REGISTRATION
(PLEASE PRINT)

Home Phone: _____ Today's Date:_____

PATIENT INFORMATION

Name_____ Soc. Sec. #_____
Last Name First Name Initial

Address_____ City_____

State_____ Zip_____ Home Phone_____ Cell_____

Cell Carrier_____ Email_____ Birthdate_____

Single___ Married___ Widowed___ Separated___ Divorced___ Sex M___ F___ Age____ Race / Ethnicity_____

Patient Employed by_____ Occupation_____

Business Address_____ Business Phone_____

By whom were you referred? _____

In case of emergency, who should be notified? _____ Phone_____
Name Relation

PRIMARY INSURANCE

Person Responsible for Account_____
Last Name First Name Initial

Relation to Patient_____ Birthdate_____ Soc. Sec. #_____

Address (if different from patient's)_____ Phone_____

City_____ State_____ Zip_____

Person Responsible Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Insurance Company_____

Contract #_____ Group #_____ Subscriber #_____

Name of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ___ Yes ___ No

Subscriber Name_____ Relation to Patient_____ Birthdate_____

Address (if different from patient's)_____ Phone_____

City_____ State_____ Zip_____

Subscriber Employed by_____ Business Phone_____

Insurance Company_____

Contract #_____ Group #_____ Subscriber #_____

Name of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company(ies

and assign directly to Dr._____ insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

Malik Rheumatology, P.A.

Today's Date:_____ Date of Visit:_____ Date of Birth:_____

Name_____ Age_____ Gender_____ Race / Ethnicity_____

Marital Status_____ How Long? _____ Previously Married_____ How Long? _____

Do you have children? _____ Number _____ Preferred Language_____

Primary Care Physician _____ Referred By _____

Have you ever been seen by a Rheumatologist before, if yes who? _____

Have you ever been diagnosed with the following? (Please circle those that apply) Please indicate year diagnosed if known.

Anxiety
Ankylosing Spondylitis
Cancer
Claustrophobia
COPD / Asthma
Crohn's Disease
Depression
Diabetes / Hypertension
Fibromyalgia
Gout / Pseudogout
Heart Disease
Hepatitis B or C / HIV
Hyperlipidemia
Hypothyroidism
Hyperthyroidism
Iritis or Uveiitis
Irritable Bowel Syndrome
Juvenile Inflammatory Arthritis
Kidney Disease
Liver Disease
Lupus
Mitral Valve Prolapse
Obstructive Sleep Apnea
Osteoarthritis
Osteoporosis
Panic Attacks
Pericarditis
Pleuritis / Pleurisy
Polymyalgia Rheumatica
Psoriasis
Psoriatic Arthritis
Raynaud's Syndrome
Reactive Arthritis
Rheumatoid Arthritis
Scleroderma
Sjogren's Syndrome
Sexually transmitted disease
Ulcerative Colitis

Have you undergone any of the following surgeries? Please indicate date of surgery.

Appendectomy_____ Gallbladder_____ Hysterectomy_____ Fractures/ Motor Vehicle Accidents_____

Joint replacement surgery_____ C-section _____ Carpal Tunnel Syndrome_____ Neck / Back Surgery_____

Do you have a family history of? (Please circle those that apply)

Ankylosing Spondylitis
Crohn's Disease
Depression
Fibromyalgia
Gout / Pseudogout
Juvenile Inflammatory
Lupus
Osteoarthritis
Osteoporosis
Psoriasis
Reactive Arthritis
Rheumatoid Arthritis
Scleroderma
Sjogren's Disease
Ulcerative Colitis

Do you use tobacco: _____ If **currently**, how much and how long _____ If **formerly**, how much and how long _____

Do you drink alcohol, if yes how much and how long? _____

Have you ever used any form of illegal drugs? _____

Do you work, if yes what do you do and for how long? _____

If retired, for how long and what kind of work have you done before? _____

Doctor's Notes:

-over-

List of all current medications:

Medications	Strength	Dose	Date started

Medication allergies and reaction

Medication	Reaction

Doctor's Notes:

Malik Rheumatology, P.A.
Basit A. Malik, MD
1700 East 30th Ave., Suite A
Hutchinson, KS 67502
Ph. #(620)663-8200 * Fax #(620)663-8201

CONSENT FOR RELEASE OF INFORMATION

I, _____, _____, _____
(Patient's Name) (DOB) (Address)

hereby authorize _____
(Name and Address of Agency or Institution)

to disclose to _____

_____

the following information from my records (specify extent or nature of information to be disclosed, type of reports)_____

_____

Specify dates of treatment : _____ to _____
The purpose or need for such information is for _____

Medical records are protected by Federal Regulations and Kansas Statues and further disclosure is prohibited without the undersigned's consent.

This authorization is subject to cancellation at any time, but would apply to any information already released in good faith.

Specify the date, extent, or condition upon which this consent expires: _____
(If left blank, expiration date is sixty (60) days after date entered below)

If applicable, disclosure made in conformity with this authorization shall be accompanied by a written statement regarding redisclosure as provided for by Federal Regulation 42 CFR Part 2.

DATE Signature of Patient

Witness Signature of Parent or Guardian,
Authorized Representative

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, **MALIK RHEUMATOLOGY, P.A.** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that **MALIK RHEUMATOLOGY, P.A.** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that **MALIK RHEUMATOLOGY, P.A.** reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should **MALIK RHEUMATOLOGY, P.A.** change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I give permission to leave a message via telephone answering machine/voicemail or family member regarding appointment reminders and/or medical information if necessary.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

_____
Patient's Signature

_____
Date

FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____.

Malik Rheumatology, P.A.
1700 East 30th Ave., Suite A
Hutchinson, KS 67502

Patient Financial Policy

Please bring your insurance identification card(s) with you each time you visit our office. A photocopy will be placed in your patient file. If you belong to an PPO/HMO plan, please make sure you have obtained a referral from your primary care physician.

Malik Rheumatology, P.A. participates with several insurance companies. It is up to the patient to be aware if we are a contracting/in-network provider with their insurance company. As a courtesy to our patients, if acceptable insurance identification is provided and effective coverage is verified, we will submit claims on your behalf.

All co-payments are due in full at the time of service. After we receive payment from your insurance company, any remaining patient balance is to be paid within 30 days of receipt of your statement unless monthly payment arrangements have been made. All patient balances are due within 90 days of receipt. Any questions regarding a non-payment from your insurance company should be directed to your insurance carrier.

Patients who do not have insurance coverage will be expected to pay at the time of service. If you cannot pay in full, a deposit will be required and we will work with you to set up a payment plan. A New Patient consult/office visit requires a $200.00 deposit payment at time of service for those who do not have insurance coverage or are considered self-pay.

We accept personal checks, money orders, cash and credit/debit cards (with the exception of American Express). Checks returned for insufficient funds will be charged a $25.00 service fee.

Delinquent accounts may be assigned to a collection agency or subject to small claims court action. All collection costs will be added to your outstanding balance and will become an additional cost to you. Any payments on accounts turned to collections are payable and due to the collection agency.

Our office policy requires a 24 hour cancellation notice. A service fee, as follows, applies to cancellations not made within the 24 hour time frame and "No Show" appointments:

Follow-up appts:	$25.00
New Patient appts:	$50.00

If you have any questions or need assistance in understanding your statement and/or insurance payments, please contact the office at (620)663-8200.

_____ _____

Patient / Guardian Signature Date

Patient Authorization to Use or Disclose Protected Health Information
To Primary Care Physician

I, _____, understand that as part of my treatment, **MALIK RHEUMATOLOGY, P.A.** may forward protected health information to the primary care physician. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of **MALIK RHEUMATOLOGY, P.A.** to release or disclose my protected health information to the primary care physician or other medical practice named below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed (*check all that apply):*

[ ] The patient's entire medical record
(Note: This requires an explanation why the entire record may be disclosed).

[ ] The patient's demographic information (*check all that apply):*
[ ] Name [ ] Address [ ] State/Zip Code only [ ] Telephone
[ ] Age [ ] Gender [ ] Race [ ] Other:_____

[ ] Medical Data/Information as related to:
[ ] Specific condition (s):_____
[ ] Specific professional services(s):_____
[ ] Specific medication(s):_____
[ ] Other:_____

[ ] Other:_____
_____

Name of the primary care physician or other medical practice, address, and fax number:
_____
_____
_____

MALIK RHEUMATOLOGY, P.A. shall send information ONLY to the above address or fax number. Any disclosure of the patient's protected health information to another address or fax number will require a separate authorization.

Purpose(s) of the information:

[ ] To permit **MALIK RHEUMATOLOGY, P.A.** to release any and all appropriate diagnoses, treatment(s), lab result(s), and other necessary health information, so the primary care physician or other practice can maintain continuity of care.

[ ] Other: _____

_____

This authorization permits **MALIK RHEUMATOLOGY, P.A.** to disclose ONLY the information determined to be the "minimum necessary" (unless the "entire medical record" option is selected above) to the primary care physician or other medical practice. Additional information shall require another authorization.

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, **MALIK RHEUMATOLOGY, P.A.** must receive the revocation in writing. The revocation must include:

- The patient's name, address, and patient number, if applicable,
- The effective date of this authorization, and the recipients of the protected health information according to this authorization,
- The patient's desire to revoke this authorization, and
- The date of the revocation, and the patient's signature.

MALIK RHEUMATOLOGY, P.A. will accept written revocations of this authorization via:

[ ] Certified U.S. mail.

[ ] Facsimile at this number:_____

ALL revocations must be sent to **MALIK RHEUMATOLOGY, P.A.** to the attention of the Privacy Officer, and are not effective until received by the Privacy Officer.

This authorization shall expire on_____. After this date, **MALIK RHEUMATOLOGY, P.A.** can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

_____ _____

Patient's Signature Date

FOR OFFICE USE ONLY

Authorization added to the patient's medical record on_____.

Authorization verified by _____ on _____.

Malik Rheumatology, P.A.

1700 East 30th Ave., Suite A
Hutchinson, KS 67502
Ph (620)663-8200 Fax (620)663-8201

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.

If you have any questions about this Notice please contact our office.
Privacy Officer
Ph (620)663-8200

Effective Date: August 2009 Revised: November 17, 2017

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

Malik Rheumatology, P.A.

1700 East 30th Ave., Suite A

Hutchinson, KS 67502

Ph (620)663-8200 Fax (620)663-8201

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or maybe at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.

- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us

specifically not to share the information.

- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. Send a letter stating the information you would like to obtain to: The Privacy Officer, 1700 East 30th Ave, Suite A, Hutchinson, KS 67502.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception:

We must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

Malik Rheumatology, P.A.
1700 East 30th Ave., Suite A
Hutchinson, KS 67502
Ph (620)663-8200 Fax (620)663-8201

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after August 1, 2009. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Privacy Officer; 1700 East 30th, Suite A, Hutchinson, KS 67502 ph. (620)663-8200

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.
This notice was published and becomes effective on August 2009.

Revised 11/17/2017