemented a billing policy in order to deliver a more convenient and consistent payment experience to our patients. Our policy requires a card to be held on file for all patients. To avoid any issues of discrimination or favoritism; all patients who receive care at our practice are required to have a card on file regardless of insurance, private pay, or visit type. To simplify the process even further, we are enrolling patients with Autopay. Card On File is the new standard in the healthcare industry nationwide, and soon all high quality medical practices will adopt it. This is the same process as reserving a hotel or renting a car.

Our practice is committed to reducing waste and inefficiency and making our billing process as simple and easy as possible. The card on file system drives down administrative costs as we will now spend less time entering card information for each transaction. We then have less paper statements to mail, which saves trees, money and time. Once your card is in the system, check-in and check-out time is much shorter for you as well. Additionally, when we are working remotely and seeing patients for virtual telemedicine visits, it is used to process charges since we are not on-site at the office to use our swipe machine. For insurance patients, the purpose of card on file is to cover any remaining balance due after insurance benefits are applied.

Please sign and date to verify you have read the policies above :

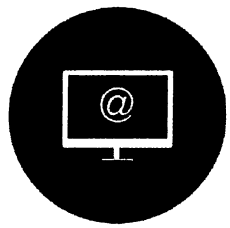
_____

Signature Date

Here's how it works:

1 We securely save your credit or debit card before or during your visit.

2 We work with your health plan to determine your payment amount for the visit.



3 Before your card is charged, we email you the amount you will be charged.

4 We process the payment for you automatically and email you the receipt.

Q: How much are you going to charge my card on file?

A: You will be charged the amount that your insurance plan determines is your responsibility, after the insurance benefit has been applied.

Q: Will you send me a statement to let me know what I owe?

A: After your appointment, you will receive an explanation of benefits (EOB) from your insurance company that confirms your patient responsibility. We receive the same letter within 7-30 days following your appointment. We will review each EOB carefully and charge your card the amount that is determined by your health plan to be your responsibility, using autopay. You will receive an email/text notification 7 days before your card is charged, and on the day of the charge.

Q: What happens if I need to dispute my bill?

A: You will only be charged the amount determined by your health plan in your EOB. However we will work with you if there has been a mistake on your bill.

Q: I do not have a deductible and/or I have dual plans. I will never owe anything. Do I still need to give you a card?

A: Due to the complexity of health plans, patients are not always aware of a payment responsibility.

Additionally, changes to health plans happen often, which can make you responsible for payments without your knowledge. So we are requiring all patients to save a card on file to ensure we are prepared in the event they do have a payment responsibility.

Q: I've always paid my bills on time. Why do I have to give you a card?

A: To be fair and consistent to all of our patients, we are implementing the policy to all patients who seek care at our practice. Additionally, we want all of our patients to benefit from this simplified way to pay medical bills. This is the same process as checking in at a hotel or renting a car.

Please sign and date to verify you have read the policies above :

_____

Signature Date

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CLINIC DISCLOSURES

Date of Service :

Patient Name :

Date of Birth : Urgent Request : Yes No

Requested Provider :

Provider Address :

Phone Number : Fax Number :

- I (Patient) authorize the release of my medical records indicated below that are pertaining to the care of Dr. Al Harash.

All Records | Ultrasound Reports | Radiology Reports | Medication List | Demographics

Visit Notes | Biopsy Reports | Lab Reports | Progress Notes | Other _____

- I (Patient) understand my ability to refuse or revoke my consent (via written request) at any time. My refusal will not affect my ability to obtain treatment.
- I (Patient) understand my legal and enforceable rights to privacy under the HIPAA Privacy Rule. This signed letter is my written consent to release the requested documents.

Patient Signature Date

Patient Representative Relationship

Requesting Provider : Verified by pdfFiller 08/18/2022

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SoCal Arthritis Communication Consent

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

I give permission for SoCal Arthritis to communicate with the following person(s) regarding:

Name: _____ Relationship: _____ Phone: _____

- ☐ My billing and payment information
- ☐ Appointment management, including scheduling, cancelling and rescheduling of appointments
- ☐ Medical information, including diagnosis's, results and treatment plans

Name: _____ Relationship: _____ Phone: _____

- ☐ My billing and payment information
- ☐ Appointment management, including scheduling, cancelling and rescheduling of appointments
- ☐ Medical information, including diagnosis's, results and treatment plans

Name: _____ Relationship: _____ Phone: _____

- ☐ My billing and payment information
- ☐ Appointment management, including scheduling, cancelling and rescheduling of appointments
- ☐ Medical information, including diagnosis's, results and treatment plans

These communications may occur when the identified person(s) joins me at my visit, or communicates for me by telephone, e-mail, or other electronic method.

I give permission to SoCal Arthritis to contact me on my cell phone, home and/or work phone using prerecorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by e-mail, text messaging, or by any other form of electronic communication, based on my communication preferences. Standard messaging rates may apply.

This disclosure form is in effect until changed or revoked by me. Only I can change who is named on this form to communicate with SoCal Arthritis about my health information. At the time of change or revocation, a new form will be completed by me.

I give permission to SoCal Arthritis to leave voicemail messages regarding labs or test results or diagnosis.

- ☐ **I decline any communication to others outside of myself or legal guardian(s).**

Signature: _____

Date: _____

(Patient or person legally authorized to sign for patient)

Printed Name: _____

Name:_____

MEDICATION LIST

NAME:	DOSE:	DIRECTIONS:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		