The Cohen Medical Centers
Rheumatology, Arthritis & Osteoporosis Center
566 St. Charles Drive
Thousand Oaks, CA 91360
Phone: (805) 449-8781 Fax: (805) 449-4224

Dear Patient:

Thank you for choosing The Cohen Medical Centers for your Rheumatology care. Please review and complete all enclosed documents prior to your appointment to expedite your check-in process. Please remember to bring your completed forms, insurance cards, driver's license, and COPIES of any recent labs or imaging reports. If it is easier for you, you may have them faxed to our office before your scheduled appointment.

Our office will usually confirm each appointment the day before so please make sure to provide accurate contact information and report any changes as soon as possible. Each appointment time is scheduled for one patient in an effort to provide appropriate attention and care. Please provide our office with at least a 24-hour notice should you need to cancel or reschedule your appointment. If you miss an appointment without giving advanced notice, you will be charged up to $50 for each missed appointment.

Co-payment amount, if applicable, will be collected at the beginning of each visit. Our office accepts cash, check, Visa and MasterCard. Please note that a $25 fee will be charged for any bounced or cancelled checks.

Our providers will not be able to provide care for any patient who declines to sign the Medical Services Agreement and Privacy Practices Form.

We look forward to meeting you and assisting you with your medical needs. Please contact our office should you have any further questions or concerns.

Sincerely,
The Cohen Medical Centers

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OFFICE HOURS

Monday – Friday: 8:00 am to 5:00 pm

We are **CLOSED** for lunch from 12:00 pm to 1:00 pm

Phones are open from 9:00 am to 12:00pm and 2:00 pm to 5:00 pm

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SCHEDULING APPOINTMENTS

Call our office during normal phone hours to make an appointment.

Any patient 15 minutes (or more) late will forfeit their appointment and will need to reschedule for a late date.

There is a $50 charge for missed appointments and appointments not cancelled at least 24 hours in advance.

PRESCRIPTIONS

For any **new** prescriptions, please call the office with medication name, dosage, directions and your pharmacy's name and phone number.

For all refills, have the pharmacy fax over a refill request form.

For any controlled substance prescriptions, please give a 72 hour notice before the fill date.

MEDICAL RECORDS AND FORMS

All requests for medical records made by another healthcare provider will be faxed to the requesting provider free of charge.

Patient requests for medical records will incur a $35 charge.

Disability forms may be completed for a fee of $35 charge.

BILLING

For all billing-related questions, please call 800-626-2468.

We accept cash, check, Visa, and MasterCard.

All copays and balances are due at the time of service.

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NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. At Shariar Cohen, MD, A Medical Corporation, we will always keep your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice, and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, reviews of your file by a doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may share your medical information with our business associates, such as our billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. We may also call and remind you of your appointments. If you are not home we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner. We may also create and distribute de-identified health information by moving all references to individually identifiable information.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we do not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any use or disclosure we make with your health information beyond the above normal uses.

You have the right to transfer charts and reports to another practice. There may be a fee associated with this transfer. You have the right to request an amendment or change to your health information. You must make this request in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make changes you request, but we will be happy to include your statement in your file. If we agree on amendment or change, we will not remove nor alter earlier documents, but will add new information.

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I acknowledge that I have received, read, and understand the NOTICE OF PRIVACY PRACTICES governed by the Health Insurance Portability and Accountability Act (HIPAA).

Name: _____

Signature: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Privacy Practices Notice, but could not obtain it for the following reason:

____ 1. Individual refused to sign.

_____ 2. Communication barriers prohibited acknowledgement.

_____ 3. An emergency situation prevented us from obtaining acknowledgement.

_____ 4. Other (please specify): _____

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MEDICAL SERVICES AGREEMENT

Patient's Name: _____

1. **MEDICAL CONSENT**: I consent to any medical treatments or procedures which may be performed on an outpatient basis (including emergency treatment or services), which may include, but are not limited to, medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the physicians, staff, or other health care providers of SHARIAR COHEN, MD, A Medical Corporation (herein referred to as "SHARIAR COHEN, MD") assisting my care.
2. **FINANCIAL AGREEMENT: I understand that all charges are due at the time of service.** I agree to pay SHARIAR COHEN, MD for all charges for healthcare services and professional services provided to me by physicians and other healthcare professionals. Acceptable forms of payment include cash, check, Visa, MasterCard, and debit card. If I am a non-insured patient, I agree to pay for my visit in full at the time of service. If SHARIAR COHEN, MD is a participating provider with my insurance company I understand that my co-pay, coinsurance, deductible and/or any outstanding balances are due at the time of service.

   I understand that my insurance policy is a contract between myself and my insurance company; SHARIAR COHEN, MD is not involved. In order for SHARIAR COHEN, MD to file claims and accept payments from my insurance company, I understand that I must present current insurance information at each visit and that SHARIAR COHEN, MD will need to verify my health insurance coverage. In the event that SHARIAR COHEN, MD is not able to verify my insurance eligibility and benefits before my visit, I agree to pay for my visit in full at the time of service. A refund will be issued if my insurance pays for the visit. I also understand that I am financially responsible for any services not covered by my insurance company. When my spouse or a financial guarantor signs this agreement, the spouse or the financial guarantor shall be jointly and individually liable with me. Should my account(s) be referred to an attorney or a collection agency for the collection, the undersigned shall pay the actual attorney's fees (including costs) and collections expenses incurred in addition to the other amounts due. Unpaid accounts referred to outside agencies for collection shall bear interest at the current rate per year from the date of referral.
3. **INSURANCE AUTHORIZATION AND RELEASE:** I request that payment of authorized benefits, including Medicare, and any other government sponsored program, private insurance, and any other health plans be made to SHARIAR COHEN, MD for any services furnished by that provider. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize SHARIAR COHEN, MD to disclose portions of or all of my records to any person or corporation which is or may be liable for all or any portion of SHARIAR COHEN, MD's charges, including but not limited to insurance companies, health care service plans, government agencies, or worker's compensation carriers. I authorize SHARIAR COHEN, MD to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give SHARIAR COHEN, MD any information required to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.
4. **RELEASE OF MEDICAL INFORMATION:** I hereby authorize SHARIAR COHEN, MD to release any information in my chart to any practitioner, doctor, hospital, or medical institution to whom I may be referred to assist in my care. Additionally, I authorize any request for medical information from any medical practitioner, doctor, hospital, or medical institution to assist in my care.
5. **PERSONAL VALUABLES:** SHARIAR COHEN, MD shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs, or other articles of unusual value and shall not be liable for loss or damage to any personal property. SHARIAR COHEN, MD, A Medical Corporation and the patient or the patient's representative, hereby enters into this agreement. The undersigned certifies that he/she has read and agreed to the foregoing, received a copy, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

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_____ _____ _____
Signature of Patient Date or Signature of Patient's Representative & Relationship Date

_____
Office Representative Signature Date

PATIENT INFORMATION SHEET

Last Name: _____ First Name: _____ MI: ____

DOB: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Email Address: _____

Driver's License Number: _____ Issuing State: _____

Employer: _____ Occupation: _____

Emergency Contacts:

1. Name: _____ Relationship: _____ Phone Number: _____

2. Name: _____ Relationship: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

Primary Insurance Coverage:

Company: _____ Effective Date: _____ Group Number: _____

Policy Number: _____ Phone Number: _____

Secondary Insurance Coverage:

Company: _____ Effective Date: _____ Group Number: _____

Policy Number: _____ Phone Number: _____

**** If you are covered under the policy of a spouse, partner, parent or legal guardian, please complete the following information:**

Last Name: _____ First Name: _____ MI: ____

DOB: _____ Social Security Number: _____

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Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Employer: _____ Occupation: _____

HEALTH QUESTIONNAIRE

Name: _____ DOB: _____ Today's Date: _____

Please give a brief Rheumatologic history including your chief complaint, the onset, current symptoms, any triggers to those symptoms, and any alleviations.

_____

_____

_____

_____

_____

_____

_____

_____

Please provide a brief previous medical history including previous diagnoses, major surgeries or major illnesses along with the dates and treatments (if possible).

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Please list any hospitalizations you have had along with the reason, date, and treatments.

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

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Please list any drug ALLERGIES that you have and the reaction that occurred:

1. _____ 2. _____

3. _____ 4. _____

Please circle the following medications that you have tried in the past:

Biologics/DMARDs:
Actemra
Arava/Leflunomide
Benlysta
Cellcept
Cimzia
Cosentyx
Cyclosporine
Cytoxan
Enbrel
Gold Injection
Humira
Imuran/Azathioprine
Kineret
Krystexxa
Methotrexate
Orencia
Otezla
Plaquenil
Prednisone
Remicade
Rituxan
Simponi
Stelara
Sulfasalazine
Xeljanz

Anti-Infam/Pain:
Arthrotec
Aspirin
Celebrex
Duexis
Etodolac
Feldene
Ibuprofen (Advil/Motrin)
Indocin
Mobic
Naprelan/Naproxen
Norco
Tramadol
Tylenol
Vicodin
Vimovo
Voltaren/Diclofenac

Fibromyalgia:
Cymbalta
Elavil/Amitriptyline
Flexeril/Cyclobenzaprine
Gabapentin
Savella

Osteoporosis:
Actonel
Atelvia
Boniva
Evista
Forteo
Fosamax
Prolia
Reclast

Gout:
Allopurinol
Colcrys/Colchicine
Uloric

GERD/Heartburn:
Dexilant
Nexium
Pepcid
Prevacid
Prilosec

Joint Injections:
Cortisone
Location:_____
Euflexxa
Hyalgan
Orthovisc
Supartz
Synvisc

Please provide any family history of Rheumatic disease

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Relative: _____ Diagnosis: _____
Relative: _____ Diagnosis: _____
Relative: _____ Diagnosis: _____
Relative: _____ Diagnosis: _____
Relative: _____ Diagnosis: _____

Social History:

Do you exercise?	YES	NO	What type and how often? _____
Do you consume alcohol?	YES	NO	If yes, how much per week? _____
Do you smoke?	YES	NO	If yes, how many per week? _____
Do you use any other drugs?	YES	NO	If yes, **what kind, how often, how many years**? _____

_____

Review of Systems

Circle the symptoms that you are currently experiencing.

GENERAL:
Fatigue
Fever
Chills or night sweats
Weight loss due to illness
Anxiety
Depression

SKIN:
Facial rash
Psoriasis
Skin ulcers
Bruises
Hair loss
Raynaud's (fingertip color change)
Skin tightening
Itching
Sun sensitivity

HEAD AND NECK:
Pain (specify location): _____
Dry eyes
arthritis
Conjunctivitis

STOMACH AND BOWELS:
Loss appetite
Difficulty swallowing
Peptic ulcers
Heartburn
Abdominal pain
Nausea/vomiting
Tarry stool or hemorrhoids
Jaundice or hepatitis
Diarrhea or colitis or diverticulitis

KIDNEYS/BLADDER:
Burning with urination
Urethral discharge
Blood in urine
Protein in urine
Kidney stone(s)
Chronic kidney/bladder infection

NERVOUS SYSTEM & MUSCLES:
Seizures or convulsions
Tingling or burning

Pain or weakness

METABOLIC:
Diabetes
Thyroid disease
Goiter
Adrenal disease
Obesity

BLOOD:
Anemia
Low white blood count
Low platelet count
Previous transfusion(s)
Low iron

DAILY ACTIVITIES:
Trouble feeding myself
Trouble dressing/grooming myself
Trouble using the bathtub
Trouble doing housework
Trouble driving
Intercourse difficult due to arthritis
Intercourse impossible due to

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Redness
History of Iritis
Ringing in the ears
Mouth sores
Dry mouth
Salivary gland enlargement
Memory loss
Lymph node enlargement

HEART AND LUNG:

Palpitations, irregular heartbeat
Murmur
Pleurisy
Wheezing or persistent cough
Chest pain or shortness of breath
Hypertension
High cholesterol or triglycerides

Blackout

JOINT HISTORY:

Pain or swelling

Jaw	Wrists	Ankles
Neck	Knuckles	Toes
Shoulders	Hips	Fingers
Elbows	Knees	

Heat or redness
Morning stiffness

BACK:

Pain or stiffness (specify location): _____
Spinal injury
Pain that interferes with sleep
Pain radiating from back to buttock or leg(s)

WOMEN ONLY:

Irregular menstrual cycles?_____
Last menstrual cycle: _____
Number of pregnancies: _____
Number of miscarriages: _____
Last PAP Smear: _____
Last mammogram: _____

CURRENT MEDICATION LIST

Name: _____ **DOB:** _____

Allergies: _____

Preferred Pharmacy: _____ **Phone #:** _____

	Medication	Dosage	Frequency	Notes	Reviewed:
1					
2					
3					
4					
5					
6					
7					

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