East Bay Rheumatology Medical Group, Inc.

REGISTRATION FORM

Referred by:				PCP name:	
PATIENT INFORMATION					
Patient's last name:	First:		Middle:	Date of birth:	
Marital Status:	Preferred language:	Sex:	Education:	Email:	
Address:					
Social Security no.:	Home phone no.:			Cell phone no.:	
Occupation:	Employer:			Employer phone no.:	
Is it ok to leave a detailed voicemail: Yes ◯ No ◯ If Yes: Preferred contact no:					
INSURANCE INFORMATION					
(**Please give your insurance card to the receptionist.**)					
Person responsible for bill:	Birth date:		Address (if different from above):	Phone no:	
Social security #:	Relationship to patient:				
Occupation:	Employer:		Employer address:	Employer phone no.:	
Primary Insurance:					
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment
Patient's relationship to subscriber:					
Secondary insurance:	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:					
IN CASE OF EMERGENCY					
Name:	Relationship to patient:		Home phone no.:	Work phone no.:	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize East Bay Rheumatology Medical Group, Inc. to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

Name: _____
DOB: _____

List of Doctors:

1.)_____
2.)_____
3.)_____
4.)_____
5.)_____

A.) What is your reason for coming to East Bay Rheumatology Medical Group?

B.) Past Medical History:

Please list all medical conditions, serious illnesses or injuries, surgeries and hospitalizations.

Condition, Surgery, Hospitalization	Date

C.) Family History:

Relationship	Age	Medical Problems

D.) Medication list:

Medication Name	Dose	Frequency	Reason for taking

E.) Allergy or Drug reaction list:

Kind of Allergy/ Drug Allergy	Type of Reaction

F.) Tobacco/ Alcohol use:

Tobacco per day:_____ How many years have you smoked?_____
If you have stopped smoking, when did you quit? _____

Alcohol per day: _____ ◯Daily ◯Occasionally

East Bay Rheumatology Medical Group, Inc.

FINANCIAL POLICY

Thank you for choosing us as your health care providers. The following statement is our financial policy. Your agreement to this policy is required prior to any treatment. The parent or legal guardian is responsible for payment at the time of the visit. Please acknowledge each statement below by initialing on the line

_____Payments are due at time of service, this includes, self- pay, co-pays, co-insurance, deductibles, non-covered and out of network services.

_____We accept VISA, MASTERCARD, CASH OR CHECKS. Positive ID is required for all credit card or check payments. There is a $25.00 fee for all returned checks.

INSURANCE

_____It is your responsibility to ascertain that your medical provider is a participating provider with your insurance company.

_____We will bill your insurance directly for services rendered. Patients will receive a statement for any remaining balances after insurance payments.

_____If we are not in network with your insurance company, you may incur a higher financial responsibility.

_____A current insurance card and positive identification is required at each visit. Failure to provide the required information will result in forfeiture of the scheduled appointment unless cash or credit card payment can be made for the total charges of the visit.

_____You are responsible for verifying benefits and coverage prior to any visits so that you are not billed for unanticipated charges. Some insurance companies do not cover some routine and non-routine services. Non-covered services will be billed directly to the patient.

_____All outstanding balances that have not been paid within 60 days will be billed to the patient and must be paid by 90 days of date of service regardless of the insurance status. **Unpaid patient balances older than 90 Days will be turned over to our collection agency.**

_____For self-pay patients without insurance, a full payment is required at the time of service**.**

I have read the above financial policy and understand and agree to its terms and allow the medical providers to treat me.

I _____have received a copy of this document,
PLEASE PRINT NAME

DATE _____

East Bay Rheumatology Medical Group, Inc.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Treatment. We may use and disclose your PHI for your treatment. For example, we may disclose your PHI to a specialist providing treatment to you.

Payment. We may use and disclose your PHI to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party.

Healthcare Operations. We may use and disclose your PHI in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

We are required by law to maintain the privacy of Protected Health Information (PHI), to provide individuals with notice of our legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI. We must follow the privacy practices that are described in this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all PHI that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

EASTBAY RHEUMATOLOGY MEDICAL GROUP, INC
13851 East 14th Street, Suite 301
San Leandro, California 94578
Tel no: (510) 357-1303
Fax no: (510) 357-5463

Acknowledgement of Receipt of Notice of Privacy Practices

East Bay Rheumatology Medical Group reserves the right to modify the privacy outlined in the notice.

Confirmation of receipt:
I have received a copy of the Notice of Privacy Practices for East Bay Rheumatology Medical Group.

_____
Name of Patient/or Patient Representative

_____ _____
Signature of Patient/or Patient Representative Relationship

_____
Date

East Bay Rheumatology
Medical Group, Inc.

C. Michael Neuwelt, M.D.
Suneet Grewal, M.D.

13851 E 14th St #301
San Leandro, CA 94578
(510) 357-1303 phone (510)
357-5463 fax
(510) 357-1040 research
www.eastbayrheum.com

CANCELLATION AND NO SHOW POLICY

East Bay Rheumatology Medical Group understands that situations arise in which patients need to cancel their appointments. It is kindly requested that if you need to cancel your appointment you provide us with 24 hours notice. This will enable us to schedule other patients in the appointment time slot vacated. With cancellations made less than 24 hours notice, we are unable to offer that slot to other patients.
Cancellation: Office appointments which are cancelled with less than 24 hours notification may be subject to a $35.00 cancellation fee.

No Show: Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as NO SHOW. Patients who No-Show three (3) or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments. Patients may also be subject to a $35.00 fee for office appointment and infusion appointment No Show.

Responsible party: The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management or physician approval. Our practice firmly believes that a good physician/patient relationship is based on understanding and good communication.

Please sign that you have read, understand and agree to this Cancellation and No show Policy.

Patient or Representative's Name (Print Name) _____

Patient or Representative's Signature _____Date _____

East Bay Rheumatology
Medical Group, Inc.

C. Michael Neuwelt, M.D.
Suneet Grewal, M.D.

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PRESCRIPTION POLICY AGREEMENT

All patients are required to sign this Prescription Policy and Agreement. Failure to adhere to the rules and regulations of this agreement may result in the dismissal of your care.

I, _____, agree to the following conjunction with my pain management treatment under the supervision of the physicians of East Bay Rheumatology Medical Group, Inc.

- Take medications as prescribed. Early refills will NOT be given. If you use up all your medications earlier than the scheduled refill date, the remaining days will be endured with no medications.
- All narcotics must come from ONE physician. You must notify our doctors of any narcotic medication orders made by other physicians while under the care of East Bay Rheumatology Medical Group, Inc.
- Refills of controlled substance medications will be made only during regular business hours, Monday to Friday, in person, once each month. Refills will not be made at night, on holidays or weekends.
- Refills will not be made if I "run out early" or "lose my prescription" or "spill or misplace my medication" or for any other reason. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
- Refills will not be made as an "emergency" such as a Friday afternoon because "I suddenly realized I will run out tomorrow." I will give East Bay Rheumatology Medical Group, Inc. at least 5 business days notice if I need my controlled medication refilled.
- All medications must be obtained at a designated pharmacy.
- The prescribing physician has complete liberty to discuss fully all diagnostic and treatment details with the dispensing pharmacy for purposes of maintaining accountability.
- Random urine toxicology screening may be done at any time. Failure to comply with random drug screen is reasonable cause from discharge from East Bay Rheumatology Medical Group, Inc.
- Script altering is a Federal offense and we will report any violations with the proper authorities
- We reserve the right to communicate with previous and present physicians that have care for you and/or your previous or present insurance carriers.

If drug dependence, tolerance or addiction occurs, I agree to accept full responsibility for the risks taken secondary to my consent of narcotic consumption for the management of my pain. Should withdrawal symptoms be encountered, I will notify East Bay Rheumatology Medical Group, Inc. This medication should be stopped slowly, with tapering. Mediation is not to be stopped on your own without medical advice. Evidence of medication hoarding, increasing use of medication without communication to East Bay Rheumatology clinic staff, hostile behavior towards our staff, refilling your prescriptions too frequently, getting the medication from multiple physicians or pharmacies, increasing amounts of medications, altering prescriptions, medication sales, unapproved use of other drugs (alcohol, sedatives or street or "illicit" drugs) during narcotic analgesic treatment or other unacceptable behavior will result in dismissal from East Bay Rheumatology Medical Group, Inc.

_____ _____

Print name of patient Date

_____

Signature of patient

_____ _____

Witness name and signature Date

East Bay Rheumatology
Medical Group, Inc.

C. Michael Neuwelt, M.D.
Suneet Grewal, M.D.

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San Leandro, CA 94578
Phone: (510) 357-1303
Fax: (510) 357-5463
Research: (510) 357-1040
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REQUEST FOR RELEASE OF MEDICAL RECORDS

DATE: _____

TO: _____
_____
_____

I, _____hereby authorize you to release to

- ☐ Dr. C Michael Neuwelt
- ☐ Dr. Suneet Grewal
- ☐ Dr. Samuel Ng
- ☐ Jeremy Verango, NP

Any information including the diagnosis and records of any treatment or examination rendered to me during the period from _____to _____.

_____ _____
Signature Witness

Date of birth: _____