Reviewed by/Date:_____ Patient Name:_____

# Advanced Rheumatology of Houston

Offices of Dr. Tamar F Brionez

## New patient history form

**Patient name** _____ **DOB**_____

**Allergies to Medicines:** _____

**Current Medications**

| Name | Dose | Times/day taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Social History**

Married/single/widowed/divorced

Number of pregnancies_____ live births_____

Occupation_____

Highest level of education_____

Drug use Y/N, if yes_____

Alcohol consumption (avg # drinks/week)_____

Tobacco Use (packs per week/day)_____

**Medical History**

Please check off all applicable personal medical diagnoses received by a doctor

□ High blood pressure □ Heart disease □ Diabetes

□ Thyroid disease □ Kidney problems □ COPD/asthma

□ Reflux □ Stomach ulcers □ Liver problems

Autoimmune Disease (Lupus/RA/Sjogrens/Vasculitis)_____

Frequent infections (please specify)_____

Other_____

Reviewed by/Date:_____ Patient Name:_____

**Surgical History (please list surgeries and dates)**

| Surgery | Date |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Family History (please list age and health conditions)

Mother - Alive/Deceased _____

Father - Alive/Deceased_____

Siblings

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Family with an autoimmune condition (lupus, rheumatoid arthritis) – yes/no

If yes, please list _____

I verify that this information is both complete and accurate.

Patient Signature:_____Date:_____

Reviewed by/Date:_____ Patient Name:_____

# Advanced Rheumatology of Houston

Offices of Dr. Tamar F Brionez

## Patient Registration


6707 Sterling Ridge Drive, Suite C
The Woodlands, TX 77382

17115 Red Oak Drive, Suite 210A
Houston, TX 77090

Office: 281-766-7886
Fax: 281-719-9320
www.advancedrheum.com


**( ) No change in address, phone number**

Name: (Last)_____(First)_____(Middle)_____

Address:_____

City:_____State:_____Zip:_____Country:_____

Birthdate:_____Phone:_____Work:_____Fax:_____

Contact by: Phone Mail Fax Email:_____Sex: M/F

Marital Status: Single/Married/Divorced/Widowed/Separated/Other SSN:_____

Race: Black/Hispanic/Native American/Oriental/Asian/White/Chinese/Filipino/Native Hawaiian

Multiracial/Pacific Islander/Japanese

Language:_____

Employment Status: Full-time/Part-time/Self-employed/Retired/Student/Child/Unemplyed/Other

Responsible Party (Party Responsible for payment): Self/Spouse/Parent/Other

Name: (Last)_____(First)_____(Middle)_____

Address:_____

City:_____State:_____Zip:_____Country:_____

Phone:_____Work:_____Fax:_____Email:_____

**( ) No change in insurance information since last visit**

Primary Insurance:_____

Insured Party: Self/Spouse/Parent/Other Group #:_____ID:_____

Name: (Last)_____(First)_____(Middle)_____

Address:_____

City:_____State:_____Zip:_____Country:_____

Phone:_____Work:_____Fax:_____

Secondary Insurance:_____

Insured Party: Self/Spouse/Parent/Other Group #:_____ID:_____

Name: (Last)_____(First)_____(Middle)_____

Address:_____

City:_____State:_____Zip:_____Country:_____

Phone:_____Work:_____Fax:_____

Reviewed by/Date:_____ Patient Name:_____

# Advanced Rheumatology of Houston

Acknowledgment of Financial Responsibility

This office does not accept responsibility for collection you insurance proceeds or for the negotiating settlement of a disputed claim. If for whatever reason your insurance company does not pay your claim in full, you are responsible for payment of the entire balance including any finance charges or collection fees that may be included.

Signature:_____ Date:_____

Assignment of Benefits

I hereby assign all medical benefits payable for serviced provided by Advanced Rheumatology of Houston including Medicare, private insurance and any other health plans to Advanced Rheumatology of Houston. I further authorize a release of any medical information necessary to process the claim and payment of benefits. A photocopy of this assignment is to be considered as valid as an original. This assignment remains in effect until I revoke in writing.

Signature:_____ Date:_____

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

X_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Reviewed by/Date:_____ Patient Name:_____

# Advanced Rheumatology of Houston

Offices of Dr. Tamar F Brionez

## Authorization for Disclosure of Confidential Information


6707 Sterling Ridge Drive, Suite C
The Woodlands, TX 77382

17115 Red Oak Drive, Suite 210A
Houston, TX 77090

Office: 281-766-7886
Fax: 281-719-9320
www.advancedrheum.com


Patient Name_____

Address_____

Date of Birth_____SSN_____

Authorizes: Name of Person/Facility_____

Address or Fax Number_____

To release the following medical information to **Advanced Rheumatology of Houston.**

Check All that May be released:

| | | | |
|---|---|---|---|
| □ History | □ Lab Reports | □ Operative Report | □ Psychological Reports |
| □ Physical | □ X-ray | □Care Plan | □ Progress Notes |
| □ EKG Report | □ Therapy Reports | □ Other (specify)_____ | |

Note: Memorial Hermann patients mus initial the following statement:
"I acknowledge and hereby consent to such that the released information may contain alcohol, drug abuse, psychiatric, HIV Testing, HIV results, or AIDS information" INITIAL HERE_____

This authorization covers patient care rendered from _____ to _____ (dates)

Purpose of Disclosure:

□ Medical Care □ Insurance □ Attorney □ Other (specify)_____

The authorization shall be valid for ninety (90) days from the date of signature below, unless revoked in writing by the patient prior to that expiration.

The patient agrees that a photocopy of this authorization may be considered valid.

□ Yes □ No

Patient Signature:_____Date:_____

Reviewed by/Date:_____ Patient Name:_____

## ADVANCED RHEUMATOLOGY OF HOUSTON

Offices of Dr. Tamar Brionez

I,_____, hereby authorize the following person/people full access to my medical records and allow them to receive medical phone messages from the clinic. I also allow the following individual(s) to speak with Dr. Brionez in regards to all my medical information, testing results, and medical decision making.

1._____

2._____

3._____

4._____

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## ADVANCED RHEUMATOLOGY OF HOUSTON

Offices of Dr. Tamar Brionez

**( ) NO CHANGE IN PHARMACY INFORMATION SINCE MY LAST CLINIC VISIT**

So that we may better serve you, please provide the following pharmacy information:

Pharmacy name: _____

Street address: _____

City:_____

Zip code:_____

Advanced Rheumatology of Houston – Notice of Privacy Policy

**Federal Law requires that we provide our patients with a Notice of Privacy Practices (NPP).**

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.

Your health information is personal and Advanced Rheumatology of Houston is committed to protecting it. In order to provide you with quality care, we need to use and disclose your health information. We are dedicated to maintaining the privacy of your health information (also known as "protected health information" or "PHI") that is in the possession of Advanced Rheumatology of Houston in accordance with applicable state and federal law. As required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), we are providing you with this Notice of our privacy practices. Advanced Rheumatology of Houston is required to follow the terms of this Notice or any revision to it that is in effect. This Notice is effective on and after June, 7, 2012, unless and until it is revised by Advanced Rheumatology of Houston.

1) **How We May Use and Disclose Your Protected Health Information.**
   Advanced Rheumatology of Houston is generally required to obtain your prior written authorization to disclose your PHI and, in certain circumstances, to use your PHI. There are, however, instances where we may use or disclose your PHI without your prior written authorization. The following are examples of instances where we may use or disclose your PHI without your prior written authorization and/or without providing you with the opportunity to object to such use or disclosure.
   a) Uses and Disclosures that Do Not Require Your Authorization. We may use and disclose your PHI in the following circumstances without your prior written authorization:
      i) We may use or disclose your PHI to provide treatment to you or for others to provide treatment to you. We may disclose your PHI to physicians, nurses, other health care personnel, hospitals, nursing homes and other health care facilities who are involved in your care. For example, we may disclose your PHI to hospitals or other facilities outside of Advanced Rheumatology of Houston to schedule procedures. We may also use your PHI to contact you to remind you that you have an appointment for treatment at our facility, or to tell you about or recommend possible treatment options or alternatives, or about health-related benefits or services that may interest you.
      ii) We may also use or disclose your PHI to your insurance company in order to receive payment for the treatment or services provided to you. For example, we will use your PHI to create the claims we submit to your insurance company, or we may provide copies of portions of your medical record to your insurance company to obtain payment of your claim or for the insurance company to determine pre-existing conditions. We may also disclose your PHI to another health care provider or insurance company for their payment-related activities to enable them to receive payment for the treatment or services provided to you or to process claims under your health insurance plan.
      iii) We may also use or disclose your PHI for our operations related to health care. For example, we may use your PHI to evaluate the quality of care you received from us, or to evaluate the performance of those involved with your care. We may also provide your PHI to our attorneys, accountants and other consultants to make sure we are complying with the laws that affect us. In addition, we may disclose your PHI to another health care provider, health insurance plan or health care clearinghouse for purposes of their operations related to health care.
   b) Uses and Disclosures that Require Us to Give You the Opportunity to Object. Unless you object, we may provide relevant portions of your PHI to a family member, friend or other person involved in your health care or in helping you get payment for your health care. For example, unless you object, statements sent to your home contain billing information for all members of your family who have had services at Advanced Rheumatology of Houston. In an emergency or when you are not capable of agreeing or objecting to these disclosures, we will disclose your PHI as we determine is in your best interest. Unless you object, we may also disclose your PHI to persons performing disaster relief activities.
   c) Other Uses and Disclosures that Do Not Require Your Authorization or Opportunity to Object. We may also use and disclose PHI without your authorization or without providing you with the opportunity to object in the following circumstances:
      i) As required or permitted by law. We may disclose your PHI to legal authorities, such as law enforcement officials, court officials, correctional institutions or government agencies, when required to do so by law. For example, we may have to disclose your PHI to report abuse, neglect or a crime to a governmental agency. We also may disclose your PHI in response to a court order.
      ii) For public health activities. We may be required to report your PHI to authorities to help prevent or control disease, injury, or disability. This may include using your medical record to report certain diseases, injuries, birth or death information, information of concern to the Food and Drug Administration or information related to child abuse or neglect. We may also have to report to your employer certain work-related illnesses and injuries for workplace safety purposes.
      iii) For health oversight activities. We may disclose your PHI to authorities and agencies for oversight activities authorized by law, including audits, investigations, inspections, licensure, disciplinary actions or legal proceedings. These activities are necessary for oversight of the health care system, government programs and civil rights laws.

iv) For activities related to death. We may disclose your PHI to coroners and medical examiners so they can carry out their duties related to your death, such as identifying the body or determining cause of death, and to funeral directors to carry out funeral preparation activities.

v) For organ, eye or tissue donation. We may disclose your PHI to organ procurement agencies who are involved in obtaining, storing or transplanting organs, if you have indicated your desire to be a donor.

vi) For medical research. In limited circumstances, we may disclose your PHI to researchers affiliated with Advanced Rheumatology of Houston who request it for medical research projects that have received IRB approval. However, these disclosures must receive special approval before any PHI is disclosed to such researchers. The IRB will require the researchers to safeguard the PHI they receive from us.

vii) For workers' compensation. We may disclose your PHI in order to comply with the laws related to workers' compensation or other similar benefits for work-related injuries or illness.

Except as described above, we may only use and disclose your PHI with your written authorization. If you give us a written authorization, you may revoke it at any time by notifying our Medical Information Department in writing. If you revoke your authorization, we will no longer use or disclose your PHI for the purposes specified in the authorization, except to the extent we have already taken action in reliance upon your authorization.

2) **Other Restrictions**

Please be aware that state and federal law may have more requirements than HIPAA on how we use and disclose your PHI. If there are more restrictive requirements, even for some of the purposes listed above, we may not disclose your PHI without your signed authorization as required by these laws. For example, we will not disclose your HIV test results without obtaining your written authorization, except as permitted by state law. There may be other restrictions on how we use and disclose your PHI other than those listed above. These laws may change from time to time. Please contact our Privacy Officer, if you have any further questions.

3) **Your Rights Related to Your Protected Health Information**

You have the following rights as a patient or customer of Advanced Rheumatology of Houston:

i) The Right to See and Copy Your PHI. Except for limited circumstances, you may look at and receive a copy of your PHI by providing Advanced Rheumatology of Houston with a written request. Such requests must be submitted to our Medical Information Department. We will respond to your request within 30 days (or 60 days if we provide written notice that extra time is needed). In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain your rights with regard to having the denial reviewed. If you ask us to copy your PHI, we will charge for those copies based on the purpose and any regulatory directives. Alternatively, we may provide you with a summary or explanation of your PHI, as long as you agree to that and to the cost, in advance.

ii) The Right to Correct or Update Your PHI. If you believe that the PHI we have in our records for you is incomplete or incorrect, you may ask Advanced Rheumatology of Houston to amend it. Such request must be made in writing to our Privacy Officer. The request must tell us why you think the amendment is appropriate. We will not process your request if it is not in writing or does not tell us why you think the amendment is appropriate. We will act on your request within 60 days (or 90 days if we provide written notice that extra time is needed). We will inform you in writing as to whether the amendment will be made or denied. If we agree to make the amendment, we will ask whether you want us to notify anyone else of the amendment. If we deny the requested amendment, we will tell you in writing how to submit a statement of disagreement and/or to request inclusion of your original amendment request in your PHI.

iii) The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI for disclosures made on or after April 14, 2003. To receive the list, you must make your request in writing to our Medical Information Department. We will respond to your request within 60 days (or 90 days if we provide written notice that extra time is needed). The list will include disclosures made during a period of up to six years unless you specify a shorter period. The first list you request within a 12-month period will be free. You may be charged our costs for providing any additional lists within that 12-month period. Please be aware that the list will not include disclosures: (1) made for treatment, payment and health care operations purposes; (2) that are a byproduct of another use or disclosure permitted under our privacy policies or by law; (3) made with your authorization; (4) made directly to you or to your family or friends; (5) for disaster relief purposes; (6) for national security purposes or to law enforcement personnel/correctional institutions; (7) made as a part of a release of limited information; (8) made before April 14, 2003.

iv) The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask us to limit certain uses and disclosures of your PHI. Such requests must be submitted in writing to our Privacy Officer. We are not required by law to agree to your request. If we do agree, we will abide by the agreement except if you require emergency treatment.

v) The Right to Choose How We Communicate With You. You have the right to request that we contact you at an alternate address, phone numbers or location (for example, at work rather than at home). If we can accommodate your request without disrupting our operations, your request will be honored.

vi) The Right to Get a Paper Copy of This Notice. Regardless of how you have received this Notice, you are entitled to receive a paper copy. You may obtain a paper copy of this Notice by contacting our Privacy Officer at 303-995-9435. The Notice is also available in our Registration area.

4) **Contact for Questions and Concerns**

If you believe your privacy rights have been violated, you may file a complaint with Advanced Rheumatology of Houston or with the Secretary of the federal Department of Health and Human Services. To file a complaint with us, put your complaint in writing and submit it to our Privacy Officer at Advanced Rheumatology of Houston, 17115 Red Oak Drive, Ste 210, Houston, Tx 77090. We will not retaliate against you for filing a complaint. You may also contact our Privacy Officer if you have questions or comments about our privacy practices.

5) **Future Changes to Our Practices and this Notice**

We reserve the right to change our privacy practices described in this Notice as allowed by law. Changes to our privacy practices would apply to all PHI we maintain. You may obtain a copy of any revised Notice by contacting our Privacy Officer at 303-995-9435. We will also make any revised Notice available in our registration area.

I acknowledge that I have read and understand the above HIPAA Privacy Policy.

Signature_____Date_____

# How did you hear about us?

□ Internet search

□ Community Impact

□ Telephone Book

□ Referral - Doctor's name:_____

□ Friend

□ Other:_____