RHEUMATOLOGY INSTITUTE
OF SAN ANTONIO

Patient Demographic Form

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ ☐ Cell ☐ Home ☐ Work

Phone Number: _____ ☐ Cell ☐ Home ☐ Work

Email: _____

Preferred Method of Contact: ☐ Cell ☐ Home ☐ Work ☐ Email

I consent to be receive appointment reminders by text. ☐ Yes ☐ No

I consent to be receive appointment reminders by email. ☐ Yes ☐ No

Primary Care Physician Name: _____

Phone Number: _____ Fax Number: _____

Pharmacy Name: _____

Phone Number: _____ Fax Number: _____

Emergency Contact Name: _____

Phone Number: _____ Relationship: _____

By signing, I acknowledge that the information provided is accurate and complete to the best of my knowledge. I affirm that I am the patient or the patient's authorized legal representative.

X _____ _____

Signature of Patient or Responsible Party Date

14615 San Pedro Ave, Ste 210, San Antonio, TX 78232
P: (210)404-0020 | F: (210)404-0325

RHEUMATOLOGY INSTITUTE
OF SAN ANTONIO

Acknowledgement of HIPPA Form

I acknowledge that I have read the HIPAA Notice of the Rheumatology Institute of San Antonio. I understand that I may authorize the following family members and/or friends to receive information about my care, including my appointment details, billing/insurance, and/or medical records.

- ☐ I do **NOT** authorize the release of any of my medical information to anyone other than myself.
- ☐ I do authorize the release of any of my medical information to anyone other than myself.

People Who May Receive My Medical Information:

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

This authorization applies to:

- ☐ Appointment details
- ☐ Billing and insurance
- ☐ Medical records and test results
- ☐ All of the above

This authorization will remain in effect unless changed or revoked in writing by me.

In general, the HIPAA Privacy Act gives individuals the right to request a restriction on uses and disclosures of Protected Health Information (PHI). You also have the right to request confidential communication (e.g., sending correspondence to your office instead of your home).

X _____ _____

Signature of Patient or Responsible Party Date

RHEUMATOLOGY INSTITUTE
OF SAN ANTONIO

Medical History

Patient Name: _____ DOB: _____

Reason for Visit: _____

Medical History

Select all medical conditions for which your are currently being treated for:

- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Sjogren's/Sicca Syndrome
- ☐ Osteoarthritis
- ☐ Lupus
- ☐ Cancer: _____
- ☐ Diabetes
- ☐ Gout
- ☐ Osteoporosis
- ☐ Ankylosing Spondylitis
- ☐ Thyroid Disorder
- ☐ Depression
- ☐ Rheumatoid Arthritis
- ☐ Giant Cell Arteritis
- ☐ Other: _____
- ☐ Seasonal Allergies
- ☐ Fibromyalgia
- ☐ Psoriatic Arthritis
- ☐ Migraines

Social History

Do you use tobacco? ☐ Yes ☐ No

Do you use alcohol? ☐ Yes ☐ No

Surgical History ☐ No surgical history

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Family History

Do you have any family history of autoimmune disease? ☐ Yes ☐ No

Condition: _____ Relationship: _____

Condition: _____ Relationship: _____

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Medical History

Patient Name: _____ DOB: _____

Current Medications ☐ Not taking any medication (s) ☐ I have a list

Please include any prescription, over-the-counter, and vitamins/supplements.

Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____

Drug Allergies ☐ No Known Drug Allergies

List all medications that you are allergic to:

Drug Name: _____ Reaction: _____
Drug Name: _____ Reaction: _____
Drug Name: _____ Reaction: _____
Drug Name: _____ Reaction: _____
Drug Name: _____ Reaction: _____

X _____ _____
Signature of Patient or Responsible Party Date

RHEUMATOLOGY INSTITUTE
OF SAN ANTONIO

Medical Record Release Form

Patient Name: _____ DOB: _____

By signing this form, I authorize _____
to release confidential health information about me, by releasing a copy of my medical records, or a summary/narrative of my Protected Health Information (PHI) to the physician/facility/entity listed below.

Rheumatology Institute of San Antonio
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The information is authorized to release is as follows:

- ☐ Complete Records
- ☐ Progress Notes
- ☐ Treatment Plan
- ☐ Medication History
- ☐ Pathology Reports
- ☐ Operative Reports
- ☐ Radiology Reports
- ☐ Hospital Reports
- ☐ Laboratory Results
- ☐ Other: _____

Conditions and Notifications
This authorization for release of information expires 12 months from the date of the patient's signature. You may revoke this authorization at any time by writing to the Rheumatology Institute of San Antonio at the address above. I understand that you will provide the information within 30 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

X _____ _____
Signature of Patient or Responsible Party — Date

_____ _____
Print Name of Patient or Responsible Party — Relationship

RHEUMATOLOGY INSTITUTE
OF SAN ANTONIO

Patient Acknowledgement of Office & Financial Policies

Patient Name: _____ DOB: _____

I acknowledge that I have received and reviewed the Office Policies and Financial Policies of the Rheumatology Institute of San Antonio. I understand it is my responsibility to read and follow these policies, and I may ask any questions for clarification.
I also understand that:

- I may request an additional copy of these policies at any time.
- It is my responsibility to follow up with my insurance provider, primary care physician, and laboratory when required.
- Failure to follow these policies may result in delays or interruptions in care, including medication refills or infusions.
- I may speak with the front desk or practice manager if I have any questions or concerns.

X _____ _____

Signature of Patient or Responsible Party Date

For Office Use Only

- ☐ Patient provided with printed copy of Office & Financial Policies
- ☐ Patient declined printed copy of Office & Financial Policies.

RHEUMATOLOGY INSTITUTE
OF SAN ANTONIO

Financial Policy

Thank you for choosing the Rheumatology Institute of San Antonio. We are committed to providing you with the highest quality of care in an efficient and cost-effective manner. Please read the following financial policies carefully and sign at the bottom to acknowledge your understanding.

Financial Responsibility

- You are responsible for all co-payments, deductibles, co-insurance, non-covered services, and any other patient financial responsibilities as determined by your insurance carrier or our policies. Payment is due at the time of service.
- **HMO Referrals:** Our office will request any necessary referrals from your Primary Care Physician (PCP); however, it is the patient's responsibility to follow up with their PCP to ensure that authorization is obtained and forwarded to our office in a timely manner. If we do not receive authorization, your appointment will be rescheduled.
- You must present a valid photo ID and insurance card(s) at every visit in order to verify coverage and ensure accurate billing.
- All co-payments, deductibles, and co-insurance amounts are due at the time of service, unless prior arrangements have been made.

Insurance Network Participation

- If we determine prior to your appointment that we are not contracted with your insurance provider, your appointment will be cancelled and you will be notified.
- If a claim is submitted and later denied due to out-of-network status, we will contact you to discuss your options and, when applicable, work with you to establish a payment agreement per insurance guidelines.

Insurance Eligibility & Coverage

- While patients are expected to understand their insurance benefits, our staff will verify eligibility before your visit and notify you of any issues.
- If you are found to have no active insurance coverage at the time of service, a cash-pay adjustment will be applied, and you will be responsible for the self-pay rate of $150.
- We will provide a Good Faith Estimate for expected charges upon request or as required. However, please note that you remain financially responsible for any remaining balance as determined by your insurance after claims have been processed.

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Financial Policy (cont.)

Collections & Past Due Accounts

- Past-due balances may be turned over to collections if unpaid.
- Returned checks will incur a $35.00 fee.
- We accept cash, checks, Visa, and Mastercard as forms of payment.

Medicare Patients

- We are Medicare participating providers and will bill Medicare directly.
- You are responsible for any co-payments, deductibles, and charges for non-covered services at the time of service.

Authorization for Payment and Information Release

Your signature below authorizes the release of any medical information necessary to process an insurance claim on your behalf. It also authorizes your insurance carrier(s) to make direct payment to the Rheumatology Institute of San Antonio for services rendered.

RHEUMATOLOGY INSTITUTE
OF SAN ANTONIO

Office Policies

Thank you for choosing the Rheumatology Institute of San Antonio. The following office policies are in place to ensure we provide high-quality, timely, and respectful care to all patients. Please read and acknowledge these policies to help us serve you better.

Appointment Policy

- Please arrive at least 15 minutes before your scheduled appointment to allow time for check-in and paperwork.
- Bring a valid photo ID and insurance card(s) to every visit. You may be asked to reconfirm your insurance and demographic information at follow-ups.
- Notify our office promptly if there are any changes to your address, phone number, insurance, or PCP.

Cancelations & Missed Appointments

- If you need to cancel or reschedule, please notify us at least 24 hours in advance.
- Missed appointment fee: $75.00 (not billable to insurance)
- Repeated missed or short-notice cancellations may result in dismissal from the practice.

Late Arrivals

- Patients who arrive more than 15 minutes late may be asked to reschedule to avoid delays in care for other patients.

Medication Refills

- Refill requests must be faxed by your pharmacy to 210-404-0325 or requested electronically.
- Allow up to 2 business days for processing.
- Requests must be submitted at least 3 business days before your medication runs out.

Follow-Up and Compliance

- Patients must maintain routine follow-up appointments as directed by their provider.
- Failure to attend follow-ups may result in:
  - Cancellation of infusions
  - Denial of medication refills
- Required labs and imaging must be completed at least 1 week prior to follow-up appointments.
- If not completed, your appointment will be rescheduled, which may delay your treatment plan.

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Office Policies

Legal Guardians

- If you are the legal guardian of a patient, official documentation (such as medical power of attorney or guardianship papers) must be provided at the time of the visit. If authorization is not received, your appointment will be rescheduled.

Non-compliance & Dismissal from the Practice

- We reserve the right to terminate care for patients who:
- Consistently miss or cancel appointments without notice
- Fail to follow medical advice or treatment plans
- Violate any office policy
- If dismissed, patients will receive written notice and will be offered 30 days of emergency care to allow time to establish care with another provider.

Patient Rights & Communication

- Patients may request a copy of these policies at any time.
- Concerns about billing, services, or care may be addressed with our practice manager or front desk team. We are committed to addressing your concerns promptly and respectfully.

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