

Patient Registration

Patient Information

First Name

Middle Name

Last Name

Date of Birth

Sex at Birth

Female Male

Mobile Phone

Home Phone

Email

Address

Suite/Apt. #

City

State

Zip

Emergency Contact Information

First Name

Last Name

Relationship

Phone #

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

- My billing and payment information
- Appointment management, including scheduling, cancelling and rescheduling of appointments
- Medical information, including diagnoses, results, and treatment plans

Care Team Information

Primary Doctor Name

Primary Doctor Number

Primary Doctor Address

City

State

Zipcode

Name of your Pharmacy

Address

City

State

Zipcode

Employer Information

Name of Employer

Address

City

State

Zipcode

Phone number

Occupation

Primary Insurance

Name

Policy Number

Secondary Insurance

Name

Policy Number

Insured Party If Different Than Patient Information Above

Name of Insured Person

Authorization and Consent to Treatment

I hereby authorize SoCal Arthritis Inc. and any of its employee and contractors to provide healthcare services for me.

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

I understand that after examining me, my healthcare provider may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to another specialist, ordering labs and tests and/or asking me to return to the office within a certain period of time. I understand that not following those recommendations can have serious negative effects on my health. I will let my healthcare provider know whenever I decide not to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision.

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

Signature

Date

Office Policies

CLINIC DISCLOSURES

- We employ and retain physicians and other healthcare providers who are specialists, we do not provide primary care services. We advise all of our patients to establish a physician/patient relationship with a primary care physician. We are happy to make recommendations for primary care physicians 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 \$40.00 fee.
 - Disability forms, worker's compensation forms and/or other legal forms should be completed by your primary care provider unless mandated by law. 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 company for new medications or biologics or services. This may delay when your medications, biologics and services will be available to you. Standard prior authorizations usually take five (5) to seven (7) business days.
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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 \$50.00 "no-show" charge. **Failure to attend two (2) appointments without attempted contact may 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, but 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 a delay, 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 fifteen (15) minutes late.

Telehealth Consent

I understand that we may offer healthcare services using telehealth technology, including telephone and video consultations. I consent to receive care in this manner and understand the risks and limitations of such technology, including potential issues with confidentiality and data security.

Generative Artificial Intelligence consent

- SoCal Arthritis Inc. may use **Generative Artificial Intelligence (GenAI)** to generate notes, communications and letters.

To provide you with the best care and attention, we are using an AI service that transcribes conversations and helps with my notes. Your information is private and we review the content for accuracy. You can ask us to stop using it at any time. Hereby you are giving consent to use this service during our visits.

- Your consent is critical and you can withdraw it at any time. This service is designed to help us focus on you during our visits instead of writing notes
- Audio recordings are temporarily saved in a secure manner until note summaries and quality checks are complete, and then they are automatically deleted.
- Your information is protected by law under HIPAA and secured using encryption technology.
- AI stores all data securely on servers located within the United States.
- Under HIPAA, your protected health information can only be used for treatment, payment, and healthcare operations, unless you request that I share it with someone else (like a family member).
- Audio recordings are automatically deleted

Opt-Out option

I decline using Artificial Intelligence

Signature

Signature

Date

Health History

Reason for Visit

Describe Current Symptoms

Date Symptoms Began

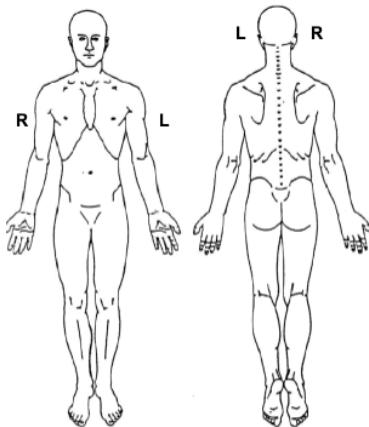
Date Treatment Began

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 on the figures below:



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 information

Symptoms Check List

check all that apply

Constitutional

- Recent weight gain/loss lbs:
- Fatigue
- Weakness
- Fever

Genitourinary

- Difficult urination
- Pain/burning urination
- Blood in urine
- Cloudy, "frothy" urine

Ear/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 up blood
- Wheezing
- Asthma

Eyes

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

Gastrointestinal

- Nausea
- Vomiting blood
- Jaundice
- Persistent diarrhea
- Blood in stools
- Black stool
- Heartburn

Musculoskeletal

- Morning stiffness, how long:
- Joint pain
- Muscle weakness
- Muscle tenderness
- Joint swelling, Joints:

Neurological

- Headaches
- Dizziness
- Muscle spasm
- Memory loss
- Night sweats
- Tingling and numbness

Skin

- 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
- Frequent infections

Psychiatric

- Anxiety
- Depression
- Difficulty staying asleep

Women Only: # of pregnancies

Women Only: # of miscarriages

Medical Records Release Authorization

Date of Service

Patient's First Name

Patient's Last Name

Date of Birth

Urgent Request

Yes No

Requested Provider

Phone

Fax

Provider Address

City

State

Zipcode

I authorize the release of my medical records indicated below to SoCal Arthritis Inc.

All Records

Ultrasound Reports

Radiology Reports

Medication List

Demographics

Visit Notes

Biopsy Reports

Lab Reports

Progress Notes

Other:

I 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 understand my legal and enforceable rights to privacy under the HIPAA Privacy Rule. This signed document is my written consent to release the requested documents.

Patient Signature

Date

Patient Representative

Date

Patient Representative's Name (if applicable)

Requesting Provider: **Dr. A. Al Harash (SoCal Arthritis Inc.)**

13768 Roswell Ave, Ste 100, Chino, CA 91710

E: socalarthritis@gmail.com

P: 909-342-7892

F: 909-342-7891

Notice of Privacy Practices

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related healthcare services.

Uses and Disclosures of Protected Health Information: Your PHI may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the organization and any other use required by law.

Treatment: We may use and disclose your PHI to provide, coordinate and/or manage your healthcare services. This includes the coordination and/or management of your healthcare services with a third party. For example, we could disclose your PHI, as necessary, to a home health agency that provides healthcare services to you. In addition, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and/or treat you.

Payment: Your PHI may be used, as needed, to obtain payment for your healthcare services. For example, your relevant PHI may be disclosed to your health insurance plan to obtain approval for coverage of healthcare services, equipment and/or supplies.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of our organization. These activities include, but are not limited to quality assessment activities, employee review activities, and/or accreditation activities. For example, we may disclose your PHI to accrediting agencies as part of an accreditation survey. In addition, we may call you by name while you are at our office. We also may use or disclose your PHI, as necessary, to contact you to check the status of your equipment.

Disclose of PHI Without Authorization: We may disclose your PHI without your authorization as required by law for public health, communicable diseases, health oversight, abuse or neglect cases, Food and Drug Administration requirements, legal proceedings, law enforcement, criminal activity, inmates, military activity, national security and Workers' Compensation.

Required Uses and Disclosures: Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization and Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your PHI.

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding and PHI whose access is prohibited.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your

best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare provider.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI, if you have any questions concerning or objections to this form, please let us know.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No PHI is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

I have read and been advised of this Notice of Privacy Practices that describes how my PHI is used and shared. I understand that Social Arthritis, Inc. has the right to change this notice at any time, and that it will provide a copy of this NOTICE OF PRIVACY PRACTICES at my request.

Signature

Date

Financial Policy

PATIENT RESPONSIBILITY

You can help ensure that you have a positive experience with us by assisting with the following:

- providing us with your picture identification and insurance card to enable it to submit your claims timely and accurately
- knowing your insurance benefits and limitations
- ensuring there is an authorization for us to treat you, if required by your insurance, including obtaining a referral
- providing us with copies of any pertinent medical records
- paying your estimated portion of the charges at the time of service
- paying any additional amount owed to us when due
- maintaining a current account balance with us at all times
- providing us with at least 24 hours advance notice if you need to cancel or reschedule an appointment

Please note that co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

All outstanding balances due are the responsibility of you. If you have been billed more than once without making a payment, you may be unable to schedule an appointment or may have to reschedule an existing appointment. Non-payment of your outstanding balances can result in dismissal as a patient.

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

PATIENT RESPONSIBILITY

Patients and/or their legal representative are ultimately responsible for all charges for healthcare services provided by us. We expect your payment at the time of your visit for all amounts owed for that visit as well as any prior balance. When your insurance plan provides immediate information regarding patient responsibility, we may request payment for your share when you schedule an appointment and/or when you present for your appointment.

If you are a new patient and you do not have insurance coverage, we require \$200.00 at the time of scheduling an appointment and payment in full the day of the appointment.

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INSURANCE

We ask all patients to provide us with their insurance cards (if applicable) and proof of identification (such as a photo ID or driver's license) at every visit. If you do not provide current proof of insurance, you may be billed as an uninsured patient. **Please provide us with all insurance coverage you have (both primary and secondary insurers).**

You are responsible for understanding the limitations of your insurance policy, including:

If a referral or authorization is necessary for office visits. If it is required and you do not have the appropriate referral or authorization, you may be billed as an uninsured patient.

Any co-payment, coinsurance or deductible that may apply.

NO SURPRISES ACT / GOOD FAITH ESTIMATE OF CHARGES

If you do not have insurance or are not using insurance to pay for your healthcare services, you have the right to receive a "Good Faith Estimate" from us explaining how much your healthcare services will cost. Under the No Surprises Act, healthcare providers must give patients who do not have insurance or who are not using insurance an estimate of their bill for healthcare services. In addition:

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment and hospital fees.
- You have the right to a Good Faith Estimate in writing at least one (1) business day before your healthcare services.

- You can also ask your healthcare provider, and any other provider you choose, for a Good Faith Estimate before you schedule a healthcare service.
- If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill.
- You should save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 1-888-774-8428.

YOUR RESPONSIBILITIES

Outstanding Balances.

After your visit to us, we will send you a statement for any outstanding balance when it is your responsibility. All outstanding balances are due on receipt. If you come to us for another visit and have an outstanding balance, we will request payment for both the new visit and your outstanding balance.

If you are unable to pay your account in full, please contact our office for alternative payment arrangements. Any balance left unpaid after ninety (90) days may be transferred to an outside collection agency.

In addition, if you have unpaid delinquent accounts, we may discharge you as a patient and/or you may not be allowed to schedule any additional healthcare services unless special arrangements are made.

Collection Process

Any patient balances for services that remain unpaid after ninety (90) days will be subject to an in-house review. You understand that you may not be able to schedule any further appointments with us until your balance is paid in full except if you are hospitalized or in a limited post-operative follow-up period. In the event your account is sent to an outside collection agency, you understand that you will be required to pay collection company fees. You will also be responsible for attorney fees and court costs if the collection proceedings advance to litigation.

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.

No-shows

In an effort to provide quality care to our patients, we must utilize our time efficiently. When a patient makes an appointment, time is set aside for their needs, and work is performed to prepare their record for the visit. When a scheduled visit is not completed, there is a loss for another patient who could have used that available time, as well as wasted staff time. Therefore, we ask that when a scheduled visit cannot be met, it be cancelled at least 24 hours prior to the time of the appointment. For late cancellations or not showing for a scheduled appointment, a \$50.00 fee may be charged.

Payment Options

We accept cash, checks, major credit/debit cards and money orders for payment (no post-dated or third-party checks).

Returned Check Fees

If we receive a returned check written by you or on your behalf, you will be charged a returned check fee of \$25.00 and will be required to pay for services by credit card. Failure to repay the amount due and the returned check fee may result in collection proceedings and may lead to dismissal of you as a patient of ours.

Medical Records

Requests for copies of your medical records must be submitted in writing. Requests can be made in person at our office, by fax, email or the Patient Passport. In accordance with applicable state and federal law, we will provide copies of requested medical records within fifteen (15) business days from the date the request is received. If records are stored off-site, an additional five (5) business days may apply. A preparation fee may apply, and costs for copies, shipping, and handling will be added as applicable. Patients are required to complete a Medical Record Release Authorization Form before the request is processed by us.

Final Costs of Services

You understand that we can only estimate your cost of services and cannot determine your final costs until all procedures have been performed and documentation has been processed by your insurance carrier. You further understand that final costs are determined by your insurance carrier, including coverage and authorization limitations, and that insurance payment is not a guarantee. Payment is subject to the terms, conditions, and coverage specifics of your individual insurance plan. Estimates provided are based on the information available from your insurance carrier at the time the estimate is given. If your insurance carrier processes your claims differently or adjusts payments based on its policies or coding interpretations, it is not the responsibility of us.

Signature

Untitled

Date

Open Payment Database

“The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>.”

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) 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 (\$10.00) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public

Signature

Signature

Date

Date

Physician-Patient Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any healthcare services rendered under this Arbitration Agreement ("Agreement") were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this Agreement, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this Agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the healthcare provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This Agreement is also intended to bind any children of the patient, whether born or unborn, at the time of the occurrence giving rise to any claim. This Agreement is intended to bind the patient and the healthcare provider and/or other licensed healthcare providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the healthcare provider, including those working at the healthcare provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the healthcare provider, and/or the healthcare provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief and/or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty (30) days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty (30) days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this Agreement, including, but not limited to sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This Agreement may be revoked by written notice delivered to the healthcare provider within thirty (30) days of signature and if not revoked will govern all healthcare services received by the patient and all other disputes between the parties.

Article 6: Severability: If any provision of this arbitration agreement should be held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

Article 7: Retroactive Effect: If the patient intends this Agreement to cover services rendered before the date it is signed (for example, emergency treatment), the patient should initial here. . effective as of the date of the first healthcare services.

I understand that I have the right to receive a copy of this Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS AGREEMENT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRA-

**TION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.
(SEE ARTICLE 1 OF THIS AGREEMENT)**

Signature

Date

SoCal Arthritis Inc.

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.

Signature

Date

Date

Communication Consent

I give my consent for SoCal Arthritis Inc. and any of its employees to communicate the results of my labs, imaging, appointments and/or any other healthcare information by the following methods:

Communication Method

- SMS messages
- Email
- Voicemail
- Phone call (only if I answer)
- Only during office visits