RHEUMATOLOGY

Sumeet Bhinder, M.D., Inc
Board Certified Rheumatologist

Practice Limited to Rheumatology

Temperature: _____
Blood Pressure: _____
Pulse: _____
Height/Weight: _____
OFFICE USE ONLY

Name/Nombre: _____ D.O.B./Fecha de Nacimiento: _____
Date: _____ Marital Status:/Estado Civil: _____
Occupation/Ocupacion: _____

Medication Allergies/ Alergia a Medicamientos: _____
_____

Please list current medications/por favor lista todos los medicamientos que toma:

Medication/Medicamiento	**Strength/Fuerza**	**Times take per day/Tiempo tomados por dia**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any surgeries/por favor escribe cualquier cirugia:

What year?/Que ano?	**Type?/Tipo**
_____	_____
_____	_____
_____	_____

Social History/Historia Social

Do you drink alcohol? Yes ☐ No ☐ How much? _____ Usted consume alcohol? Si ☐ No ☐ Cuanto? _____
Do you smoke? Yes ☐ No ☐ How long? _____ Usted fuma? Si ☐ No ☐ Cuanto Tiempo? _____

Females Only:

Pregnancies/ Embarazos? _____ Miscarriages/Abortos espontáneos? _____
Abortions/Abortos _____

Family History/Historia Familiar:

Do any family members have the following? Algún miembro de la familia tiene lo siguiente?
Relation/Relación?
Rheumatoid Arthritis/Artritis Reumatoide: _____
Gout/Gota: _____
Lupus: _____
Osteoporosis: _____
Osteoarthritis/Osteoartritis: _____
Diabetes: _____
Cancer: _____

6001 Truxtun Ave A, Suite 160, Bakersfield, California 93309
Office (661) 588-4001 • Fax (661) 588-4042

RHEUMATOLOGY

Sumeet Bhinder, M.D., Inc
Board Certified Rheumatologist

Practice Limited to Rheumatology

Name/Nombre: _____ D.O.B./Fecha de Nacimiento: _____
Date: _____
Pharmacy/Farmacia: _____

Please circle symptoms you are currently having: Por favor circule los síntomas que está teniendo actualmente?

Fever/Chills	Fiebre/escalofríos
Severe weight loss	Pérdida de peso severa
Loss of appetite	Pérdida de apetito
Sores in mouth/nose	Llagas en la boca/nariz
Severe headache	Dolor de cabeza intenso
Sinus congestion	Congestión nasal
Tender temples	Templos tiernos
Sudden loss of vision	Pérdida repentina de la visión.
Chest pain/Palpitations	Dolor en el pecho/palpitaciones
Severe abdominal pain	Dolor abdominal severo
Severe Diarrhea/Constipation	Diarrea severa/estreñimiento
Skin ulcers	Úlceras cutáneas
Patchy hair loss	Pérdida de cabello en parches
Rash/Redness	Sarpullido/Enrojecimiento
Swollen glands	Glándulas inflamadas
Panic attacks	Ataques de pánico
Depression	Depresión
Nervousness	Nerviosismo
Double vision	Visión doble
Poor sleep	Pobre sueño
Red painful eyes	Ojos rojos y dolorosos
Joint pain/swelling	Dolor/inflamación articular
Muscle pain	Dolor muscular
Morning Stiffness	Stiffnes de la mañana Si ☐ No ☐
If yes, how long? _____	En caso afirmativo,cuánto tiempo? _____

6001 Truxtun Ave A, Suite 160, Bakersfield, California 93309
Office (661) 588-4001 • Fax (661) 588-4042

RHEUMATOLOGY

Sumeet Bhinder, M.D., Inc
Board Certified Rheumatologist

Practice Limited to Rheumatology

PATIENT INFORMATION: PLEASE PRINT

Patient Name: _____ D.O.B: _____ Sex: ☐Male or ☐ Female

Home Phone #: (_____)_____ Cell Phone #: (_____)_____ Other #: (_____)_____

Email: _____ Marital Status: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Social Security #: _____ (only if you have Medicare) Marital Status:

RESPONSIBLE PARTY

Name: _____ D.O.B. _____

Relationship: _____ Contact Phone #: (_____)_____

Street Address: _____ City: _____ State: ____ Zip: _____

INSURANCE INFORMATION

Primary Insurance: _____ Name of Subscriber: _____

Relationship: _____ Subscriber DOB: _____ Subscriber SS #: _____

Secondary Insurance: _____ Name of Subscriber: _____

Relationship: _____ Subscriber DOB: _____ Subscriber SS #: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone #: (_____)_____ ☐ Home ☐ Mobile ☐ Other _____

EMPLOYER INFORMATION

Patients Employer: _____ Occupation: _____

Work Number #: _____ Work Address: _____

6001 Truxtun Ave A, Suite 160, Bakersfield, California 93309
Office (661) 588-4001 • Fax (661) 588-4042

Patient Name: _____ D.O.B: _____

Insurance Coverage/Benefit Disclaimer

Please provide us with your current insurance plan information at the time of each visit and notify us of any changes. We will request a copy of your insurance card to copy or scan and keep on file for our records. I understand that any insurance benefits made by Sumeet Bhinder M.D. Inc., are not in any way guarantees of payments. Rather, either they are written or oral statements received from the insurance company or third-party investigator as to the benefits of my insurance plan. I also understand that these inquiries are being done as a courtesy to me, and I have the right, and am encouraged to verify the information I receive by contacting the insurance company myself. I also understand that if I agree to receive any treatment, that I accept full responsibility for any cost incurred and not paid by my insurance company. Your health insurance is a contract between you and your insurer. Any charges not paid by your insurer for any reason are your responsibility. It is your responsibility to understand your insurance benefits, including plan limitations, the difference between screenings or preventative care benefits versus diagnostic procedure benefits and need for referrals or pre-certifications. We will make every effort to verify your benefits, identify your financial liabilities and obtain any necessary pre- certifications prior to your appointment on your behalf; however, this is not a guarantee of payment. Please be aware of and provide any required referrals or authorizations in advance of the appointment or service. If you do not provide these before care is given, you will be responsible for the cost of the care. When in doubt, contact your plan directly for clarification.

Our doctors belong to many insurance plans, but participation differs by doctor. You can request a list of plans that our providers participate by calling our billing office at 661-588-4001 Ext 308. Before your appointment, please be sure your doctor is in-network and the services are covered under your plan. If your doctor is out-of-network, you will be billed for the costs of care. If you would like a cost estimate, we would be happy to provide one. We will also help you find out if you have out-of-network benefits. Refer to our out-of-network policy below for more details. Please let us know at any time if you do not want us to submit a claim to your plan.

OPEN BALANCES

It is our policy to collect payment in full at the time of service. If you need to make special payment arrangements, it is your responsibility to initiate this effort with our offices. As a last resort, patients who fail to adhere to our financial policies may be sent to collections, occur additional costs and be terminated from our practice. Identified balances on account may be refunded only during the final week of the month.

Laboratory Services

Our office will provide the insurance information necessary for FOUNDATION LAB., LAB CORP., QUEST DIAGNOSTICS, UNILAB, RDL, ADVENTIST LABORATORIES, and WEST PAC LABORATORIES to process your lab results. Any services provided by the facilities mentioned that are not covered by the insurance and incur a balance will be the responsibility of the patient or legal guardian.

Address Change

It is important that we have your correct address information on file. Please advise us anytime there is any change to your address, telephone or other contact information.

Co-payment/Co-insurances/Deductibles

You are expected to pay your co-payment and any co-insurance and/or deductible amounts, if known, at the time of service.

Payments
Payments are due at the time services are provided or upon receipt of a statement from our billing office. We accept payment in the form of cash, check, money order, or credit card (American Express, MasterCard, Visa and Discover). Returned checks are subject to a fee of $25.00. We do not accept traveler's checks.

As a service to our clients, we provide a courtesy (bill pay reminder) /call and possibly other important calls that may be placed using a prerecorded message

Non-Medical Fees
Additional fees may apply to the following:

- Returned checks
- Copying fee of medical records
- Completion of disability or other forms
- No show fees
- Official letterhead documents

Missed Appointments
Sumeet Bhinder MD Inc. requires 24-hour notice (Two Business days) cancellation or reschedule notice for each office visits. Procedures and surgeries may require 48-hours (Three business days) or more. Please note that weekends and holidays are not considered business days. If you miss your appointment, or do not cancel with the required notice, additional feesmay apply:

- Office Visit: $35.00
- New Patient Visit: $50.00
- IV Infusion Appointment: $50.00

Out-of-Pocket Network Providers

- If the doctor is not in your insurance plan, the following applies:
- Full payment is due at the time of service.
- Payment expected on the date of service may be an estimate of your total charges.
- You will be quoted an estimated fee before service/ IV infusion treatments are performed.
- Even if you have out-of-network benefits, you are ultimately responsible for the full fee charged.
- Depending on your plan, payment may be sent to you. If you receive this payment, you must reimburse Sumeet Bhinder M.D. Inc immediately.

Non-Covered Services
Medicare Patients. Medicare may not cover some services your doctor recommends. You will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help you decide whether you want to receive services, knowing you are responsible for payment. You must read the ABN carefully.

Non-Medicare Patients
Any service not covered by your plan are your responsibility and must be paid in full at the time of service or upon receiving a bill.

Refunds
All credit balances will automatically be applied to any open balance on your account, including any amounts owed to other Sumeet Bhinder M.D. Inc Group practice providers. A refund is issued (unless any outstanding balances) when an overpayment has been identified. If you feel a refund is due and you have not received one, please contact our billing office at (661) 588-4001 EXT 308.

Failure to Pay
If you do not pay your bill, your account may be sent to an outside collection agency. If your account is sent to a collection agency, you will need to contact them directly to settle your balances

Infusion Treatments
We have a full-time employee that will try to get your infusion authorized and your medications ordered for delivery at our office in time for your appointment. The Patient is still ultimately responsible for the authorization and delivery. You may call the IV Infusion Authorization Clerk at (661) 588-4001 EXT 304 to check on your authorization and delivery of your medication or insurance company dispensing pharmacy.
The following situations may affect your IV Treatment:

- Delivery of your medication
- Authorization for your treatment
- If you change insurance companies, or your employer changes policy number on your insurance cards, you must bring in the new insurance information four weeks prior to your appointment and check with the Infusion Authorization Clerk to make sure we do not have to re-start the Authorization process. Each time you change insurance or change policy number's we need to resubmit your authorization. Your infusion appointment may need to be canceled until we get a new authorization approval from your insurance company.
- If your insurance has not paid your past two claims your infusion treatment could be put on hold until the issue is resolved. This is to help the patient not incur a balance that they are unable to pay. You may contact our billing department to figure out a solution, or insurance company.

Policy and Fee Changes
These policies and fees are subject to change. Our office will do our best to keep you informed of any modifications.

We know medical care can become expensive. If you have concerns about your ability to pay, you can contact us for help in managing your account. If you have questions about these policies, feel free to ask our Office Manager for more details or call the billing office 661-588-4001 EXT 308, also located on your billing statement.

By signing this form, I attest that I have read and understand all that has been written. I have been given the opportunity to ask any question that I may have regarding this form. I understand that I have the right to review the notice prior to signing this consent. By refusing to sign this consent, Sumeet Bhinder M.D. Inc. has the right to refuse treatment. I have the right to request restrictions as to how my health information may be used or disclosed and that Sumeet Bhinder M. D. Inc., is not required to agree to the requested restrictions. By signing this consent, I authorize the release of information to process any claims that Sumeet Bhinder M.D. Inc. requires receiving payment for the company or any company that they have involved in my care.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Patient's Reassignment and Release Statement

By signing below, I understand and accept the financial policies of Sumeet Bhinder M.D. INC. I authorize payment of any insurance coverage and benefits to Sumeet Bhinder M.D. INC. and authorize them to release any medical information necessary to process claims. I give Sumeet Bhinder M.D. INC. permission to apply payments received to balances among its locations, including application to oldest balances first. I understand that I am ultimately financially responsible for the services I receive from Sumeet Bhinder M.D. INC. Should I neglect to meet my financial responsibility, I understand that I may be charged additional fees incurred in the collection process, including from third party collection agencies.

SIGNATURE (Patient or Parent/Legal Guardian if Minor) _____

Assignment of Insurance Benefits and Authorization to Release Information Related to Medical Services Provided

I, hereby, assign all benefits to Sumeet Bhinder M.D. INC. For services rendered to me or said minor patient. I authorize any holder of medical information about me or said minor to release to my insurance company any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made to Sumeet Bhinder M.D. INC. and authorize release of medical information necessary to pay the Claim. I have given all my insurance information for billing purposes and understand the billing procedures. I understand that I am responsible for all charges not covered by my insurance policy including but not limited to, co-payments, deductibles, and non-covered Services. I also agree to complete all necessary paperwork in order for my claim to be paid by my insurance company and accept full liability for all charges if Payment is not made in my behalf by my insurance company.

Consent for Medical Treatment

I, the undersigned, the patient (or the patient's duly authorized representative) do hereby voluntarily consent to and authorize medical care encompassing all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician, his assistants or designees. I am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me as to the results of treatment or examinations performed. This form has been fully explained to me and I certify that I understand and accept its contents.

All the above will be discussed with me, by the attending physician or office staff prior to any proposed testing or any type of surgical procedures to be scheduled.

SIGNATURE (Patient or Parent/Legal Guardian if Minor)_____

HIPPA Privacy Authorization Form

Medical Records: Authorization for Use or Disclosure of Protected Health Information (Required by the Heath Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Patient Name: _____ D.O.B. _____

****1. Authorization ****

I Authorize _____ (Healthcare provider) to use and disclose the protected health information described below to

Sumeet Bhinder M.D. Inc, 6001 A-Truxtun Ave Suite 160, Bakersfield, CA 93309

Phone: 661-588-4001 FAX: 661-588-4042 or 661-588-4082Att: Medical Records

****2. Effective Period****

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____

****OR****

b. ☐ All past, present, and future periods.

****3. Extent of Authorization****

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

****OR****

b. ☐ I authorize the release of my complete health record with the exception of the following information:

- ☐ Mental Health records
- ☐ Communicable disease (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

****4.** This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

****5.** This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

**6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

**7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

**8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of patient or Personal Representative

_____

Printed name of patient or personal representative and his or her relationship to patient

_____

Date

RHEUMATOLOGY

Sumeet Bhinder, M.D., Inc
Board Certified Rheumatologist

Practice Limited to
Rheumatology

Authorization to Leave Messages

Patient Name (Print): _____ **D.O.B.** _____

Address: _____ **City:** _____ **State:** _____ **Zip**: _____

Which of the following communications means are appropriate/acceptable for Sumeet K. Bhinder M.D. Inc. to communicate with you: **(Please check all that apply)**

☐ Home Phone#	☐ Okay to leave a message?	☐ Email Address Messages	☐ Yes	☐ No
☐ Cell Phone#	☐ Okay to leave a message?	☐ Automated Messages	☐ Yes	☐ No
☐ Work #	☐ Okay to leave a message?	☐ Written Communication	☐ Yes	☐ No

☐ **Detailed Message**: Leave a message stating the reason we are calling and leaving detailed lab, appointment, or prescription information.

☐ **Short message:** Leave a message stating employee name, Company, and call back number.

With whom may we share information about your health? **Please list below.**

Note: in order for Sumeet K. Bhinder MD Inc. to disclose your private Health information, the representative listed must be able to provide (**2**) two of the (**3**) identifiers listed below:

1. Last 4 digits of patient's social security number 2. Patient's date of birth 3. Patient's zip code

Authorization to Disclose Healthcare Information

Name	**Relationship to You**	**Their best contact #**	**May Discuss Diagnosis/Treatment**	**May Discuss Billing Info**
_____	_____	_____	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
_____	_____	_____	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
_____	_____	_____	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**

Do you have a legal documentation that states who will make decisions for you if you are not capable? ☐ **Yes** ☐ **No**

If yes, Name: _____ **Relationship to patient** _____

Check one: ☐ **Healthcare Proxy/Agent** ☐ **General Power of Attorney** ☐ **Healthcare Power of Attorney**

If you would like information about appointing a Healthcare Proxy /Agent, please let us know.

I understand that it is my responsibility to update this list in order to keep accurate authorized people to discuss and use the patient's healthcare information.

☐ **Patient /** ☐ **Legal Representative Signature:** _____ **Date:** _____

RHEUMATOLOGY

Sumeet Bhinder, M.D., Inc
Board Certified Rheumatologist

Practice Limited to Rheumatology

Autorizacion para dejar Mensajes

Nombre del paciente (letra de molde): _____ **Fecha de nacimiento:** _____

Direccion: _____ **Ciudad:** _____ **Estado:** _____ **Codigo Postal**: _____

Cual de estos medios de comunicacion son Apropiados/ aceptables para que Sumeet K. Bhinder M.D. Inc. se comunique con usted **(Favor de marcar todo lo que aplique)**

☐ Telefono de Casa	☐ Podemos dejar mensaje?	☐ Mensage a correo electronico	☐ SI	☐ No
☐ Telefono Celular	☐ Podemos dejar mensaje?	☐ Mensaje automatico	☐ SI	☐ No
☐ Telefono de Trabajo	☐ Podemos dejar mensaje?	☐ Comunicacion escrita	☐ SI	☐ No

- ☐ **Mensaje Detallado**: Dejar un mensaje que indica la razon porque estamos llamando como estudios de sangre, citas o informacion de sus recetas.
- ☐ **Mensaje Simple:** Dejar mensaje que indica el nombre del empleado, la empresay el numero de telefono para que regrece la llamada.

Con quien podemos compartir informacion sobre su historial medico o sobre su salud.

Nota: Para que Sumeet K. Bhider MD Inc. pueda revelar informacion medica privada, el representante tiene que proveer (**2**) de las (**3**) identificasiones mensionadas abajo:

1. Ultimos cuatro Dijitos del numero social del paciente 2. Fecha de nacimiento del paciente 3. Codigo postal del paciente

Autorizacion Para Revelar Informacion Medica

Nombre	Relacion a usted	Mejor numero para contactar	Podemos discutir Diagnosis/Tratamiento	Podemos discutir Informocion finaciera
_____	_____	_____	☐ Si ☐ No	☐ Si ☐ No
_____	_____	_____	☐ Si ☐ No	☐ Si ☐ No

Tiene algun documento legal que define quien puede tomar decisions sobre usted cuando usted no pueda? ☐ **Si** ☐ **No**

Si, Nombre: _____ **Relacion Al Paciente** _____

Marque uno: ☐ **Agente Provedor Medico/ Poder legal para atencion medica** ☐ **Poder general de abogado** ☐ **Poder Medico de abogado**

Si usted desea information sobre nombramiento de agente medico provedor/ poder legar para atencion medica favor de notificarnos.

Yo entiendo que es mi responsabilidad de mantener la lista actualizada con las personas autorizadas con las cuales pueden discutir mi informacion medica.

☐ **Paciente /** ☐ **Representante legal firma:** _____ **fecha:** _____

Acknowledgement of Receipt of Notice of Privacy. Practices

Patient Name: _____ D.O.B: _____

Address: _____City:_____Zip:_____

Facility Name: Sumeet Bhinder M.D. Inc.

I have been given a copy of Sumeet Bhinder M.D. Inc.'s Notice of *Privacy Practices ('Notice],* which describes how my health information is used and shared. I understand that Sumeet Bhinder M.D. Inc. has the right to change this Notice at any time. I may obtain a current copy by contacting the Facility Privacy Official or HIPM Officer for Sumeet Bhinder M.D. Inc. At our office (6001 A-Truxtun Ave. Suite160, Bakersfield, CA 93309), call 661-588-4001, or e-mail us at manager@sbhindermd.com

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

Signature of Patient: _____ Date: _____

Personal Representative's Title: _____
(e.g. Guardian, Executor of Estate, Health Care Power of Attorney)

For Facility use only: Complete this section if you are unable to obtain signature.

1. If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

_____

_____

2. Describe the steps taken to obtain the resident's (or personal representative's) Signature on the *Acknowledgement:*

_____

_____

Completed by:

Signature of Facility Representative: _____ Date: _____

Print Name: _____ Date: _____

Office Use Only: Scan under Miscellaneous/HIPPA Acknowledgement