As a new patient, we block out extra time for you so that Dr. Greene can do a full evaluation, ask questions and perform an examination.

If you cannot keep your appointment, we require at least ***TWO FULL BUSINESS DAYS' NOTICE***. Due to our high new patient referral demand, *should you fail to show up for your appointment, we will not see you as a patient.*

We may not always do courtesy calls to remind you of your appointment, so please mark your calendar accordingly.

Rudy R. Greene M.D. FACR

Board Certified Rheumatology

540 Catalina Drive

541-535-5523 Phone

541-535-5368 Fax

APPT DATE AND TIME:

Welcome to our practice! We have scheduled an appointment for you, at the date and time listed above.

- **Please complete and bring the enclosed forms (or mail them prior to your appointment).**
- **We do not treat illness or injury arising from Motor Vehicle Accident or Work Comp claims.**
- **Also, please remember to bring VALID ID, your insurance card(s), prescription card and medication list with you.**
- ***Please bring your COMPLETED paperwork with you, or we will not be able to see you at that time and will need to reschedule your appointment.***
- ***We are a non-narcotic office. This means that we do not prescribe narcotics.***
- **We *do not do disability evaluations* nor do we fill out disability forms, nor do we communicate with lawyers. However, our notes will be available should you need them.**

Our office hours are Monday-Thursday between the hours of 9:00 a.m. and 12:00 p.m., and from 1:00 p.m. and 4:00 p.m. , closed on Fridays.

Sincerely,

The Staff

Dr. Rudy Greene complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, or gender.

Atención: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-368-1019

PATIENT INFORMATION

FORM MUST BE FILLED OUT COMPLETELY
OR WE CAN NOT BILL YOUR INSURANCE

Legal Name_____ Date of Birth __/___/___ Sex: _____

Address: _____

City_____ State_____ Zip_____ Cell # _____ Home #_____

Social Security _____ Email address _____

Present Employer_____ Work Number _____

Married_____ Single _____ Divorced _____ Widow_____ Domestic Partner_____

Race _____ Ethnicity _____

Primary Doctor_____ Phone _____

Referring Doctor_____ Phone _____

Preferred Pharmacy_____ Phone _____

Emergency Contact/ relationship _____ Phone _____

Primary Insurance: **_____**

Insured's name_____ Date of Birth_____

Address if different from above: _____

ID Number_____ Group Number _____Phone _____

Relationship to Insured: Self_____ Spouse_____ Child_____

Secondary Insurance: **_____**

Insured's Name_____ Date of Birth_____

ID Number_____ Group Number _____Phone_____

Relationship to Insured: Self_____ Spouse_____ Child_____

***** NOTE: You will need to update this form annually. *****

Ok to leave a message on home phone? □ yes □ no

SIGNATURE **_ _____ Date_____**

Patient Name: _____ DOB: _____

PAST MEDICAL HISTORY: If you have had any of the following problems, circle it and write the date you were first told you had that problem.

Diabetes _____ Heart attack _____ Hepatitis _____
High blood pressure _____ Angina (chest pains) _____ High cholesterol _____
Rheumatic fever _____ Heart murmur _____ AIDS _____

Other Medical Problems (Please List): _____

_____

_____

Surgeries (list and give approximate dates): _____

_____

_____

HABITS:

SMOKING- *I am a current smoker* □ *I am a non-smoker:* □
Pack(s) per day _____ Yrs smoked? _____ Yr. Quit: _____

ALCOHOL- *I currently drink alcohol* □ *I am a non-drinker* □
Average alcohol use: _____

COFFEE- *I currently drink coffee* □ *I do not drink coffee* □
Daily coffee use: _____

RECREATIONAL DRUGS- *I am a current drug user* □ *I do not use drugs* □
Current drug use: _____

FAMILY MEDICAL HISTORY: If Living (age) If Deceased (age at death)

Father: _____
Mother: _____
Brothers and Sisters: _____

_____

_____

Number of children, and their ages: _____

_____

If your children have health problems, please list : _____

_____

_____

Patient Name _____ **DOB:** _____

Has any blood relative had any of the following problems? (please circle)

Rheumatoid Arthritis	Osteoarthritis	Osteoporosis	Heart attack
Other types of Arthritis	Diabetes	High blood pressure	High Cholesterol
Sudden death	Lupus		

Additional comments _____

_____

_____

_____

_____

_____

_____

Who is at home with you? _____

_____

Last grade of schooling completed? _____

_____

What recreational interests do you have? _____

_____

_____

List any vitamins or supplements you may be taking.

_____

_____

_____

_____

_____

Have you seen another Rheumatologist? If so, who: _____

SIGNATURE _____ ***DATE*** _____

MEDICATION LIST

PATIENT NAME:_____ DOB: _____

ALLERGIES: _____

PHARMACY:_____ Date: _____

MEDICATION	HOW MANY MILLIGRAMS	HOW OFTEN YOU TAKE IT

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION PERSUANT TO HIPAA

Patient Name: _____ Date of Birth: _____

By signing this form, I authorize (name and address of physician/clinic/entity)

_____

to release confidential health information about me, by releasing a copy of my medical records, to the

physician/clinic/entity listed below (name and address)

_____

The health information that relates to dates of service from _____ to _____

may be released and may include (circle all that apply): Entire medical record, History & Physicals, Lab reports, Radiology reports, Treatment records, Pathology reports, Billing records, Insurance records, Medication records or Other:
_____ (specify)

For the purpose of:
_____
_____

_____ _____
Printed Name of Patient **Signature of Patient or representative**

_____ _____
Date **Printed name of representative and relationship**

- **I understand that unless revoked in writing, this authorization is valid for 12 months from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.**

- **Unless specifically excluded below, this authorization includes release of specially protected information including referral, diagnosis and treatment information related to my health care.**

- **(Please circle all that apply to EXCLUDE the information from authorization and disclosure):**

Substance Abuse Mental Health Conditions Sexually Transmitted Diseases HIV/AIDS

- **I understand once my health care information is released, the person or organization that receives it may re-disclose the information and that it may no longer be protected by privacy laws.**

- **I understand release of my records may take up to 30 days.**

- **I understand that I do not have to sign an authorization as a condition for receiving treatment or health care benefits (treatment, payment or enrollment).**

Patient Name _____ DOB: _____

RELEASE OF INFORMATION MEDICAL AND BILLING (OPTIONAL)

This authorization is to release medical information to others in your life who you want to have involved in your care that are not your medical providers. By signing this form, you are permitting Rudy R. Greene, MD to disclose medical and billing information to the people listed below.
Examples include: spouse, caregiver or facility, family, transportation, etc.

Name:	Phone Number:	Relationship:
Name:	Phone Number:	Relationship:
Name:	Phone Number:	Relationship:

<u>This information is valid until revoked by the patient</u>

_____ _____
Print Patient Name Date

_____
Patient Signature (or printed name and signature of representative)

AUTHORIZATION FOR MEDICAL TREATMENT AND AGREEMENT OF FINANCIAL RESPONSIBILITY

I, _____, authorize Dr. Rudy Greene and his medical staff to administer treatment as deemed necessary for my benefit. I also authorize the use of any anesthetics and/or medications, with the exception of_____(allergy or other reason). I acknowledge that no guarantee or assurance has been made to the results that may be obtained.

I also understand that it is my responsibility to complete all tests (i.e. blood work, x-ray, MRI, CT, etc.) that Dr. Greene necessarily prescribes. If I do not complete the test for any reason, I release Dr. Greene of all responsibility.

I understand that it is my (the patient) responsibility to verify with my health insurance company that the services being provided to me by Dr. Greene's office are covered and authorized by my insurance company. I understand that it is also my responsibility to have a referral in place, if it is required by my health insurance company. This is to include any referral needed to see any other doctor that Dr. Greene may feel necessary for me to see to help with any of my medical concerns. I understand that it is my responsibility, as well, to verify with my health insurance company that I am covered for tests (such as those referenced in the preceding paragraph) that Dr. Greene may order.

I accept financial responsibility for all charges that are not paid by my health insurance company. I understand there will be a finance charge of 1.5% per month (18% annual percentage rate) assessed to unpaid balances after 90 days. I accept financial responsibility for all charges that are not paid by my health insurance company. I understand that any copay and deductible will be due at the time of service.

I hereby certify that I have read, fully understand, and agree to this Authorization for Medical Treatment and Agreement of Financial Responsibility.

Responsible Party Signature_____ Date_____

If patient is a minor, signature of parent/guardian_____

Relationship to patient_____

***The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Rudy R. Greene, MD or insurance company to release any information required to process my claims*.**

ACKNOWLEDGMENT AND CONSENT

I understand that ***Rudy R. Greene M.D.*** (referred to below as "This Practice") will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility from my health insurance, submit bills, claims and other related information to insurance companies (or others who may be responsible to pay for some or all of my health care;) and
- Perform various office administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care**.**

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a ***Notice of Privacy Practices*** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the ***Notice of Privacy Practices*** may be revised from time to time, and that I am entitled to receive a copy of any revised ***Notice of Privacy Practices*****.** I also understand that a copy or a summary of the most current version of This Practice's ***Notice of Privacy Practices*** in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the ***Notice of Privacy Practices***, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I will read the copy of the Notice of Privacy Practices in the office.

By: _____ Date: _____
(Patient)

By: _____ Date: _____
(Patient Representative)

Description of Representative's Authority: _____

CANCELLATION POLICY

Please be assured that we value your time and hope that you value ours. We make every reasonable effort to stay on schedule throughout the day, while we remain committed to providing each patient with the highest quality of care.

- **If you need to reschedule an appointment, we will be happy to accommodate you, but we do ask for at least TWO FULL BUSINESS DAYS' advance notice.**
- ***Please note that we are closed on Fridays--a cancellation on Friday for a Monday appointment is not sufficient notice*.**
- **We charge a $75.00 fee for an appointment not canceled within TWO FULL BUSINESS DAYS of the appointment time. After the second missed appointment without appropriate notice, we will not reschedule an appointment for you.**

We may not make confirmation calls prior to your appointment. Please mark your calendars accordingly.

If you are a new patient and you miss your first appointment, we *will not* be able to reschedule an appointment for you.

I hereby acknowledge receipt of Dr. Greene's Cancellation Policy.

Signature _____ **Date** _____

Print Name _____

If patient is a minor, signature of parent or guardian _____

Relationship to patient _____

DIRECTIONS

Coming from North

Take I-5 South to Ashland Exit 19. Make a Right at the stop sign and follow to Valley View Rd. Take a left on Valley View Rd. Follow into Ashland, you will see signs for the Hospital. Take a Right on Maple St. which is the street the hospital is on. Catalina Drive is the third street on the left, just before the hospital. Our building (540 Catalina) is the second building on the left-hand side.

Coming from South

Take I-5 North to Ashland Exit 19. Make a Left at the stop sign and follow to Valley View Rd. Take a left on Valley View Rd. Follow into Ashland, you will see signs for the Hospital. Take a right on Maple St. which is the street the hospital is on. Catalina Drive is the third street on the left, just before the hospital. Our building (540 Catalina) is the second building on the left-hand side.

For Your Convenience
We now accept
MasterCard, Visa, and Discover

Your co-pay, if applicable, is due at time of service. We will not bill you for your co-pay amount.

Thank you for your cooperation,

The Staff of Rudy Greene, M.D.