ARTHRITIS TREATMENT CENTER

Bett Eng, M.D. David Klashman, M.D., F.A.C.R. Sheherbano Mehdi, M.D.

Welcome to our practice

Prior to your appointment, please read this patient information packet and fill out the accompanying forms.

Our practice is limited to adult patients ages 18 years and over.

Our office hours are Monday to Friday 8:00 a.m. to 5:00 p.m. Our phones are off every day between 12:00 and 2:00 p.m. for lunch. During this time, you can leave a voice message for the doctors and staff.

Patients are seen by appointment only. If you are unable to keep your scheduled appointment, please call the office as soon as possible. If you arrive more than 10 minutes later than your scheduled time, you may be asked to reschedule your appointment. Patients who miss three consecutive appointments may be dismissed from our practice.

Proof of medical insurance is required at all patient visits. Please confirm with our staff that we accept your insurance. Co-pays and deductibles are due at the time of service. The patient will be responsible for any unpaid claims. Any balance that remains unpaid for more than 120 days will be considered delinquent. There is a $25 fee for checks that are returned for insufficient funds.

We do not accept workers' compensation insurance, auto accident claims, and personal injury claims.

A fee will be charged for any forms that are filled out by the physician. These forms include those for DMV handicap placard, disability, jury duty, travel insurance, etc.

Prescriptions are filled and refilled via fax, phone, and electronically. Narcotic prescriptions will not be refilled on the weekend.

Follow up visits will be required every six months for general prescriptions, every three months for controlled substances, and at most every thirty days for narcotics.

_____	_____	_____
Patient signature	Patient Name (printed)	Date

☐ Bett Eng, M.D.
☐ David J. Klashman, M.D.
☐ Sheherbano Mehdi, M.D.

ARTHRITIS TREATMENT CENTER
23441 Madison St., Ste. 340, Torrance, CA 90505
Phone: (310) 373-0340

Today's Date_____

PATIENT INFORMATION RECORD

PLEASE PRINT AND ANSWER ALL QUESTIONS COMPLETELY

1	Name of Patient - Last Name	First Name	Initial	Birthday Mo. Day Yr.	Age
	Address	City	Zip Code	Family Physician	
	Marital Status (Circle one) S M W D Sep	Sex M F	Soc.Sec.# (Last 4 #s)	Ethnicity	E-mail
	Cell Phone	Home Phone	Work Phone		
	Employer	Occupation	Refered by		
	Bus. Address	City	Zip Code		

MEDICAL INFORMATION

2	List any medication to which you may be allergic		
	Name of friend or relative in case of an Emergency.	Relationship	Phone #
	In the event you are not able to speak for yourself, who do you designate to make medical decisions for you?		Phone #

Please Check 1 Box: ☐ **PPO** ☐ **HMO** ☐ **PRIVATE** ☐ **MEDICARE**

PRIMARY INSURANCE INFORMATION

MediCare patients need only enter Ins. Name & Number

Co-pays are to be paid at the time of your office visit.

3	Name of Insured - Last Name	First Name	Initial
	Employer	Bus. Address	
	Name of Insurance Carrier		
	Policy Holder Relationship to Patient	Policy #	

CHECK BOX IF SAME AS 1: ☐

Birthday Mo. Day Yr.

Soc. Sec. #

Certificate #

SECONDARY INSURANCE INFORMATION

4	Name of Insured - Last Name	First Name	Initial	DOB
	Name of Insurance Carrier			

ASSIGNMENT OF BENEFITS

I authorize **Arthritis Treatment Center** to release medical information to my Insurance Co. for processing of medical claims.

I further authorize my Insurance Co. to make payment directly to the above named Group of physicians. I also understand that I am fully responsible for any/and all unpaid charges, including out-of-network, non-covered or not considered medically necessary by my Insurance Co.

In addition, I am aware that any unpaid balances may result in denied access to appointments.

Date_____ Signed_____

IMPORTANT **- Please fill out BEFORE arriving and bring your actual insurance card with you -Thank You.**

Welcome to the Arthritis Treatment Center

David J. Klashman, M.D. **Bett Eng, M.D.** **Sheherbano Mehdi, M.D.**

Medical History

NAME _____ OCCUPATION _____

DOB_____ ☐ MALE ☐ FEMALE How were (or who) recommended us to you? _____

Who is your primary physician (Internal Medicine or Family Practice)? _____

Briefly, what is your medical problem?_____

_____

Have you been allergic to any medications? If so which ones? _____

_____

What medications are you currently using? Dose? How many times a day? Please provide a listing of your medications if you take more than five (5).

NAME OF MEDICATION	DOSE YOU ARE TAKING	HOW MANY EACH DAY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT OR PAST MEDICAL PROBLEMS

Are you now under treatment for any illness? Which? _____

What serious illness have you had in the past? _____

List past surgeries _____

Have you broken or fractured any bone? _____

FAMILY HISTORY

MOTHER ☐ LIVING ☐ NOT LIVING AGE____ (Now or at death)
FATHER ☐ LIVING ☐ NOT LIVING AGE____ (Now or at death)

HOW MANY BROTHERS? _____ ILLNESSES? _____

HOW MANY SISTERS? _____ ILLNESSES? _____

IS THERE ANY FAMILY HISTORY OF ARTHRITIS? _____

CHECK THE ACTIVITIES THAT YOU NEED HELP DOING?

☐ Bathing ☐ Getting in/out of a chair ☐ Toileting ☐ Grooming
☐ Dressing ☐ Getting in/out of a bed ☐ Walking ☐ Eating

Do you use an assistive device? ☐ YES ☐ NO

SOCIAL HISTORY

☐ Single ☐ Married ☐ Divorced ☐ Widowed

How many children do you have and what are their ages _____
Do you smoke? ☐Yes ☐No Have you ever smoked? ☐Yes ☐No
Do you drink alcohol and how much? Tell the truth_____
Do you have stairs in your home? ☐ Yes ☐ No

When was your last Bone Density test? _____
Do you participate in recreational exercise ☐ Yes ☐ No
Do you consume caffiene? ☐ Yes ☐ No
How many cups per day? _____

OVER

Pharmacy:

REVIEW OF SYSTEMS

Please mark all symptoms that pertain to you

FOR THE MEN

☐ Prostate trouble

☐ Discharge from the penis

Date of your last colonoscopy _____

FOR THE WOMEN

Are you past menopause? ☐ Yes ☐ No
If not, are your periods regular? ☐ Yes ☐ No

Date of your last pap smear _____

Date of your last mammogram _____

Date of your last colonoscopy _____

GLAND or HORMONAL DYSFUNCTION

Are you on hormone replacement? ☐ Yes ☐ No Thyroid ☐ Yes ☐ No
Female hormones ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No

Other _____

KIDNEY and BLADDER

☐ History of bladder or kidney infection

☐ Pain or burning with urination?

Do you get up at night to urinate? How many times? _____

☐ Blood in the urine?

☐ History of kidney stones

GENERALLY

☐ Fever
☐ Chills
☐ Sweats
☐ Weight change Up / Down
☐ Headache
☐ Dizziness
☐ Unusual fatigue

SKIN

☐ Bruising
☐ Rash
☐ Hives
☐ Hair loss
☐ Psoriasis
☐ Itching

HEART and CIRCULATION

☐ History of heart attack / heart trouble
☐ High Blood Pressure

☐ Aneurysm
☐ Heart murmur
☐ Chest Pain
☐ Irregular heart beat
☐ Fingers turn color in the cold

NERVOUS SYSTEM or PSYCHIATRIC PROBLEMS

☐ Any fits, convulsions, seizures or epilepsy?

☐ Have you or are you being treated by a psychiatrist?

☐ Any numbness, tingling, burning, in your arms or legs?

☐ Have you had any head injury?

DISEASE of the BLOOD

☐ Anemia

☐ Unusual Bleeding

☐ Vein Inflammation (Thrombophlebitis)

☐ Are you slow to heal?

LUNGS

☐ Are you short of breath?
☐ Do you have cough?
☐ Do you wheeze?
☐ Do you have asthma?
☐ Have you coughed up blood / mucous?

HEAD, EARS, EYES, NOSE and THROAT

☐ Eye inflammation (iritis)
☐ Unusual eye redness
☐ Dry eyes
☐ Vision getting worse
☐ Glaucoma
☐ Dry mouth
☐ Mouth sores
☐ Hearing loss
☐ Ear ringing
☐ Hoarseness
☐ Sore throat
☐ Trouble swallowing

STOMACH and INTESTINES

☐ Nausea
☐ Vomiting
☐ Constipation
☐ Diarrhea
☐ Blood in your stool
☐ Very black stool
☐ History of ulcers
☐ Liver disease or Hepatitis
☐ Heartburn or indigestion

OTHER

☐ Cancer
☐ Hepatitis
☐ Shingles

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23441 MADISON STREET, SUITE 340, TORRANCE, CA 90505
PHONE : 310.373.0340 FAX: 310.373.7142

PATIENT CONTACT INFORMATION/RESTRICTION

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner (check all the apply):

□ Home/Cellular Telephone _____

□ OK to leave messages with detailed information.

□ Leave messages with call back number only.

□ Work Telephone _____

□ OK to leave messages with detailed information.

□ Leave messages with call back number only.

□ Written Communication

□ OK to mail to my home address

□ OK to email _____

☐ I prefer not to give my email

I hereby consent to the release of Protected Health Information to the following individuals. I understand this authorization will be in effect until which time it is revoked.

Name(s)	*Relationship*
_____	_____
_____	_____

Patient Signature	Date
_____	_____
Print Name	Birthdate

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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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. It also describes your rights and our legal obligations with respect to your medical information. If you have any information about this notice, please contact our privacy office listed below:

Contact: Teresa M. Neria or Georgina Licup
Telephone: 310.373.0340 **Fax:** 310.373.7142
Address: 23441 Madison Street, Suite 340, Torrance, CA 90505

USES AND DISCLOSURES OF HEALTH INFORMATION. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes.

Treatment: We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. We may share your medical information with other physicians or health care providers who will provide services, which we do not provide. Or, we may share this information with a pharmacist who needs it to dispense a prescription to you or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

Payment: We use and disclose medical information about you to obtain payment for the services we provide.

Health Care Operations: We may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or, we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with “business associates” that

perform administrative services for us. We have a confidentiality of your medical information. Under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other healthcare providers, health care clearinghouses or health plans that have a relationship with you.

Appointment Reminders: We may use and disclose medical information to contact and remind you about your appointments. If you are not at home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Change of Ownership: In the event that this medical practice is sold or merged with another organization, your health information/ record will become the property of the new owner, although you will maintain the right to request that the copies of your health information be transferred to another physician or medical group.

WHEN THIS MEDICAL PRACTICE MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION.

Except, as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

YOUR HEALTH INFORMATION RIGHTS

Right to request special privacy protections: You have the right to request restrictions on certain uses and disclosers of your health information by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject you request, and will notify you of our decision.

Right to request confidential communication: Within reason, you have the right to request that you receive your health information in a specific way or at a specific location. We will comply with requests submitted in writing which specify how or where you wish to receive these communications.

Right to inspect and copy: You have the right to inspect and copy your health information with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances. If we deny your request to access your child's record because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have the right to have them transferred to another mental health professional.

Right to amend or supplement: You have the right to request that we amend your health information that you believe is incorrect or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial policy and how you can protest this denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the

information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

Right to an accounting of disclosures: You have the right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs *treatment, payment, health care operations, notification, and communications* of this Notice of Privacy or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official accounting would reasonably likely to impede their activities. You have the right to a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer(s) listed at the beginning of this Notice of Privacy Practices.

Changes to this Notice of Privacy Practices: We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and we will offer you a copy.

COMPLAINTS: Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Office listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Office of Civil Rights
Hubert H. Humphery Building
200 Independence Avenue SW
Room 509F HHH Building
Washington, DC 20201

You will not be penalized for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

DRS. ENG, KLASHMAN, AND MEHDI

23441 Madison Street, Suite 340
Torrance, CA 90505
310.373.0340

Privacy Officers – Teresa M. Neria or Georgina Licup

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that I will be offered a copy of any amended Notice of Privacy Practices at the time of my first appointment.

_____ _____

Patient Signature Date

_____ _____

Print Name Birthdate

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I hereby give my consent for Drs. Eng, Klashman, and Mehdi to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Drs. Eng, Klashman, and Mehdi's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Eng, Klashman, and Mehdi ATTN: Privacy Officer, 23441 Madison Street, Suite 340, Torrance, CA 90505

With this consent, Drs. Eng, Klashman, and Mehdi can call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent Drs. Eng, Klashman, and Mehdi may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent Drs. Eng, Klashman, and Mehdi may fax to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Drs. Eng, Klashman, and Mehdi restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Drs. Eng, Klashman, and Mehdi use and disclosure of PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it Drs. Eng, Klashman, and Mehdi may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

Print Name _____