Chelsea I. Clinton, M.D.
18585 Sigma Rd., Ste. 102
San Antonio, TX 78258
Phone: 210-591-0688 Fax: 210-546-1238

NEW PATIENT PACKET

Welcome to C.I Clinton Rheumatology, PLLC. We look forward to getting to know you and providing you with excellent rheumatologic care. Please bring your health insurance card, photo identification, current medication list and any labs, imaging reports or other medical records that may assist us with your care. All initial visits do take place in-person at our Sigma Road location in San Antonio.

Sincerely,

Chelsea I. Clinton, M.D. and staff

PATIENT DEMOGRAPHICS

Last Name:_____ First Name:_____ Middle: _____

Age:_____ Date of Birth:_____ Social Security:_____ - _____ - _____

Gender:_____ Race/Ethnicity:_____

Street Address:_____

City:_____ State: _____Zip: _____ Email:_____

Home #: _____ Mobile #: _____ Work #: _____

Emergency Contact Name/Relationship: _____/_____

Emergency Contact Phone: _____

Primary Care Physician (PCP):_____

Who referred you? _____

Preferred Pharmacy:_____ Phone: _____

Pharmacy Address/Location:_____

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PRIMARY INSURANCE INFORMATION

Primary Insurance:_____ Phone: _____

Subscriber ID: _____ Group Number: _____

Policy Holder Name: _____

Policy Holder Relationship to Patient:_____

Policy Holder Social Security Number: _____ Policy Holder Date of Birth: _____

Employer Name:_____ Employer Phone: _____

Occupation / Department: _____

ADDITIONAL INSURANCE INFORMATION

Additional Insurance:_____ Phone: _____

Subscriber ID: _____ Group Number: _____

Policy Holder Name: _____

Policy Holder Relationship to Patient: _____

Policy Holder Social Security Number: _____ Policy Holder Date of Birth: _____

FINANCIAL RESPONSIBILITY AGREEMENT

I agree to assign insurance benefits from my insurance policies to C.I. Clinton Rheumatology, PLLC (CICR) to pay for services and other items. I understand and agree that health and other insurance policies are an arrangement between an insurance carrier and me, and I am ultimately responsible for paying for services rendered by CICR regardless of whether my insurance pays for them. Furthermore, I understand that CICR will prepare any necessary reports and forms to assist me in collecting monies owed by the insurance company, and that any amount authorized to be paid directly to CICR will be credited to my account upon receipt. However, I understand and agree that all services I receive are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, all fees for professional services I receive will be immediately due and payable.

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INFORMED CONSENT

It is my desire and intent to receive diagnostic and clinical Rheumatologic medical services and related treatment (my "Care") from C.I. Clinton Rheumatology, PLLC and its licensed and unlicensed staff ("CICR"). I understand that CICR provides Care in an effort to assist or enable me to remedy or recover from an ailment. I understand, however, that CICR cannot guarantee any specific result from the provision of Care. I also understand and agree that my receipt of Care is voluntary and where CICR makes treatment recommendations (including medical procedures), I ultimately have the choice over whether or not to accept or participate in the treatment. Accordingly, I understand that I may withdraw from treatment at any time.

I give CICR the permission and authority to perform (or order) labs, xrays or other diagnostic studies. I understand that these clinical procedures are usually beneficial, but they can sometimes cause harm. I also understand that, in rare cases, underlying physical deformity or pathology may render me susceptible to injury. CICR will inform me if they are unable to treat me, but it is my responsibility to make known any pathological illnesses or deformities of which I am aware, and of which CICR would otherwise be unaware. CICR provides rheumatologic care which cannot and does not encompass every medical specialty; I understand and agree that I must consult with the correct specialist for proper diagnostic and clinical procedures for non-rheumatologic care.

I understand that CICR may prescribe medication as needed. I understand that all medications have the potential for side effects and that medications prescribed for rheumatologic conditions can have serious potential side effects such as an increased risk for serious infections. I agree to review any literature provided by CICR before starting my medication and I agree to accept the risks that accompany the medication I'm prescribed. I agree not to change my dose or discontinue that medication without the knowledge and guidance of CICR or, when applicable, another licensed healthcare provider.

I understand that CICR may prescribe, perform, or recommend medical procedures such as injections and aspirations of joints or soft tissues. I understand that these medical procedures have the potential for side effects. Though typically safe, it is possible to have a negative reaction to the medication injected or procedure itself including infection, bleeding, pain, skin discoloration/scarring, and the risk that the procedure/medication is not effective. Regardless, I am willing to accept these risks and, by either asking or permitting CICR to perform these procedures, I am doubly confirming my acceptance of the risks associated with these procedures.

I further understand that CICR may prescribe or recommend exercise, physical training, and/or lifestyle adjustments. I understand that these recommendations or prescriptions also have the potential for side effects. Though typically safe, it is possible to injure myself while performing exercise, physical training, and/or lifestyle adjustments. Regardless, I am willing to accept these risks and perform any such exercises, physical training, and/or lifestyle changes.

Although my participation is entirely voluntary, I understand that achievement of the best possible results from the Care will require that I adhere to CICR's treatment recommendations and appointments scheduled. I further understand that other treatments may exist in addition to CICR's recommendations or prescriptions.

After reading the above, I hereby request that CICR provide Care for me, and I hereby accept the risk of any unknown side effects associated with the Care or medication prescribed.

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Notice of Privacy Practices

Effective Date: January 1, 2013

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:

Daniela Segura at *(210) 591-0688* .

WHO WILL FOLLOW THIS NOTICE?

✓ C.I. Clinton Rheumatology, PLLC (including Dr. Clinton and Staff)

We understand that medical information about you and your health is personal and are committed to protecting this information. When you receive care at C.I. Clinton Rheumatology, PLLC ("CICR") a record of the care and services you receive is made. Typically, this record contains your treatment plan, history and physical, test results, and billing record. This record serves as a:

- Basis for planning your treatment and services;
- Means of communication among the physicians and other health care providers involved in your care;
- Means by which you or a third-party payor can verify that services billed were actually provided;
- Source of information for public health officials; and
- Tool for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as "medical information"). It also describes your rights and our obligations regarding the use and disclosure of medical information.

OUR RESPONSIBILITIES.

CICR will:

- Make every effort to maintain the privacy of your medical information;

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- Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction; and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- CICR will notify you, and the Department of Health & Human Services, of any unauthorized acquisition, access, use or disclosure of your unsecured medical information that presents a significant risk of financial, reputational or other harm to you, to the extent required by law. Unsecured medical information means medical information not secured by technology that renders the information unusable, unreadable, or indecipherable as required by law.

THE METHODS IN WHICH WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

- **For Treatment.** We will use and disclose your medical information to provide, coordinate, or manage your health care and any related service. For example, we may share your information with your primary care physician or other specialists to whom you are referred for follow-up care.
- **For Payment.** We will use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to disclose your medical information to a health plan in order for the health plan to pay for the services rendered to you.
- **For Health Care Operations.** We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run CICR in an efficient manner and provide that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing.
- **Appointment Reminders.** We may use and disclose medical information in order to remind you of an appointment. For example, CICR may provide a written or telephone reminder that your next appointment with CICR is coming up.
- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the surgical outcome of all patients for whom one type of procedure is used to those for whom another procedure is used for the same condition. All research projects, however, are subject to a special approval process. Prior to using or disclosing any medical information, the project must be approved through this research approval process. We will ask for your specific authorization if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.

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- **As Required by Law.** We will disclose medical information about you when required to do so by federal or Texas laws or regulations.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you to medical or law enforcement personnel when necessary to prevent a serious threat to your health and safety or the health and safety of another person.
- **Sale of Practice.** We may use and disclose medical information about you to another health care facility or group of physicians in the sale, transfer, merger, or consolidation of our practice.

SPECIAL SITUATIONS.

- **Organ and Tissue Donation.** If you have formally indicated your desire to be an organ donor, we may release medical information to organizations that handle procurement of organ, eye, or tissue transplantations.
- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Qualified Personnel.** We may disclose medical information for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the audit or evaluation, or otherwise disclose your identity in any manner.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following activities:

- To prevent or control disease, injury, or disability;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
- To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence.

All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.

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- **Lawsuits and Disputes.** If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:

- In response to a court order or subpoena; or
- If CICR determines there is a probability of imminent physical injury to you or another person, or immediate mental or emotional injury to you.

- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner when authorized by law (*e.g.,* to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.
- **Inmates.** If you are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide you treatment.
- **Other Uses or Disclosures.** Any other use or disclosure of PHI will be made only upon your individual written authorization. You may revoke an authorization at any time provided that it is in writing and we have not already relied on the authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information collected and maintained about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records.

  To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer for CICR. If you request a copy of the information, CICR may charge a fee established by the Texas Medical Board for the costs of copying, mailing, or summarizing your records.

  CICR may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by CICR will review your request and denial. The person conducting the review will not be the person who denied your request. CICR will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information maintained about you is incorrect or incomplete, you may ask CICR to amend the information. You have the right to request an amendment for as long as the information is kept by CICR.

  To request an amendment, your request must be made in writing and submitted to CICR. In addition, you must provide a reason that supports your request.

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CICR may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, CICR may deny your request if you ask us to amend information that:

- Was not created by CICR, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by CICR;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations.

  To request this list you must submit your request in writing to CICR. Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists within the 12-month period, you may be charged for the cost of providing the list. CICR will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information CICR uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information CICR discloses about you to someone who is involved in your care or the payment for your care.

  CICR is not required to agree to your request, unless the request pertains solely to a healthcare item or service for which CICR has been paid out of pocket in full. Should CICR agree to your request, CICR will comply with your request unless the information is needed to provide you emergency treatment.

  To request restrictions you must make your request in writing to CICR. In your request, you may indicate: (1) what information you want to limit; (2) whether you want to limit CICR's use and/or disclosure; and (3) to whom you want the limits to apply.

- **Right to Request Confidential Communications.** You have the right to request that CICR communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that CICR contact you only at work or by mail.

  To request that CICR communicate in a certain manner, you must make your request in writing to the Privacy Officer. You do not have to state a reason for your request. CICR will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

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CHANGES TO THIS NOTICE.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting the Privacy Officer.

COMPLAINTS.

If you believe your privacy rights have been violated, you may file a complaint with CICR or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with CICR, contact the Privacy Officer at *(210) 591-0688*. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. The address for the Office of Civil Rights is:

Secretary of Health & Human Services
Region VI, Office for Civil Rights

U.S. Department of Health and Human Services

1301 Young Street, Suite 1169

Dallas, TX 75202

All complaints should be submitted in writing.

You will NOT be penalized for filing a complaint.

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SIGNATURE PAGE

By placing my signature in the appropriate space below, I hereby:

- Certify, represent, and agree that any information that I have provided to CICR is true and accurate;
- Represent and agree that I have read, understand and have been supplied with a copy of the Notice of Privacy practices;
- Represent that I have read, understand, accept, and agree to the Informed Consent and Financial Responsibility Agreement;
- Represent that I am personally empowered, or am duly authorized by the patient as the patient's general agent, to execute these agreements and this document.

_____ _____

Patient (or Parent/Guardian/Representative) Signature Witness Signature

_____ _____

Patient Name (Please Print) Witness Name (Please Print)

_____ _____

Date Signed Date Signed

_____

Parent/Guardian/Representative Name (Please Print)

_____

Relationship to Patient (for Guardian or Representative)

CONSENT TO TREAT AN EMANCIPATED MINOR

By my signature, I warrant that I am over the age of 16 years, and that I reside separate and apart from my parents and/or Guardian. I further warrant that I am managing my own financial affairs, and hereby consent to treatment by C.I. Clinton Rheumatology, PLLC.

Signature:_____ Date: _____

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Authorization for Release of Patient Information (page 1)

Information regarding patient for whom authorization is made:

Full Name: _____
Other Name(s) Used: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone: ( ) _____ Email (*Optional*): _____

Information regarding health care provider/entity authorized to disclose this information:

Name: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone: ( ) _____ Fax: ( ) _____

Information regarding person or entity who can receive and use this information:

Name: C.I. Clinton, Rheumatology, PLLC
Address: 18585 Sigma Rd. Ste. 102, San Antonio, TX, 78258
Phone: (210) 591-0688 Fax: (210) 546-1238

Specific information to be disclosed:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.

Include: (*Indicate by Initialing*)	**Reason for release of information:**
_____ Drug, Alcohol or Substance Abuse Records	***(Choose all that Apply)***
_____ Mental Health Records (Except Psychotherapy Notes)	☐ Treatment/Continuing Medical Care
_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)	☐ Personal Use
	☐ Billing or Claims
_____ Genetic Information (Including Genetic Test Results)	☐ Insurance
	☐ Legal Purposes
	☐ Disability Determination

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Authorization for Release of Patient Information (page 2)

The individual signing this form agrees and acknowledges as follows:

Voluntary Authorization: This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

Effective Time Period: This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: - _____

Right to Revoke: I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Special Information: This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative: _____

Date: _____

If Legal Representative, relationship to Patient: _____

Witness (optional): _____

Date: _____

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OFFICE POLICIES of C.I. CLINTON RHEUMATOLOGY, PLLC

Please initial to indicate that you have read and will comply with our office policies.

_____**1. PAYMENTS.** You must pay all applicable fees, deductibles, co-insurance, copayment and prior balances at the time of your appointment. We accept cash, check, Visa, MasterCard or Discover. A service fee will be applied to your account for each returned check, and patients who present checks that are dishonored will be required to pay future amounts with cash or credit card. Post-dated checks are not accepted. For patients without health insurance or with plans in which our office does not participate payment is due in full at the time of service.

_____**2. INSURANCE CLAIMS.** Insurance is a contract between you and your insurance company. It is your responsibility to know if your insurer has any deductible, copayment, co-insurance, out-of-network amount, usual and customary limit, or any other type of benefit limitation, and you agree to make full payment. In order for CICR to bill your insurance company we require that you provide correct insurance information. Incomplete or inaccurate insurance information may result in patient responsibility for the entire bill.

_____**3. REFERRALS.** It is your responsibility to determine if your health insurance plan requires a primary care office referral and to obtain this referral before the scheduled visit. If the referral is not available at the time of your visit you will be asked to reschedule your appointment. It is also your responsibility to determine whether CICR is an in-network provider recognized by your insurer. If CICR is not considered in-network then you will be responsible for payment in full.

_____**4. ADMINISTRATIVE FORMS.** A fee or separate office visit is required for administrative forms or letters requested by our patients including, but not limited to, disability/FMLA forms or paperwork for patient assistance programs.

_____**5. CANCELLATIONS.** If you need to cancel or reschedule your appointment, please call at least 24 hours before your scheduled appointment. Patient's will be charged a $40 fee for each late cancellation or missed appointment for follow-up visits and a $60 fee for new patient late cancellations. CICR will NOT reschedule new patients if they miss a new patient appointment without notifying CICR in advance.

_____**6. MEDICATION REFILL REQUESTS.** We will only approve a medication refill request after business hours or on weekends if it is an emergency. Please ask Dr. Clinton to write your prescriptions at the time of your visit or make refill requests during business hours.

_____**7. NARCOTIC PRESCRIPTIONS.** Dr. Clinton does not routinely prescribe narcotics. If you are accustomed to taking narcotic medications, then a referral to pain management will be indicated if the prescription is not already being filled by another physician.

_____**9. LAB RESULTS.** A patient portal is available for you to review your lab results online. We ask that you not call the office to check on lab results unless either specifically instructed to by Dr. Clinton or if your follow up is based on these results. Otherwise, we will call you to report abnormal results that need attention.

"I, the Guarantor of Payment and Responsible Party, agree to the above policies and agree to the terms regarding payment and payment responsibilities."

Signature of Patient:_____**Date:**_____

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PATIENT PORTAL CONSENT FORM

CI Clinton Rheumatology, PLLC offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physician. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks, we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

HOW THE SECURE PATIENT PORTAL WORKS

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or passphrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

PROTECTING YOUR PRIVATE HEALTH INFROMATION & RISKS

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message much reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

Only you can make sure these two factors are present. We need you to make sure we have your correct email address and are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

If you pick up secure messages from a website, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

PATIENT ACKNOWLEDGEMENT & AGREEMENT

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures Regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. All of my questions have been answered and I understand and concur with the information provided in the answers.

_____ _____

Patient Name Date

_____ _____

Patient Signature Email Address