CHICAGO ARTHRITIS

REGISTRATION FORM

Today's date:	Primary Care Physician & Phone Number:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Preferred Phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )
Would you like to sign up for our Patient Portal? ❑ Yes ❑ No	Please Check Appropriate Box: ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Hispanic/Latino/Latina	Email Address:

Pharmacy Name : Pharmacy Phone Number:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist when you are finished completing the forms.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( ) Cell Phone no: ( )

Are you a Patient Being seen without Insurance	❑ Yes ❑ No	Is this a Self Funded Plan ❑ Yes Is this an Employer Funded Plan ❑ Yes	Is this a Work Comp Case ❑ Yes

Occupation:	Employer:	Employer address:	Employer /Work phone no.: ( )

Please indicate primary insurance	❑ Advocate Physician Partner(HMO) ❑ Aetna ❑ Aetna HMO ❑ BCBS of Illinois(Non-HMO) ❑ Cigna ❑Great West	❑ Humana ❑ Illinois Public Aid(Medicaid) ❑Land of Lincoln ❑ Medicare ❑ Medicare Rail Road	❑ Presence Saint Joseph Healthcare Preferred (HMO) ❑ Ravenswood Physician Partners (HMO) ❑ United Health Care(Non-HMO)	❑ Other ________________ ________________ ________________ ________________ ________________

Subscriber's name:	Subscriber's SSN:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

For Office Use Only: Patient kept the copy of HIPPA Privacy Notices given to them ❑ Yes ❑ No Initials: __________
Patient kept a copy of Credit Card Policy given to them ❑ Yes ❑ No Initials: __________

Revised 6/23/2014/rg

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Medical History Form

Patient Name:_______________________________________ Date:______________________

Primary Physician:_________________Referring Physician:___________________________

Reason for visit:____

Please check any of the following that apply:
[]Joint Pains []Morning Stiffness []Fevers []Weight change []Hair loss
[]Mouth sores []Pain in eyes []Dry mouth []Dry eyes []Chest pain
[]Shortness of breath []Palpitations []Heartburn []Abdominal pain
[]Nausea/vomiting []Diarrhea []Blood in stool []Pain with urination []Genital ulcers []Weakness []Numbness []Tingling
[]Rash []Purple fingers in cold

Activity Level: Check any of the following you have DIFFICULTY with:
[] Bathing [] Toileting [] Cooking [] Cleaning [] Exercise

Personal Medical History
[] Osteoarthritis [] Rheumatoid arthritis [] Psoriasis/Psoriatic arthritis
[] Ankylosing spondylitis [] Gout [] Pseudogout [] Osteoporosis
[] Lupus [] Myositis [] Scleroderma [] Heart disease
[] Cancer [] Asthma [] COPD
[] High blood pressure [] High cholesterol [] Diabetes [] Thyroid disease
[] Fibromyalgia [] Kidney disease [] Tendinitis
[] Other (Please list)____

Surgical History:____

Current Medications:____

____

Medication Allergies:____

Employment: []Fulltime [] Part time []Retired [] Disabled Occupation:____________________

Smoking History: [] Non Smoker [] Former Smoker [] Current Smoker - Amount per day:___________

Alcohol use [] No [] Yes- Amount:______________________________

Illegal drug use [] No [] Yes- List:_________________________________

Family History
[] Rheumatoid Arthritis [] Psoriasis [] Lupus [] Gout [] Ankylosing spondylitis [] Vasculitis
[] Other Arthritis [] Other medical conditions

Do Not Fill In (for office use only)

BP_______ HR________ Ht________ Wt_______

[] Medicare [] Public Aid []Cash pay

[] HMO____________________

[] INS Carrier__________ Primary[] Secondary[]

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Chicago Arthritis
Patient registration Form
Disclosures and Consents

Patient Name:	**Date of Birth:**
ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize direct payment of my insurance benefits to Siddharth Tambar, MD or Chicago Arthritis for services rendered to my dependents, or me, by the physician or those under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay, out of pocket cost, deductible; co-insurance or balance due that Siddharth Tambar, MD is unable to collect from my insurance carrier for whatever reason.	
Medicare/Medicaid/Tricare/Champus: I certify that the information given by me in applying for payment under these programs are correct. I authorize the release of any of my, or my dependant's records that these programs may request. I herby direct that payment of my, or my dependant's authorized benefits be made directly to Siddharth Tambar, MD or the physical on my behalf.	
Authorized to release non-public personal information: I certify that I have read and been offered a copy of the HIPPA Notice of Privacy Practices. I herby authorize Siddharth Tambar, MD or those under his supervision to release any of my or my dependant's medical or incidental nonpublic information that may be necessary for medical evaluation, treatment, consultation or the processing of insurance benefits.	
Authorization to Mail, Call or E-mail: I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a representative(s) of Siddharth Tambar, MD or my physician to mail, call, or e-mail with communications regarding my healthcare, and diagnostic test results. I understand that I have the right to rescind this authorization at any time by notifying Siddharth Tambar, MD to that effect in writing.	
Lab/X-Ray/Diagnostic Services: I understand that I may receive a separate bill if my medical care includes lab, x-ray, and diagnostic services. I further understand that I am financially responsible for any co-pays, co-insurances, deductibles, or balance due for these services if they are not reimbursed by your insurance for whatever reason.	
Referrals to outside Physician(s) and Healthcare Provider(s)or Facilities: I understand that I may receive orders for additional care to other Physician(s) or other Healthcare Provider(s) or Facilities. Our office will be able to provide you with referrals for those visits/treatments if they are required by your insurance. However, we are not responsible for any charges that are incurred for that visit/treatment from the provider, healthcare provider, or facility.	
Consent to treatment: I hereby consent to evaluation, testing and treatment as directed by Siddharth Tambar, MD or those under his supervision.	

Patient Signature: __________________________________Date:___________

Guarantor Signature: ______________________________Date:___________
(if different than patient)

Guarantor Name (please print):______________________________________

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Here are a few things about our practice that we would like to inform you of

In order to obtain the best medical care possible, we expect the highest level of service and care from ourselves. We will always work closely with your primary care physician in order to provide the best and most appropriate care for you. We also expect patients to take an active role in their care and work within the guidelines that the clinic operates.

Appointments

- We will always try to schedule your appointments promptly and at your convenience.
- If you cannot make an appointment, please give more than 24 hours notice. We try to provide courteous and respectful care to our patients, and expect the same in return.
- If you do not show for a scheduled appointment or cancel less than 24 hours before a scheduled appointment, you will be charged a no show or late cancellation fee. These fees are as follows:
    - New patient appointment- $50
    - Follow up appointment- $25
    - Procedure appointment (including but not limited to injection, ultrasound, EMG, infusion, prolotherapy)- $100
    - Regenerative Medicine Procedure appointment (including but not limited to Platelet Rich Plasma and Stem cell treatments)- $350

Arrive 15 minutes before your scheduled appointment time in order to properly check in and prepare for your visit.

- Refills/Prescriptions given at the time of your visit
- Our Office will not fax or phone in any prescriptions to your pharmacy. All prescriptions are sent electronically to your pharmacy so you will not receive any paper prescriptions.
- Please make sure to ask for refills before leaving the office.
- We do not fill routine refill requests via the phone, fax, or email.
- You may be due for another appointment if you're due for refills, so please schedule one.
- Laboratory Test Results, X-ray Results or any Medical Testing Results
    - Our office does not give any testing results via the phone, fax or email.
    - Follow up appointment is needed to obtain any and all results that were ordered by your physician.

If you have any suggestions on how to improve your experience in the clinic, please let us know.

Patient Name:_______________________________________Date:______________

Patient Signature:____________________________________

Person Signing for Patient:______________________________Date:______________

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Below you will find a list of our office billing policies. These are NON- NEGOTIABLE Policies and apply to every patient account.

Let us know if your insurance has changed in any way, even if only your policy number. We need this information in order to properly write for your medications, labs and radiology tests. We also require the patients social security number for this as well. Your record will not be seen or shared with any outside facility. Our records are completely private.

- If you are a member of an HMO, please make sure your primary care physician provides us with an authorized referral for your visit.
- Our office does require some form of banking/credit or debit account be kept on file with our office.
- To establish care you must read and sign our financial policy.

REFERRAL before your appointment.

- You will be responsible for obtaining all required referrals for your office visit(s). If you are seen in our office without a referral you are responsible for the total cost of your visit.

Co-payments/Insurance cards/Photo ID are expected at the time of check-in.

- Cash and/or credit cards are the only method of payment accepted by our office for your co-payment. If you are unable to provide your co-payment at the time services are rendered you will be asked to reschedule your appointment.

- You must have a current copy of your insurance card at every visit to be seen by the physician.

- You must provide a current photo ID at every visit to be seen by the physician.

Insurance/Billing/Financial Policy for Chicago Arthritis

General Rheumatology Services

Our clinic participates in many insurance health care plans. If you are unsure if this practice is in network with your specific health insurance carrier and your specific health insurance plan/policy, we encourage you to contact your respective health insurance company for clarification. If you are covered by one of our accepted insurance plans, and can provide a valid insurance card or other evidence of coverage, we will bill your insurance for your rheumatology services. You are responsible for providing us with your most current copy of insurance card at the time of service. Illinois State law requires insurance carriers to pay claims within 30 days of reception. Insurance carriers who fail to comply with these state standards are subject to additional requirements and penalties. Many, in fact most, insurance carriers have been very slow in reimbursing physicians for services rendered and are therefore not in compliance with these regulations. In situations when your insurance carrier pays its portion and leaves you accountable for the remaining payment portion, you will be accountable to submit this payment within 30 days from receipt of our billing statement. If your insurance carrier delays or withholds payment for 90 days or longer, both the insurance and patient portions will become your responsibility. If your account is more than 90 days past due, it may become your responsibility to pay the remaining portion that appears on your patient account statement. You will be billed for the total account balance, and if not paid within 90 days, your account will be sent to a collection agency. Payment plans are available if needed. If you intend to set up a payment plan with our office Payment plans are available for a six month time period. After the expiration of the six month time period your account is expected to be paid in full. You must contact our office within 30 days following the receipt of the patient responsibility statement. We strongly suggest you monitor your personal account with us, contact our Billing Department at 773-897-5374. As your balance ages beyond 30 days, we

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recommend calling your insurance carrier and request a “claim status report”. If you are not covered by one of our accepted plans, you must pay in full at the time of service. ***Please be aware that there could be additional charges at your office visit including ultrasound, injection, and medication charges if you have any additional procedures done during your visit.*** Many insurance plans do provide reimbursement for “out-of-network” care. Please contact your insurance company as to know how to submit a claim form and the rules governing visits to out-of-network physicians. A complete list of costs associated with office visits can be obtained at the front desk.

Regenerative Medicine Procedures

You must pay in full for your procedure prior to scheduling your procedure. The regenerative medicine procedures are not covered by insurance plans. Regenerative medicine services include, but are not limited to, Initial Consultations, Platelet Rich Plasma, Prolotherapy, Platelet Lysate Injection, and Autologous Mesenchymal Stem Cells. A financial quote for each individual procedure will be provided at your consultation. The quote will be valid for 90 days. If medical decision making is provided for anything other than these regenerative medicine procedures, a fee may be billed to your insurance company. In order to schedule a telephone review for a regenerative treatment, we require that a non- refundable deposit is taken of $250.00 prior to scheduling the appointment.

You are responsible for making sure your billing information and all appropriate referrals and documentation are in place prior to your visit with Siddharth Tambar MD and Chicago Arthritis.

Agreement to Financial Policy: Please remember we directly bill insurance companies as a direct courtesy, to you the patient. We will make our best effort to work with each patient and their insurance provider to reconcile any payment disputes; however there is a limit to the services we can provide due to the high administrative cost involved. Again, we strongly suggest you monitor your account carefully and we will ensure our best effort to make this process as smooth as possible. In order to ensure continuity of care with our practice, we require that you maintain credit card information on our secure database. We understand your concerns with providing us this confidential information but assure you that this information will be kept confidential. You will be given 90 days from the date of your first billing statement to either pay your balance in full or set up a payment plan with our office. We will not charge your credit card during that 90 days time frame as you will have multiple opportunities to pay off any account balances.

Credit Card Information:

Name of Patient: ____________________________ ______________________ ____________

Name of Cardholder: ____________________________ _______________________________

Card Type: ___M/C ___Visa ___Amex ___Discover Expiration Date: __/__CVV #: ______

Credit Card Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Billing Address:____

____

Authorized Signature: _____________________________Date: _________________________

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DebitCard Information:
Name of Patient: ___________________________ _____________________ ____________

Name of Cardholder: ___________________________ ______________________________
Card Type: ___M/C ___Visa ___Amex ___Discover Expiration Date: __/__CVV #: ______

Credit Card Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Billing Address:____
____

Authorized Signature: ____________________________Date: ________________________

Banking Account Information:
Name of Patient: ___________________________ _____________________ ____________

Name of Banking Institution: ____________________Phone Number:______________
Checking Account Number:_____________________ Routing Number:_____________

Billing Address:____
____

Authorized Signature: ____________________________Date: ________________________

I hereby *acknowledge receiving care* and services from Siddharth Tambar MD, and Chicago Arthritis LLC. I authorize Siddharth Tambar MD and Chicago Arthritis LLC to bill the credit, debit card or bank account I have provided above, to keep on file for such services, and agree to take all further actions required to pay the charges in full and to perform the obligations set forth in my agreement with my credit card issuer or bank. I have read, understand and agree to this these policies. (Parent or guardian complete if patient is a minor.)

Patient Name:___________________________________ Date:_________________
(please print)

Patient Signature:________________________________

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Notice of Privacy Practices and Consent to Privacy Practices at Chicago Arthritis

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED ANDDISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected Health Information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your
health care bills, to support the operation of the physician’s practice, and any other use required by law. Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military

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activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information (fees may apply) Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality. You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket. You have the right to request to receive confidential communications – You have the right to request confidential communication 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 i.e. electronically. You have the right to request an amendment to your protected health information – 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 – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations;
required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request. You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached. You have the right to obtain a paper copy of

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this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

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 Officer of your complaint. We will not retaliate against you for filing a complaint.

Privacy Officer:
Rachel Gilley
1-773-348-7171
2800 North Sheridan Road, Suite 308
Chicago, Illinois 60657

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 protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Privacy Officer in person or by phone at our main phone number. Please sign the accompanying “Acknowledgment” form.

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Billing Policy changes regarding Banking Information

Beginning in January 1, 2014, Chicago Arthritis will begin placing patient credit cards on file. Transaction Express will be the credit card transaction company that we will be utilizing. Transaction Express stores your information on a separate and secure site and enables us to run credit card transactions within our computer system. Office personnel will not have access to your card, and only the last 4 digits of your card will be viewable in our system. Transaction Express is certified as a Level One Service Provider with
the Payment Card Industry (PCI) Data Security Standard, They are audited as well as our office and scanned for PCI compliance and is regularly scanned for vulnerabilities by Controls can and as credentials as follows:

- **Approved Scanning Vendor** - As an Approved Scanning Vendor (ASV), Control Scan is positioned to help businesses comply with the Payment Card Industry Data Security Standards' (PCI DSS) vulnerability scanning requirement. With data security compromises on the rise, it is critical that business owners' systems are scanned regularly by a certified scanning vendor.
- **Qualified Security Assessor** – Control Scan is a Qualified Security Assessor (QSA) which certifies that we are qualified to assess and validate an organization's compliance with the PCI DSS standard. The PCI Security Standards Council maintains an in-depth and on-going certification process for companies seeking QSA certification.

Effective January 1, 2014 and forward, all New Patients will be required to have a credit card on file. We appreciate your cooperation and assistance in this process.

Credit cards on file will be used for:

- **Unpaid Patient balances that are over 90 days past due**

  If your insurance carrier assigns any additional patient responsibility amounts, we will run the credit card on file for this amount after 90days from the date of your first billing statement from our office. For all patient responsibility amounts assigned by insurance, our office reviews these amounts to ensure your claim has been properly adjudicated. If what is adjudicated by insurance company does not match your benefits we verified with insurance at the time of service, we will contact you and your insurance carrier. Members typically receive their explanation of benefits prior to the provider, so if you disagree with the patient responsibility amount owed, it is your responsibility to contact your insurance carrier immediately. In a 90 day period will have the opportunity to pay your balance(s) in full or set up a payment plan with our office. Our office will always inform when your credit card on file is being charged for any outstanding balances.

- If your credit card is mistakenly run, we will immediately issue you a refund back on the credit card you have on file.
- During the time you leave a credit card on file, if it expires or otherwise becomes uncollectible, we will expect you to promptly provide a new means of payment.

Know your insurance benefits. Your insurance plan is a contract between you and your insurance company, even if your employer provides it. We provide the medical service and submit the claim on your behalf. We do

our best to verify your benefits prior to the appointment (sick or well) to make sure we collect the appropriate amount owed and to make sure your visit will be covered by your insurance plan. We do our best to notify and educate the patient of any learned information from insurance that may affect the visit**. However, it remains the policy holder's responsibility to know their insurance policies Chicago Arthritis cannot know every detail to your specific plan. Ultimately, you are responsible for knowing what services are covered, how often, and how much of the cost is your responsibility**. You will be responsible for any portion of services that your insurance does not cover. The policy holder should familiarize themselves and those bringing in their children for service with the insurance policy and any specific c laboratory requirements should a sample need to be submitted to the lab for analysis.

As we never expect to have a breach to our EMR system or our payment processing system, If ever there is a breach to the Transaction Express processing server from our office or on the part of Transaction Express you will be notified of the breach within 24 hours of our office being made aware of such event. Please visit the below link for more information PCI compliance and standards.

https://www.pcisecuritystandards.org/organization_info/index.php

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