



Dear Patient,

Thank you for choosing Cohen Medical Centers for your Rheumatology and Regenerative medicine 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 \$75 for each missed appointment.

Co-payment amount, if applicable, will be collected at the beginning of each visit. Our office accepts cash, check, Visa, MasterCard, American Express, Discover, Apple Pay and Google Pay. 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,
Cohen Medical Centers



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 8:00 am to 12:00pm and 1:00 pm to 5:00 pm

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 \$75 charge for missed appointments and appointments not cancelled at least 24 hours in advance.

PRESCRIPTION

- 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 \$25 charge.
- Disability forms may be completed for a fee of \$25 charge.

BILLING

- For all billing-related questions, please call our front office.
- We accept cash, check, Visa, MasterCard, American Express, Discover, Apple Pay and Google Pay.
- All copays and balances are due at the time of service.



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.



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):



MEDICAL SERVICES AGREEMENT

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



MEDICAL SERVICES AGREEMENT

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.

.....
Patient Name

.....
Signature of Patient

.....
Date

.....
or Signature of Patient’s Representative & Relationship

.....
Date



PATIENT INFORMATION SHEET

Last Name		First Name		M.I.	Date of Birth
Address		City	State		Zip
Primary Phone Number			Secondary Phone Number		
Email Address			Social Security Number		
Driver's License Number:			Issuing State		
Employer			Occupation		
Emergency Contacts					
Name		Relationship		Phone Number	
Name		Relationship		Phone Number	
Primary Care Physician					
Name			Phone Number		
Preferred Pharmacy					
Name			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		M.I.	Date of Birth
Address			City	State	Zip
Primary Number			Primary Number		
Email Address			Social Security Number		
Employer			Social Security Number		

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

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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.

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

1.	2.
3.	4.



Please check the box with the following medications that you have tried in the past

Biologics/DMARDs:		Anti-Infam/Pain:		Osteoporosis:	
Actemra		Arthrotec		Actonel	
Arava/Leflunomide		Aspirin		Atelvia	
Benlysta		Celebrex		Boniva	
Cellcept		Duexis		Evista	
Cimzia		Etodolac		Forteo	
Cosentyx		Feldene		Fosamax	
Cyclosporine		Ibuprofen (Advil/Motrin)		Prolia	
Cytosan		Indocin		Reclast	
Enbrel		Mobic		Gout:	
Gold Injection		Naprelan/Naproxen		Allopurinol	
Humira		Norco		Colcrys/Colchicine	
Imuran/Azathioprine		Tramadol		Uloric	
Kineret		Tylenol		GERD/Heartburn:	
Krystexxa		Vicodin		Dexilant	
Methotrexate		Vimovo		Nexium	
Orencia		Voltaren/Diclofenac		Pepcid	
Otezla				Prevacid	
Plaquenil		Fibromyalgia:		Joint Injections:	
Prednisone		Cymbalta		Cortisone	
Remicade		Elavil/ Amitriptyline		Location	
Rituxan		Flexeril/Cyclobenzaprine		Euflexxa	
Simponi		Gabapentin		Hyalgan	
Stelara		Savella		Orthovisc	
Sulfasalazine				Supartz	
Xeljanz				Synvisc	



Please provide any family history of Rheumatic disease

Relative:	Diagnosis:
Relative:	Diagnosis:
Relative:	Diagnosis:
Relative:	Diagnosis:
Relative:	Diagnosis:

Social History:

	YES	NO	
Do you exercise?	<input type="checkbox"/>	<input type="checkbox"/>	What type and how often?
Do you consume alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much per week?
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how many per week?
Do you use any other drugs?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what kind, how often, how many years?
		



Please circle YES or NO if you have ever experienced or are currently experiencing any of the following conditions or symptoms. Please specify where applicable.

Head and Neck System:

Severe dry eyes (diagnosed by ophthalmologist, requiring prescription eye drops) or dry mouth? Yes / No
 Uveitis, Iritis, Scleritis, or other inflammatory eye conditions? Yes / No
 Recurrent oral or nasal ulcers every 6 weeks? Yes / No
 Patchy/focal hair loss? Yes / No
 Fixed facial rash different from rosacea or acne? Yes / No
 Severe rash when exposed to UV light (sunlight)? Yes / No

Cardiovascular System:

Pericarditis / fluid around heart? Yes / No
 Heart attack(s)? Yes / No
 Pericardial Effusion? Yes / No
 Cardiac stents? Yes / No
 If so, how many:
 Acute heart failure? Yes / No
 Pulmonary Hypertension? Yes / No
 Myocarditis? Yes / No
 Cardiomyopathy? Yes / No
 Atrial Fibrillation or an abnormal heart rhythm? Yes / No
 Valvular heart disease (e.g., Endocarditis, Mitral or Aortic valve disease, or valve replacement)? Yes / No

Pulmonary System:

Interstitial Lung Disease? Yes / No
 Frequent cases of Pleurisy? Yes / No
 Pleural Effusion? Yes / No
 COPD? Yes / No
 Chronic cough? Yes / No
 Recurrent Pneumonia? Yes / No
 Pulmonary Embolism? Yes / No
 Positive TB test? Yes / No
 Chronic lung infections (e.g., valley fever, MAC, bronchiectasis)? Yes / No
 If so, please specify:

Vascular system

Deep Vein Thrombosis (DVT) or blood clots? Yes / No
 Vasculitis/angiitis? Yes / No
 Blood disorders (e.g., anemia)? Yes / No
 If so, please specify:

Gastrointestinal System:

GERD? Yes / No

Gastritis? Yes / No
 Gastric ulcer? Yes / No
 Barrett's Esophagus? Yes / No
 Gastroparesis? Yes / No
 Difficulty swallowing? Yes / No
 Irritable Bowel Syndrome? Yes / No
 If so, please specify constipation, diarrhea, or both:
 Recurrent Diverticulitis? Yes / No
 SIBOe? Yes / No
 Chronic diarrhea (>4 weeks)? Yes / No
 Colitis (e.g., Crohn's, Ulcerative Colitis, Collagenous Colitis)? Yes / No
 If so, please specify:
 Fatty liver? Yes / No
 Gallbladder disease? Yes / No
 Recurrent Pancreatitis? Yes / No
 Malabsorption? Yes / No
 Hepatitis B or C? Yes / No

Musculoskeletal System

Prolonged morning stiffness improving with stretching and time? Yes / No
 Joint pain that improves throughout the day? Yes / No
 OR joint pain that worsens throughout the day? Yes / No
 Recurrent joint swelling? Yes / No
 Generalized muscle aches? Yes / No
 Recurrent Achilles Tendinitis? Yes / No
 Plantar Fasciitis? Yes / No
 Rotator Cuff Tear? Yes / No
 Meniscus Tear? Yes / No
 Bursitis (e.g., GT bursitis in hips, SA bursitis in shoulders)? Yes / No
 If so, please specify:
 Do you have Tendinitis? Yes / No
 If so, where?
 Joint replacements? Yes / No
 If so, please specify:
 Gout or Pseudogout/CPPD? Yes / No

Psychiatric System:

Severe anxiety? Yes / No
 Moderate to severe depression? Yes / No
 Bipolar Disorder? Yes / No
 Psychosis? Yes / No
 ADHD? Yes / No
 Restless Leg Syndrome? Yes / No

Genitourinary System:

Frequent UTIs? Yes / No
 Interstitial Cystitis? Yes / No
 Blood in your urine? Yes / No
 Urethritis? Yes / No
 Recurrent Prostatitis? Yes / No
 Enlarged prostate? Yes / No
 Recurrent kidney stones? Yes / No
 Urinary incontinence? Yes / No
 Abnormal protein in your urine? Yes / No

Neurologic System:

Migraines? Yes / No
 TIA or stroke? Yes / No
 If so, how many:
 Neuropathy? Yes / No
 Memory loss that has been diagnosed by a neurologist? Yes / No
 Multiple Sclerosis? Yes / No
 Tremors? Yes / No
 Muscle disorder? Yes / No
 If so, how many:
 Carpal Tunnel Syndrome? Yes / No
 Cubital Tunnel Syndrome? Yes / No

Dermatology System:

Psoriasis that has been diagnosed by a healthcare provider? Yes / No
 Eczema? Yes / No
 Atopic Dermatitis? Yes / No
 Raynaud's or finger discolorations (purple or white) in cold weather? Yes / No
 Finger ulcerations? Yes / No
 Nail pitting, nail ridges, or other nail changes? Yes / No

Other:

Hashimoto's? Yes / No
 Unintentional weight loss? Yes / No
 Recurrent miscarriages? Yes / No
 Cancer? Yes / No
 If so, please specify:



CURRENT MEDICATION LIST

	Medication	Dosage	Frequency	Notes	Reviewed:
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
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23.					
24.					
25.					



Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: Date of Birth: (mm/dd/yyyy)

The information you may release subject to the signed release form is as follows:			
Completion Records		History & Physical	Progress Notes
Care Plan		Lab Reports	Radiology Reports
Pathology Reports		Treatment Record	Operative Reports
Hospital Reports		Medication Record	
Other (please Specify):			

Authorization

I hereby Authorize: Physician/Healthcare Facility

To:
 Name
 Address
 City State Zip Code

Signature of patient or legal/personal Representative of patient Relationship if other than Patient

Patient's Name (Print) Date

IMPORTANT WARNING: This transmission is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is **STRICTLY PROHIBITED**. If you have received this communication in error, please immediately notify us by telephone and return this original message or destroy it.