Electronic Communication Consent Form

I consent that Upland Rheumatology Center can provide their services and communicate with me via mobile phone, messages, email, and any kind of online communications, provided that these communications comply with privacy regulations.

Contact Information Change

I accept that I am responsible of notifying Upland Rheumatology Center when my contact information changes.

Consent Cancellations

I know that I can revoke this consent at any time by contacting the clinic.

I consent to the use of mobile phone communications.

☐ Yes ☐ No Phone #: ( )_____

I consent to the use of texting (messaging) communications.

☐ Yes ☐ No

I consent to the use of email communications.

☐ Yes ☐ No Email: _____

I sign this consent form on the behalf of

☐ Myself ☐ My family ☐ Someone as a legal guardian

Date of Signature _____

Signature _____

Upland Rheumatology Center

886 West Foothill Boulevard
Ste E
Upland, California 91786
TEL: 909 932-1122
FAX: 909 932-9292

MEDICAL SERVICES AGREEMENT

(READ CAREFULLY BEFORE SIGNING)

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 Upland Rheumatology Center, A Medical Corporation (herein referred to as "Upland Rheumatology Center") assisting my care.

2. **FINANCIAL AGREEMENT: I understand that all charges are due at the time of service.** I agree to pay Upland Rheumatology Center 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, Discover 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 Upland Rheumatology Center 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.

   Patient or Guardian Initials _____

   I understand that my insurance policy is a contract between myself and my insurance company; Upland Rheumatology Center is not involved. In order for Upland Rheumatology Center to file claims and accept payments from my insurance company, I understand that I must present current insurance information at each visit and that Upland Rheumatology Center will need to verify my health insurance coverage. In the event that Upland Rheumatology Center 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 individual 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 Upland Rheumatology Center 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 Upland Rheumatology Center to disclose portions of or all of my records, including my medical records to any person or corporation which is or may be liable for all or any portion of Upland Rheumatology Center's charges, including but not limited to insurance companies, health care service plans, governmental agencies, or worker's compensation carriers. I authorize Upland Rheumatology Center 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 Upland Rheumatology Center 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 Upland Rheumatology Center 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:** Upland Rheumatology Center 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.

   Upland Rheumatology Center, 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 agree to the foregoing, received a copy thereof, 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.

_____	_____		_____	_____
Signature of Patient	DATE	or	Signature of Patient's Representative	DATE
_____	_____		_____	
Medical Practice's Representative	DATE		Name & Relationship of Representative to Patient	

Upland Rheumatology Center

Morris Kokhab MD, Mary Khaleghi NP
Stacy Schulman MD, Ebrahim Sadeghi MD

886 West Foothill Boulevard Ste E
Upland, California 91786
TEL: 909 932-1122
Fax: 909 932-9292

PATIENT INFORMATION

Please completely fill out this form to ensure the fastest and best healthcare service.

We may ask you to look over this information from time to time to make sure it stays up-to-date.

Patient Name **Last:** **First:**	
Address:	**Date of Birth:** **Age**:
City, State Zip	**Social Security Number:**
Home Phone:	**Work Phone:**
Mobile Phone:	**Email Address:**
Employer:	**Occupation:**
Emergency Contact #1 **Name**_____ **Phone:** _____ **Relationship :** _____	**Emergency Contact #2** **Name:**_____ **Phone**_____ **Relationship:** _____
Primary Care Physician Name & Phone Number:	**Pharmacy Name and Phone Number:**
Insurance Subscriber Information: If you are covered under the policy of a spouse, partner, parent, or lega guardian, please tell us about them below if not please skip.	
Subscriber Name:	**Social Security Number**
Date of Birth:	**Address**
Home Phone:	**Work Phone:**
Mobile Phone:	**Email Address:**
Employer:	**Occupation:**

NOTICE OF PRIVACY PRACTICES:

Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" of Upland Rheumatology Center, a Medical Corporation. Our "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office at (909) 932-1122.

I acknowledge receipt of the "Notice of Privacy Practices" of Upland Rheumatology Center, a Medical Corporation.

Signature: _____ Date: _____
(patient /legal representative)

Print Name: _____
(Patient)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

FOR OFFICE USE ONLY

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith effort made to obtain the individual's acknowledgment, and the reasons why the acknowledgment was not obtained.

Reasons why the acknowledgment was not obtained:

__ Patient refused to sign this acknowledgment even though the patient was asked to do so and the patient was given the Notice of Privacy Practices.

__ Other: _____

Signature: _____ Date: _____
(provider representative)

Print Name: _____
(provider representative)