



REGISTRATION FORM

PLEASE FILL OUT ALL SECTIONS completely

Name: _____ I Prefer to be called: _____

Date _____

Address: _____ City: _____

State: _____ Zip _____

Phone: Home (____) _____ Cell (____) _____ Work (____) _____

Preferred Contact Phone Number is my: Home Phone Work Phone Cell Phone

Gender: Male Female

Date of Birth: _____

Social Security Number:(this is required for billing purposes) _____

Email: _____ (This is required to communicate with our office via email and our patient portal)

Would you like to joint our email newsletter list? Yes No

Check Appropriate Box: Widow Single Married Partnered Separated Divorced

Ethnicity Caucasian African American Asian Native American Other _____

Preferred Language Spoken _____

Employer _____ Work Phone _____

Person to contact in case of emergency _____ Phone _____

Preferred Pharmacy (name, address, phone number): _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Who referred you to our office: _____

You must provide a valid picture ID and your insurance card at the time of each visit along with any referrals require by your Insurance company.



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/eyes Chest pain Shortness of breath
- Palpitations Heartburn Abdominal pain Nausea/vomiting Diarrhea
- Blood in stool Pain with urination Weakness Numbness Tingling
- Rash Purple fingers in cold

Activity Level: Check any of the following you have DIFFICULTY with:

- Bathing Toileting Cooking Cleaning Exercise Other (describe)

Please describe your current weekly exercise regimen:

Personal Medical History

- Osteoarthritis Tendinitis Rheumatoid arthritis Psoriasis/Psoriatic arthritis
- Ankylosing spondylitis Gout/Pseudogout Osteoporosis Lupus
- Myositis Scleroderma Heart disease Cancer Thyroid
- Asthma/COPD High blood pressure High cholesterol Diabetes Fibromyalgia
- Kidney disease Heart burn
- Other (Please list) _____

Surgical History: _____

Current Medications: _____

Medication Allergies: _____

Employment: Fulltime Part time Retired Homemaker Disabled

Occupation: _____

Smoking History:

Smoking status: Non Smoker Former Smoker Current Smoker - Amount per day: _____

Alcohol use: No Yes- Amount: _____

Illegal drug use: No Yes- List: _____

Height _____ **Weight:** _____

Family History

- Rheumatoid Arthritis Osteoarthritis Psoriasis Lupus Vasculitis Gout Other

Do Not Fill In (for office use only)

BP _____ HR _____ Ht _____ Wt _____
 Medicare Public Aid Cash pay HMO _____ INS Carrier _____ Primary Secondary



House Rules

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

-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

-With your written consent you have access to your medical records from our office. However we do not routinely give test results via the phone, fax or email.

-Follow up appointment is needed to discuss test results, interpretation, and plan with the physician.

Financial Policy

Acceptance of our financial policy is mandatory in order to be seen in our clinic. This includes having a credit or debit card on file with our office to cover any outstanding account balances. We comply with all appropriate state, federal, and medical regulations regarding protection of your information and privacy.



INSURANCE AND BILLING POLICIES:

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

1. 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.
2. If you are a member of an HMO, please make sure your primary care physician provides us with a REFERRAL before your appointment.
 - a. *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.*
3. Co-payments 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.
4. You must have a current copy of your insurance card at every visit to be seen by the physician.
5. Our office makes every attempt to obtain payment from your insurance company in a timely manner.
6. Our office will contact you if there is ever any issue with our office receiving payment from your insurance company. If there are any problems receiving payment from your insurance company:
 - a. You will have 30 days from the day of the denial to correct any issues with your insurance company that may be preventing our office from receiving payment.
 - b. Our office will only bill your insurance company within a 90 day period after the date of the corresponding visit. After 90 days, if your insurance company has not paid your claim, payment is expected from you (the patient) in full. Our office will then provide you with the appropriate billing codes in order to bill your insurance company directly.
7. Billing Statements are sent out the first of every month (30 day cycle).
8. Within 90 days of your first billing statement you will have to complete one of the two options listed below.
 - a. Pay your account balance in full.
 - b. Set up a payment plan.
9. Failure to comply will result in your account being sent to a collection agency.
10. Once your account is in collections you will be required to make payment directly to the collection agency.
11. We require a form of payment on file, either credit or debit card, in case your account is over 90 days unpaid in which case your card will be charged for any outstanding balance.



Financial Policy

General Rheumatology Services

Our clinic participate 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. 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. 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 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 determine 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 Platelet Rich Plasma, Prolotherapy, Platelet Lysate, Bone marrow aspirate concentrate, and other Regenxx injection treatments. A financial quote for each individual procedure will be provided at your consultation. The quote will be valid for 90 days.

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 House rules, Financial, Billing, and Insurance Policies

We will make a best effort to work with each patient and their insurance provider to reconcile any payment disputes. We strongly suggest you monitor your account carefully and we will ensure our best effort to make this as smooth a process 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 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 (Last, First, MI) _____

Name of Cardholder (Last, First, MI) _____

Card Type: ___ M/C ___ Visa ___ Amex ___ Discover Expiration Date: ___ / ___ CVV #: _____

Credit Card Number: _____

Billing Address: _____

Phone Number: _____

Authorized Signature: _____ Date: _____

I hereby acknowledge receipt of the services, authorize Siddharth Tambar MD and Chicago Arthritis LLC to bill the credit card 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. I have read, understand and agree to this policy. (Parent or guardian complete if patient is a minor.)

By signing below I hereby acknowledge I have read all of the above in its entirety and agree to the house rules, financial polices, and insurance/billing policies of Siddharth Tambar MD and Chicago Arthritis.

Print Name

Date

Signature



Advance Beneficiary Notice (ABN)

As a consumer of healthcare services, you are responsible for understanding your own benefits. By signing this document, you acknowledge that you are responsible for any relevant co-pays, deductible, and coinsurance costs that may be incurred.

The below list of services represents your full treatment plan as recommended by your physician along with the charge that will be submitted to your insurance. You will be responsible for any co-pays, deductibles, and coinsurance in accordance with your benefits.

Service	Cost

Name (Printed): _____

Signature: _____

Date: _____

NOTE: Your health information will be kept confidential. Any information that we collect about you will be kept confidential according to relevant privacy laws. When a claim is submitted to your insurance, it will contain information relevant to your condition and treatment. This information will be kept confidential by your insurance carrier.



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

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 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 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 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:

1-773-348-7171

618 West Fulton street

Chicago, Illinois 60614

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. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Acknowledgment of Notices of Privacy Practices

I, _____ have received a copy of the Notice of Privacy Practice at Siddharth Tambar MD and Chicago Arthritis, and I consent to the above privacy practices.

Signature Parent/Guardian (if necessary)

Date

Zoom.com Instructions

1. We will be emailing and texting you an invitation containing a Zoom Meeting Link to access your TeleHealth appointment. Please be in a private location with a reliable internet connection for your appointment.
2. Click the link five minutes prior to your appointment.
If you are using a computer, you are ready for your appointment.
If you are using your mobile device, you will be prompted to download the Zoom app. The app is free and very easy to use!
3. For Android users, you will be prompted to download Zoom from the Google Play Store. Please select "Google Play Store" and then, "Install."
4. For iOS users, you will be prompted to download Zoom from the App Store. Press "Install." You may need to double click the side button to authorize download.
5. Exit the app, and click the Zoom Meeting Link once again. You will automatically be redirected to the meeting. Enable the Video and Audio for your session.

You're ready for your appointment!

Example of Zoom link:

Siddharth Tambar MD is inviting you to a scheduled Zoom meeting.

Topic: TeleHealth Visit with Dr. Tambar - New Patient Evaluation

Time: Mar 24, 2020 02:00 PM Central Time (US and Canada)

Join Zoom Meeting Link:

<https://zoom.us/j/713832407?pwd=ZGwyM2tGa1NMeCtMMnZSWmhrV0ZJZz09>

Meeting ID: 713 832 407

Password: 704872