2002 RT 17M, Goshen, NY, 10924
Tel: 845-200-2995/Fax: 845-210-5787

Welcome to Integrated Rheumatology Care!
Thank you for choosing us to be part of your healthcare team!

Dr. Jenny Cabas-Vargas and Dr. Bella Fradlis are committed to maintaining high quality rheumatology care.
Our office is located at 2002 Route 17M, First Floor, Suite 7, Goshen, NY, 10924
Our phone number is 845-200-2995. Our fax number is 845-210-5787.
Our website is: https://integratedrheumcare.com

Checklist of items to bring to your first visit:
Registration forms if not previously submitted online
Insurance Card(s) - we will not bill your insurance for our visit, but your insurance information will be kept on file for laboratories and any other ancillary studies that are requested as well as prior-authorizations of your medications.
Photo ID
List of your current medications and dosages
Previous medical records from doctors, hospitals, if applicable.

IMPORTANT INFORMATION ABOUT OUR PRACTICE:
Regular Office Hours
Our regular office hours are 8:30 AM to 4:00 PM, Monday through Thursday and 8:30 AM to 12:30 pm on Fridays. Please call during these hours for all routine matters such as appointments, prescription refills, referrals and general questions. Appointment times may not coincide exactly with office hours as staff and physician hours may differ.

Telephone calls during Office Hours
When calling our office, always call the same number: 845-200-2995. There may be times, when all of the staff is on another call or working with a patient, when you may need to leave a message for a call back.

Prescription Refills
The best way to get prescriptions refilled is to send as a request through your patient portal or have your pharmacy send the request electronically to our office. This is the most efficient process for refills.
If your pharmacy does not participate in electronic prescriptions (this would be rare), you may call and leave your information and request a refill. Please remember to leave your full name,

date of birth, your phone number, your pharmacy name and phone number and the name and dosage of the medication that you would like to be refilled.
Please remember that refills can only be given if you have been seen by the doctor usually within the last 6 months but at times even more recently. If it has been more than a year, you will need to schedule an appointment.
Please allow 24 to 48 hours for refills.

Test Results
When the doctor orders diagnostic testing or labs, you will be scheduled to discuss the results, or we will coordinate a time to discuss those results. We will alert you if an emergent problem is detected.

Billing
Our practice is out of network with all commercial and federal insurances (Medicare and Medicaid). You are responsible for all charges related to the delivery of medical care, which are expected to be paid before the visit.
Patients can see us through a "pay as you go/pay per visit" model or can choose to enroll in monthly membership.

Appointments
Appointments can be made by phone or you can use the online booking option through our website (https://integratedrheumcare.com). Appointments made online will remain as tentative until confirmed by our staff.
Cancellations are expected 48 hours prior to your appointment.
Please arrive on time for your appointment.

Forms
Disability and other Forms will be completed by our office over 5-7 business days.
Please allow sufficient time if you require forms to be completed.
Patients not enrolled in our membership program will be responsible for a fee per form which starts at $25 but may be higher depending on the form type.

Communication Via E-mail and Patient Portal messaging, Text messaging
Limit email content to non-urgent medical questions and matters. Please do not use email or the patient portal to communicate urgent situations. If an urgent situation occurs, please contact the office by phone. If you are experiencing a medical emergency, dial 911 or go to the nearest Emergency Department. Although we will attempt to reply to your messages and emails as quickly as possible, it may take more than one business day. In some cases we may call you by phone directly rather than respond by text or email.
Emails intended for discussion of symptoms, clinical questions or therapy adjustment with communication between you and your doctor over a period of several days are considered an E-Visit. These may be subject to additional fees if you are not enrolled in our membership plan.

Controlled Substance Prescriptions

Controlled substances such as narcotics will be prescribed only if your doctor considers them as indicated and necessary.
Any patient that will require chronic narcotic therapy for pain management will require a Controlled Substance Prescription Contract to be signed and will require periodic office visits in order to monitor safe use of these medications.

Code of Conduct
For the health and safety of all patients and staff of Integrated Rheumatology Care we expect to treat each other with dignity and respect and adhere to the following:
• Respect other patients' right to privacy, which is protected by federal law.
• Violent, aggressive, and/or inappropriate behaviors are not permitted and will not be tolerated. Any verbal and/or physical threats or actions against staff and/or other patients will be grounds for discharge from our practice.
• Sexual misconduct, including sexual assault, harassment, exploitation, or intimidation of staff and/or patients, or unwelcome behaviors of a sexual nature is grounds for discharge from our practice.
• Personal belongings and valuables are the responsibility of the individual patient. Our practice will not be responsible for any lost or missing items.
• Weapons, recreational drugs, alcohol and smoking are not permitted in our office.
• During Telehealth visits (also called telemedicine), patients should be in a private location where they can speak freely about their health, patients should be fully dressed for their video visits and cannot be driving or walking on the street during these visits.

Please print your name and sign: ________________________________

X__________________________________

I am the parent/guardian of this patient: ____________________________________

Date: ____________________

Patient Demographics Form

Full name:______________________
Date of Birth:____________________
Primary phone:________________ ❍ Home ❍Mobile

Secondary phone:_______________ ❍ Home ❍Mobile ❍ Work

Email:___________________________

Address:___________________________________
____
____

Emergency Contact:________________________________
Relationship to patient:______________________________
Phone number:____________________________________
Email address:____________________________________
Address:____
____

Preferred pharmacy:

Name:______________________________
Address:____________________________
____
Phone number:_______________________

Please take the time to fill out this form. This information will help your doctor get ready for your visit.

Name of your Primary Care Physician: ___________________________________

How did you learn about our practice? __________________________________

- **I have seen Dr. Cabas-Vargas or Dr. Fradlis at their prior practice**
- **My Primary Care Physician Referred me**
- **Another specialist or other practitioner referred me**
- **I found the practice on the internet**
- **A friend or family member referred me**

WHAT IS THE REASON FOR YOUR VISIT? - Briefly describe what are your current symptoms? How long have you experienced these symptoms/problems? (Approximately)

____

____

REVIEW OF SYSTEMS - Please circle if you are experiencing any of the following symptoms:

Fatigue
Fever
Night sweats
Weight loss
Weight gain
Dry eyes
Feels like something in my eye (gritty/sandy sensation)
Blurred vision/double vision
Redness in the eyes
Vision loss
Hearing loss
Ringing in ears
Loss of smell
Nosebleeds
Nose sores
Mouth sores
Difficulty swallowing
Hoarseness of voice
Cough
Shortness of breath
Coughing up blood
Wheezing
Snoring/sleep apnea
Chest pain
Irregular heartbeat/palpitations
Shortness of breath at night
Numbness/Tingling of a limb

Weakness of a limb
Abdominal pain
Constipation
Diarrhea
Heartburn
Nausea/Vomiting
Jaundice
Foamy urine
Change in the color of your urine
Blood in urine
Painful urination
Difficulty with urination
Waking up at night to pass urine
Skin ulcers
Skin rashes
Itchy skin
Muscle pain
Morning stiffness
Joint pain/Joint swelling
Neck pain
Back pain
Headaches
Difficulty with balance/vertigo
Depression
Anxiety
Hearing or seeing things that are not real

RHEUMATIC/AUTOIMMUNE DISEASE: Have you been diagnosed with any of the following rheumatic or autoimmune diseases? (Please circle)

Osteoarthritis
Gout
Childhood Arthritis/JIA

Scleroderma
Pseudogout
Rheumatoid Arthritis

Psoriasis Psoriatic Arthritis
Reactive Arthritis Ankylosing spondylitis or
Spondyloarthritis
Cutaneous lupus (Discoid lupus, SCLE) Systemic Lupus Erythematosus (SLE)
Crohn's Disease or Ulcerative Colitis Sjogren's Syndrome
Raynaud's Fibromyalgia
Polymyalgia Rheumatica Temporal Arteritis/Giant Cell Arteritis
Vasculitis ANA positive
Myositis (polymyositis, dermatomyositis, inclusion body myositis)

HEALTH MAINTENANCE QUESTIONNAIRE - Please complete if applicable for age/gender:

Have you had a chest x-ray over the last year?

☐Yes ☐No

Date of your last mammogram (women 40 years and older): _________________
Date of your last bone densitometry/DEXA (post-menopausal women and men older than 70 years old): ___________________________
Date of your last colonoscopy (patients 45 and older): _________________________
Date of your last eye exam (patients on hydroxychloroquine): ____________________
Last tuberculosis test (PPD or Quantiferon TB): ________________________________
Last Hepatitis B/C test (for patients on immunosuppressive medications):
____

PROCEDURES/SURGICAL HISTORY: Please check if you have had any of the following surgeries/procedures:

☐Angioplasty/Cardiac stents ☐Carpal Tunnel Surgery
☐Cardiac bypass surgery ☐Cardiac pacemaker placement
☐Hernia repair ☐Knee replacement

☐Hip replacement ☐Back surgery
☐Neck surgery ☐Carpal tunnel release
☐Appendectomy ☐Cholecystectomy (gallbladder removal)
☐Spleen removal ☐Blood transfusion
☐Tonsillectomy ☐Thyroid resection
☐Breast surgery ☐Fracture repair
☐Cataract extraction ☐LASIK
☐Hysterectomy ☐C-Section
☐Chemotherapy ☐Radiation
☐Bariatric surgery (Gastric bypass, Gastric sleeve, Lap band)

GYNECOLOGIC HISTORY (women only):

Date of last menstrual period: ___________________
Last pap smear: ______________________________
Number of pregnancies: ________________________
Number of miscarriages/pregnancy losses: _________
Past fertility treatments:
☐Yes ☐No

SOCIAL HISTORY - Please check if you have history of any of the following:

☐Current tobacco use (cigarette, cigar, pipe, chewing tobacco, smokeless tobacco)
☐Former tobacco use
☐Never used tobacco
☐Alcohol daily use > 2 drinks per day
☐Caffeine > 2 cups daily
☐ Marijuana use - medicinal or recreational (circle one)
☐Recreational drug use (cocaine, etc.)
☐Opioid abuse/dependence

MARITAL STATUS:

☐Never Married

☐Married ☐Divorced
☐Separated ☐Widowed

OCCUPATION (type of work): ________________________________

IMMUNIZATION HISTORY:

☐ Flu vaccine ☐ Pneumonia vaccine
☐ Zoster/shingles vaccine ☐ Covid-19 vaccine

MEDICATION ALLERGIES - Please list below:

____

____

What is your most recent weight and height?

Weight: ______________

Height: ______________

HIPPA - Notice of Privacy Practices
Your Information. Your Rights. Our Responsibilities.

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.

YOUR RIGHTS:

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Getting an electronic or paper copy of your medical record:

- **You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.**
- **We will provide a copy or a summary of your health information. We may charge a reasonable cost-based fee if you require a full copy of your records.**

Ask us to correct your medical record

- **You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.**
- **We may say "no" to your request, but we'll tell you why in writing within 60 days.**

Request confidential communications

- **You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.**
- **We will say "yes" to all reasonable requests.**

Ask us to limit what we use or share

- **You can ask us not to use or share certain health information for treatment, payment, or our operations.**
- **We are not required to agree to your request, and we may say "no" if it would affect your care.**
- **If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.**
- **We will say "yes" unless a law requires us to share that information.**

Get a list of those with whom we've shared information

- **You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.**
- **We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.**

Get a copy of this privacy notice

- **You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.**

Choose someone to act for you

- **If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.**
- **We will make sure the person has this authority and can act for you before we take any action.**

File a complaint if you feel your rights have been violated

- **You can complain if you feel we have violated your rights by contacting us using the information on page 1.**
- **You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- **We will not retaliate against you for filing a complaint.**

Your Choices:
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- **Share information with your family, close friends, or others involved in your care**
- **Share information in a disaster relief situation**
- **Include your information in a hospital directory**
- **Contact you for fundraising efforts**

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In the following cases we never share your information unless you give us written permission:

- **Marketing purposes**
- **Sale of your information**

In the case of fundraising:

- **We may contact you for fundraising efforts, but you can tell us not to contact you again.**

Our Responsibilities:

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.
Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

Effective Date of Notice (Today's Date):
Please sign your name: X ______________________________________
Date: ______________________________
I am the parent/guardian of this patient:______________________________________

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.
The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.
The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email or send a text to you to confirm your appointments?

☐Yes ☐No

May we leave a message on your answering machine at home or on your cell phone?

☐Yes ☐No

May we discuss your medical condition with any member of your family?

☐Yes ☐No

If YES, please name the members allowed:____
____

Print your full name: _________________________________
Date: ____

Please sign your name:**_________________________________**

I am the parent/guardian of this patient:_______________________________

Consent for Treatment

I give permission to Integrated Rheumatology Care, PLLC to give me medical treatment.

I understand Integrated Rheumatology Care PLLC is a private practice and out of network with commercial and federal insurances (Medicare and Medicaid) and will not bill my insurance benefits to pay for the care I receive.

I understand that:

- I must pay in full for the cost of the service prior to the service being rendered
- If I have a commercial insurance plan, I may submit for reimbursement if my insurance participates in out-of-network benefits.
- The amount of reimbursement by a commercial insurance may not be equivalent to the full cost of the service billed by Integrated Rheumatology Care, PLLC.
- If I am a Medicare patient, I cannot seek reimbursement from Medicare/CMS at any time as my doctor has opted out of Medicare and I have voluntarily signed a private contract with Integrated Rheumatology Care, PLLC.

I understand that:
I have the right to refuse any procedure or treatment.
I have the right to discuss all medical treatments with my clinician.

Full Name:____
Signature:____
Date: ____
I am the parent/guardian of this patient:______________________

INFORMED CONSENT FOR TELEMEDICINE SERVICES

INTRODUCTION
Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:
*Patient medical records
*Medical images
*Live two-way audio and video
*Output data from medical devices and sound and video files
Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.
EXPECTED BENEFITS
*Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
*More efficient medical evaluation and management.
*Obtaining expertise of a distant specialist.
POSSIBLE RISKS
As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:
*In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);

*Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
*In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
*In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error.

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

- I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent,
- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment,
- I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee,
- I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. Dr. Jenny Cabas-Vargas/Dr. Bella Fradlis has explained the alternatives to my satisfaction,
- I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
- I understand that it is my duty to inform Dr. Jenny Cabas-Vargas/Dr. Bella Fradlis of electronic interactions regarding my care that I may have with other healthcare providers.
- I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
- I attest that I am located in the state of New York and will be present in the state of New York during all telehealth encounters with Dr. Jenny Cabas-Vargas/Dr. Bella Fradlis.

PATIENT CONSENT TO THE USE OF TELEMEDICINE:
I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I understand a copy of this form will be available for me.
I hereby authorize Dr. Jenny Cabas-Vargas/Dr. Bella Fradlis to use telemedicine in the course of my diagnosis and treatment.

Please sign your name: X____
Date: ____
I am the parent/guardian of this patient:_________________________

2002 RT 17M, Suite 7, Goshen, NY, 10924
Tel: 845-200-2995/Fax: 845-210-5787

<u>HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION</u>

Date: ____________________

THE PATIENT. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name: ____

Date of Birth: ____

Social Security Number: _______________________________________

AUTHORIZATION. I authorize ____ ("Practice/Doctor/Hospital") to disclose the following: (check one)

☐ - All of my medical-related information.

☐ - My medical information ONLY related to: _______________________

☐ - My medical-related information from ___________ to _____________

☐ - Other:____

Hereinafter known as the "Medical Records."

DISCLOSURE. The Practice/Doctor/Hospital has my authorization to disclose Medical Records to:

Integrated Rheumatology Care, PLLC
Dr. Jenny Cabas-Vargas or Dr. Bella Fradlis
2002 Rt 17M, Suite 7, Goshen, NY 10924
Tel: 845-200-2995 Fax: 845-210-5787

TERMINATION. This authorization will terminate: (check one)

☐ - Upon sending a written revocation to the Authorization Party.

☐ - On the following date: _________ or one year after today's date

ACKNOWLEDGMENT OF RIGHTS.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient/Patient Representative:

X:_____________________________________

Date: _____________________________

Print Name: ________________________

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Tel: 845-200-2995/Fax: 845-210-5787

Medicare Opt out/out of Network Notification

NOTIFICATION TO MEDICARE PATIENTS

This is a notification to our Medicare patients of a recent decision we have made in our practice, and to explain its benefits and its impact on you. As you know, our new medical practice is in a small, personal

office setting. In order to spend more time with our patients and to decrease practice complexity and administrative costs, we do not have any insurance/third party billing services (including government programs such as Medicare).

You may not know that it is voluntary for doctors to contract with Medicare. Once contracted, he/she must comply with Medicare's numerous restrictions/regulations (often quite complex and confusing) and can only be paid the fixed amount that Medicare will allow. Even if the patient desires to pay the doctor's real charges, it is prohibited by Medicare.

Doctors may choose NOT to contract with Medicare since it is a voluntary system. We have made the decision to not contract with Medicare. We will still be offering you our medical services, but it will be outside of the Medicare payment system. You will be asked to pay us directly for our services as we do with our non-Medicare patients. Due to Medicare regulations, you cannot seek and you will not receive reimbursement from Medicare/the Federal Government/secondary (medigap) insurance for our services.

There will be NO change in your Medicare benefits. Your Medicare and secondary insurance benefits will continue to be in full effect for lab, x-rays, hospital services and for services you receive from all doctors contracted with Medicare. This change only affects our charges. There will be NO changes in our medical services to you.

You will be given a payment receipt for our services which may be useful for tax purposes, but it cannot be sent to Medicare OR your secondary insurance for reimbursement. Also, our charges are reasonable given that we pass on our administrative cost savings to our patients. A copy of our sample charges is listed on our website and will be disclosed in full prior to scheduling or rendering any services to you.

In our opinion, when a doctor decides not to contract with Medicare there are wonderful benefits for both doctors and patients. They are free to have a private professional relationship which means they make individual agreements on medical services and on reimbursement for these services which is fair to both. Whereas the terms are set and agreed to voluntarily by the doctor and the patient only, mutual fairness is the natural result. This is the type of relationship we want to have with our patients!

In order to be treated by us it will be necessary (as dictated by Medicare) for you to sign and return to us the enclosed private contract.

Thank you for your consideration, and please let us know if there are any questions we can assist you with!

Sincerely,
Jenny Cabas-Vargas, MD and Bella Fradlis, MD

Please confirm you have received and read the above notification:

Please sign your name:X____________________________________

Date: ____

I am the parent/guardian of this patient:____________________

Private Contract

This agreement is between: Jenny Cabas Vargas, MD/Bella Fradlis, MD, whose principal place of business is 2002 RT17M, Suite 7, Goshen, NY, 10924 and

Medicare Beneficiary -

Full Name:_______________________________________

Who lives at the following address:__________________________________

Medicare Number:____

and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Beneficiary or his/her legal representative that Physician has opted out of the Medicare program effective on August 30, 2022. The physician is not excluded from participating in Medicare Part B under [1128] 1128, [1156] 1156, or [1892] 1892 of the Social Security Act.

Beneficiary or his/her legal representative agrees, understands and expressly acknowledges the following:

*Beneficiary or his/her legal representative accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

*Beneficiary or his/her legal representative understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

*Beneficiary or his/her legal representative agrees not to submit a claim to Medicare or to ask the physician to submit a claim to Medicare.

*Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

*Beneficiary or his/her legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

*Beneficiary or his/her legal representative understands that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

*Beneficiary or his/her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care situation.

*Beneficiary or his/her legal representative acknowledges that a copy of this contract has been made available to him/her:

Executed on the following date: ________________

By: Integrated Rheumatology Care PLLC
Jenny Cabas-Vargas, MD
Bella Fradlis, MD

Patient or legal Representative Full Name:_____________________________________

Patient or legal Representative Signature:X___________________________________