INLAND RHEUMATOLOGY & OSTEOPOROSIS MEDICAL GROUP, INC.

548 N. 13th Ave., Suite 204, Upland, CA 91786
Tel: (909) 982-0099 Fax: (909) 931-0402

Dear:

Welcome to Inland Rheumatology. You have been scheduled for a CONSULTATION APPOINTMENT with the following provider:

DOCTOR:
DATE: TIME:
OFFICE:

If you are unable to keep the scheduled appointment, please kindly give us 24-hour notice. Because you are reserving a time slot that could have been use by other patients, we RESERVE the right to charge $25.00 for a missed appointment or one that was cancelled with less than 24 hours of notice.

Here at Inland Rheumatology, it is our desire to make your experience with us a pleasant one. Please read the following information regarding our office practices and policies.

Our medical clinic hours are 8:00 AM to 5:00 PM, Monday through Friday.
Our laboratory hours are 8:30 AM to 11:30 AM, and 1:30 PM to 4:30 PM.

It is the goal of our telephone room staff to answer each and every incoming call. If you are unable to get through, please try calling again in 10 to 15 minutes.

When calling, if you are directed to the voicemail of the doctor's medical assistant, please leave a message. We will make every effort to return your call by the end of the day.

To expedite medication refill authorization, requests are to be FAXED to our office by YOUR PHARMACY. Allow 24 to 72 hours for the refill request to be processed.

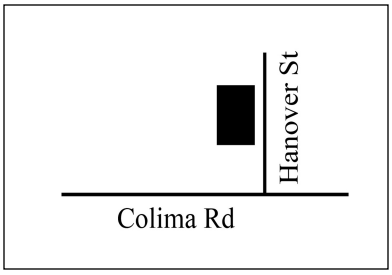
Every effort will be made by our staff to confirm your scheduled appointment with us. However, ultimately it is the patient's responsibility to keep the scheduled appointment.

Thank you,

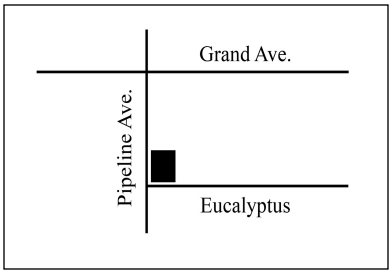
IROMG

SATELLITE OFFICES

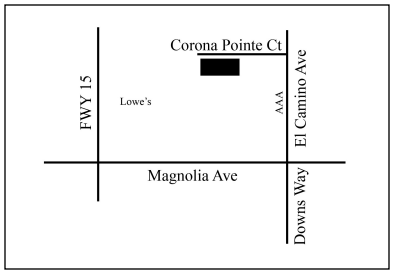
1661 Hanover St, #104
City of Industry, CA 91748



14375 Pipeline Ave
Chino, CA 91710



1280 Corona Pointe Pl, #112
Corona, CA 92879



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PATIENT REGISTRATION FORM

NAME (LAST, FIRST INIT)	HOME PHONE NO.	DATE OF BIRTH	DL#
ADDRESS	CITY	STATE	ZIP CODE
SOCIAL SECURITY NO.	SEX (M/F)	MARITAL STATUS	
OCCUPATION	EMPLOYER	EMPLOYER PHONE NO.	
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE
REFERRING PHYSICIAN	IN CASE OF EMERGENCY CONTACT PERSON AND PHONE NO.		
INSURANCE INFO. PLEASE PROVIDE COPY OF INS. CARD	INSURANCE NAME & ADDRESS		
SUSCRIBER NO.	GROUP NO.	COVERAGE FROM	COVERAGE TO
CLAIM NUMBER	INSURED'S NAME	INSURED'S DATE OF BIRTH	
INSURED'S SEX (M/F)	INSURED'S PHONE NO.	INSURED'S SSN	
INSURED'S ADDRESS	CITY	STATE	ZIP CODE
INSURED'S EMPLOYER		EMPLOYER'S PHONE NO.	
EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE
INSURANCE INFO. PLEASE PROVIDE COPY OF INS. CARD	INSURANCE NAME & ADDRESS		
SUBSCRIBER NO.	GROUP NO.	COVERAGE FROM	COVERAGE TO
CLAIM NUMBER	INSURED'S NAME	INSURED'S DATE OF BIRTH	
INSURED'S SEX (M/F)	INSURED'S PHONE NO.	INSURED'S SSN	
INSURED'S ADDRESS	CITY	STATE	ZIP CODE
INSURED'S EMPLOYER		EMPLOYER'S PHONE NO.	
EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS BE MADE DIRECTLY TO THE PHYSICIAN PROVIDER FOR SERVICES RENDERED.

SIGNED (INSURED OR AUTHORIZED) DATE

I AUTHORIZE ANY INSURANCE COMPANY, ORGANIZATION, EMPLOYER, HOSPITAL, PHYSICIAN, OR PHARMACIST TO RELEASE ANY INFORMATION TO THIS CLAIM AND THE EXPENSES REPORTED.

SIGNED (INSURED OR AUTHORIZED) DATE

INLAND RHEUMATOLOGY & OSTEOPOROSIS MEDICAL GROUP, INC.

FINANCIAL POLICY

Dear patient,

SECTION I: BILLING AND CO-PAYMENT

1. We will provide courtesy doing of your primary carrier and with accurate insurance billing information, including billing address, claim form if needed, and copy of insurance card. This information will be given to the receptionist at the time of service. Payment will be made to provider of service.

2. All accounts are due and payable within 45 days from the date of service, regardless of insurance coverage. Patient is responsible for all non-covered treatment, if insurance denies coverage of payment.

3. All co-payments and deductibles are payable at the time of service.

4. When Patient switches to an HMO, Patient will be responsible for all unauthorized services.

SIGNATURE _____ DATE _____

SECTION II: MEDICARE PATIENTS WITH SECONDARY INSURANCE

1. When your secondary insurance (i.e. AARP, UNITED INS, etc.) electronically crosses over, the provider has permission to receive all payments.

SIGNATURE _____ DATE _____

SECTION III: HMO PATIENTS

1. Patients are responsible for all changes that are made with their HMO insurance, IPA's, primary physicians, etc.

2. All changes must be given to our office. New forms must be filled out, signed, and given to billing prior to visit.

3. Patient is responsible for knowing where all tests such as labs and x-rays are to be performed. We are not financially responsible for tests performed at non-contracted providers.

SIGNATURE _____ DATE _____

INLAND RHEUMATOLOGY & OSTEOPOROSIS MEDICAL GROUP, INC.

PATIENT ACKNOWLEDGMENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.

Obtain payments from third-party payers.

Conduct normal healthcare operations such as quality assessment and physician certifications.

I have been informed by you of your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such NOTICE OF PRIVACY PRACTICES prior to signing the consent. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the NOTICE OF PRIVACY PRACTICES . I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment payment or healthcare operations. I also understand that you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this acknowledgment in writing at any time, except to the extent that you have taken action relying on this acknowledgment.

PATIENT NAME _____ SIGNATURE _____

AUTHORIZED REPRESENTATIVE _____ RELATIONSHIP_____

DATE _____

DESIGNATED FAMILY MEMBER AUTHORIZATION FORM (OPTIONAL)

Protected Health Information will only be released from this office with a properly executed authorization from patient or his/her personal representative, except for treatment, payment, or healthcare operations (TPO), and as otherwise required by law.

However, in the event that a family member is required to discuss my medical condition, I assigned the following person to be the primary source of communication regarding my medical condition. Additionally, I understand that this authorization will remain in effect until revoked in writing by me.

PATIENT NAME _____ SIGNATURE _____

AUTHORIZED REPRESENTATIVE _____ RELATIONSHIP_____

DATE _____

ANSWER PHONE AUTHORIZATION FORM (OPTIONAL)

I give the above entity my permission to leave non-emergency messages are normal tests results on my answer phone. I understand that this authorization will remain in effect until revoked in writing by me.

SIGNATURE _____ DATE _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE:

NAME OF FACILITY: _____

STREET ADDRESS: _____

CITY _____ STATE _____ ZIP _____

TO RELEASE INFORMATION TO:

INLAND RHEUMATOLOGY & OSTEOPOROSIS MEDICAL GROUP, INC.
548 N 13th AVE, SUITE 204
UPLAND, CA 91786
TEL: (909) 982-0099 FAX: (909) 931-0402

I realize that such a release may include information which may be considered contagious, communicable, or a venereal disease, which may include but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).

PATIENT INITIALS _____

I also realize that such a release may include information pertaining to alcohol use or abuse, drug history and/or any mental disorders, including but not limited to schizophrenia, depression, and/or manic depression.

PATIENT INITIALS _____

I WAIVE all rights and privileges allowed by the law relating to: (A) disclosure of confidential information, (B) defamation, (C) invasions of rights of privacy, and I release INLAND RHEUMATOLOGY & OSTEOPOROSIS MEDICAL GROUP, INC. and/or its agents or recipients from any legal responsibility arising from this request for medical records. I understand that this request may be revoked at any time, but that revocation may not be applied retroactively, once the information has been released in good faith. I also understand that, should I fail to list a mailing address, my records WILL NOT be processed.

PATIENT INITIALS _____

NAME OF PATIENT _____ DATE OF BIRTH _____

SIGNATURE _____ DATE _____

INLAND RHEUMATOLOGY & OSTEOPOROSIS MEDICAL GROUP, INC.

NOTICE OF PRIVACY PRACTICES

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 takes effect on **April 15, 2003** and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices in the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, and other people who are taking care of you. We may also share medical information about you to your other healthcare providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our healthcare operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses, and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and healthcare operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and asked for information about you by name.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your healthcare, according to our professional judgment. We will also use out professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with the coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions, and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim, or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacement, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify the person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other all authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoena or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format that you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, **we will charge you $0.25 for each page, and postage** if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates share your medical information for purposes other than treatment, payment, and healthcare operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. It we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you want to change. If we accept a request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer at your office.

5. QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US Department of Health and Human Services. We will not retaliate in anyway if you choose to file a complaint.

INLAND RHEUMATOLOGY & OSTEOPOROSIS MEDICAL GROUP, INC.

NEW PATIENT PRE-VISIT SURVEY

Dear Patient,

Please kindly fill out the following survey prior to your scheduled consultation visit. It is designed to assist our physicians in understanding your health issues and your primary concerns.

1. What is your primary reason for seeing a rheumatologist today?

☐ Rheumatoid arthritis ☐ Osteoarthritis ☐ Fibromyalgia ☐ Positive Lab Test ☐ Other _____

2. What year did you have the first symptoms of your condition? _____

3. Please describe the symptoms of your condition?

_____

_____

_____

_____

_____

_____

_____

4. How much PAIN have you had because of you condition over the past week?

NO PAIN _____ PAIN AS BAD AS CAN BE

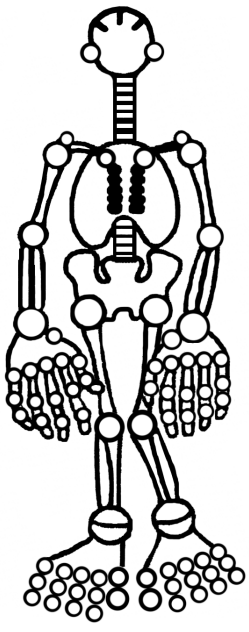
5. How much of a problem has UNUSUAL FATIGUE been for you over the past week?

NO FATIGUE _____ MAJOR FATIGUE

6. Please rate your ability to perform the following tasks:

	Difficulty		
a. Getting out of bed	☐ None	☐ Some	☐ Much
b. Dressing yourself	☐ None	☐ Some	☐ Much
c. Washing yourself	☐ None	☐ Some	☐ Much
d. Opening jars	☐ None	☐ Some	☐ Much
e. Getting in/out of a car	☐ None	☐ Some	☐ Much
f. Bending down	☐ None	☐ Some	☐ Much
g. Walking	☐ None	☐ Some	☐ Much
h. Going up/down stairs	☐ None	☐ Some	☐ Much
i. Getting a good night sleep	☐ None	☐ Some	☐ Much

7. Please check the joints that are currently causing you symptoms:



☐ None

8. Please indicate if you ever had had any of the following medical problems:

☐ Hypertension	☐ Coronary Artery Disease	☐ Stomach ulcer / bleeding	☐ Rheumatoid arthritis
☐ High cholesterol	☐ Congestive Heart Failure	☐ Irritable Bowel Syndrome	☐ Osteoarthritis
☐ Diabetes	☐ Atrial fibrillation	☐ Migraines	☐ Fibromyalgia
☐ Hypothyroidism	☐ COPD / Emphysema	☐ Depression	☐ Osteoporosis
☐ Asthma	☐ Kidney failure / disease	☐ Anxiety	☐ Osteopenia

☐ Cancer _____ ☐ Broken bones _____

☐ Other _____ ☐ Other _____

9. Please indicate all surgeries you have ever had?

☐ Tonsillectomy	☐ Appendectomy	☐ Gallbladder	☐ Hernia Repair _____
☐ Cesarean section	☐ Hysterectomy	☐ Tubal Ligation	☐ Other _____

☐ Knee replacement _____ ☐ Carpal tunnel surgery _____

☐ Arthroscopic surgery _____ ☐ Neck surgery _____

☐ Hip replacement _____ ☐ Back surgery _____

10. Please list any medications which you are allergic to: ☐ None _____

11. Please write down your current medications, including non-prescribed drugs and supplements, and their dosages.

1. _____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

12. Social Data:

Occupation _____ ☐ Retired ☐ Disabled ☐ Unemployed ☐ Student ☐ Homemaker

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Number of Children ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ ____

Tobacco Use ☐ Never ☐ Past _____ ☐ Current _____

Alcohol Use ☐ Never ☐ Past _____ ☐ Current _____

Please check if you have experienced any of the following in the past month:

☐ Fever	☐ Rash	☐ Shortness of breath	☐ Constipation	☐ Neck pain	☐ Insomnia
☐ Weight gain	☐ Mouth sores	☐ Wheezing	☐ Diarrhea	☐ Back pain	☐ Depression
☐ Weight loss	☐ Hair loss	☐ Chest pain	☐ Bloody stools	☐ Numbness & tingling of hands	☐ Anxiety
☐ Fatigue	☐ Headaches	☐ Palpitations	☐ Black stools	☐ Numbness & tingling of feet	☐ Stress
☐ Loss of appetite	☐ Dry eyes/mouth	☐ Heartburn	☐ Muscle pain	☐ Color changes to the fingers	☐ Poor memory
☐ Swollen glands	☐ Cough	☐ Stomach pain	☐ Muscle weakness	☐ Leg swelling	☐ Sexual problems