Beverly Hills Rheumatology
Office of Daniel J. Wallace, MD

Patient Registration

Date: _____ ☐ Update ☐ Change

Personal Information			
Patient Name (Last, First, MI)		Address	
Social Security #		City, State	ZIP Code
Date of Birth	Sex Assigned at Birth ☐ M ☐ F	Home Phone	Work Phone
Marital Status ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Separated ☐ Widowed		Cell Phone	
Primary Language		Email Address	
Primary Care Physician First Name	Last Name	**Referred by** First Name	Last Name

Employment Information			
Employment Status ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Not Employed ☐ Retired ☐ Student			
Name of Employer/Union/Guild		Occupation	
Employer Address		Employer City, State	ZIP Code

Beverly Hills Rheumatology
Daniel J. Wallace, MD
414 North Camden Dr Suite 1100
Beverly Hills, CA 90210

Phone: 310-360-9197
Fax: 310-360-6219
jody@danielwallacemd.com

Additional Information			
Driver's License State/ID	Mother's Maiden Name	Place of Birth City & State	Pharmacy
Driver's License ID#/ID#	Patient's Maiden Name	Place of Birth City & State	Pharmacy Phone & Fax#

Emergency Contact			
Name	Relationship	Home Phone	Work Phone
Address, City	State & Zip Code	Legal Guardian ☐ Yes ☐ No	Cell Phone

Guarantor Information		
Name of Person Who is Financially Responsible for the Patient		Relation to the Patient
Employer	Social Security Number	Date of Birth

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Insurance Information - For Testing and Procedures All Consultations are Fee For Service and Not Billed to Insurance			
Subscriber Name		Subscriber DOB	Subscriber SSN
Primary Insurance ☐ PPO ☐ POS ☐ HMO		Subscriber ID	Phone Number
Member Effective Date	Relationship to Subscriber	Group Number	Group Name
Primary Insurance Claim Address			
Subscriber Name		Subscriber DOB	Subscriber SSN
Secondary Insurance ☐ PPO ☐ POS ☐ HMO		Subscriber ID	Phone Number
Secondary Insurance Claim Address			
Member Effective Date	Relationship to Subscriber	Group Number	Group Name

Insurance Information (Medicare Patients Only)			
Subscriber ID#	Relationship to Subscriber	Part A Effective Date	Part B Effective Date
Have you assigned your benefits to a HMO? ☐ Yes ☐ No		(If Yes) Medical Group Name	

Please sign so we may have your insurance authorization on file

I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment.

Signature: _____ Date: _____

Please provide your insurance card(s) and driver's license to the receptionist along with this form.

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Updated Medical History (Return Patients)

Name: _____ DOB: _____ Date: _____

Pharmacy Information:

Name: _____ Phone: _____ Fax: _____

List of hospitalizations and surgeries:

1.	5.
2.	6.
3.	7.
4.	8.

List all medication allergies if any:

1.	4.
2.	5.
3.	6.

Current Medication List:

Medication	Dosage	Tablets in a day

Primary Care Doctor:

Name: _____ Phone: _____

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Date of last physical with PCP:	
Date of last eye exam:	
Date of last bone density:	
Date of last pap smear (female):	
Date of last mammogram (female):	
Date of last colonoscopy:	
Date of last tuberculosis test:	
Date of last flu vaccine:	

Social History: Have you ever smoked? ☐ Yes ☐ No

Do you smoke?

☐ Some a day smoker ☐ Former smoker ☐ Never smoker ☐ Quit date

_____

Do you drink alcohol?

☐ Never ☐ Occasional ☐ Moderate ☐ Heavy

Do you drink caffeine?

☐ Never ☐ Occasional ☐ Moderate ☐ Heavy

Family History

Mother: ☐ Alive ☐ Deceased Age at Death: _____

Father: ☐ Alive ☐ Deceased Age at Death: _____

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List all medical issues:

Mother	Father	Paternal Grandfather	Paternal Grandmother
Maternal Grandfather	**Maternal Grandmother**	**Sister**	**Brother**
Other:	**Other:**	**Other:**	**Other:**

Notes or questions for your doctor:

1. _____

2. _____

3. _____

4. _____

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Consent to release medical records

Patient Name: _____ Home Number: _____

Date of birth: _____ Cell Number: _____

I hereby authorize and request that _____
Name of facility/individual

_____
Address *City/State/Zip* *Phone number/fax number*

Release information from my records to the following:

Name of the Facility/individual: Beverly Hills Rheumatology Office of Daniel J. Wallace, MD

414 North Camden Dr Suite 1100 (*Address*) Beverly Hills, CA 90210 (*City/State/Zip*) 310-360-9197 (*Phone number*) 310-360-6219 (*Fax number*)

Please be specific regarding record and dates requested Information to be released:

☐ Diagnosis and record of treatment _____

☐ Laboratory and/or X-ray reports _____

☐ Entire file (excluding confidential and psychiatric records, if any) _____

Other: _____

Be advised that if you are requesting a copy of your medical record, a copying fee shall apply.
It is prohibited by law to release/disclose the attached/enclosed information to anyone except those specified above.
I understand that this Authorization alone may not authorize release psychiatric or HIV information:

In signing, I am aware that this authorization is valid for 1 year after today

Patient Signature: _____ Date: _____

Disposition/date: Mailed certified/return receipt requested (date) _____

Faxed (date and time) _____ ID Verification by: _____

Records given to patient / date and time _____ Provider's approval: _____

Patient will pick up _____ Patient paid date: _____

Office policies/agreement

Financial agreement - As the responsible party, you are responsible if your insurance company declines to pay for any reason. The patient or the responsible party must:
- Inform this office of the current address and phone number for the patient and the responsible party.
- Present all current insurance cards prior to each office visit.
- Pay any required fees at the time of the visit, as well as all previous balances due.
- Pay any additional amount owing within 30 days of receiving a statement from our office.
- Returned Checks – If a payment is made on an account by check, and the check is returned for any reason, the responsible party will be responsible for the original check amount in addition to a $35 service charge.
- Collections – The responsible party may be sent to collections after 90 days past due, and interest will be added. If your account is sent to collections, you will be discharged from the practice. Once the balance is settled, your account will be reviewed to be reinstated as a patient.

Late Policy – Our office tries to allow a 15 minute grace period from the time you are requested to be in for your appointment. Past the 15 minutes, you may be given the option to wait for another appointment time on the same day if one is available, or you may be asked to reschedule your appointment. If you are seen past the 15 minute grace period you will be charged a late fee of $50.

No Show Policy – If you are unable to keep an appointment, our office requires at least 24 hour notice. You can cancel/reschedule an appointment by speaking to someone from the office in person or on the phone, leaving a voicemail message, or emailing a staff member who will confirm receipt of your message. New patients will be charged $150 for a no show, follow up visits will be charged $75 for a no show.

External prescription history – I authorize Beverly Hills Rheumatology and its Affiliated Providers to view my external prescription history via the MyChart service. I understand that this information may be needed to best assist with my care.

Prescription policy – I understand that my doctor will attempt to refill prescription request within 72 hours (Monday –Friday). Refill request may be done in person at my appointment, via phone or voicemail, via letter to my doctor's office, or through CS link. I understand I must allow adequate time to ask for refills before I run out of medicine, including enough lead time for us to prepare prescriptions for you to mail to a prescription service.

Narcotics policy - Due to increasing reports of abuse of narcotics, and the subsequent surveillance of the prescription practices of physicians by the state, this office normally will not prescribe continuous pain medication. I understand if I require strong narcotics on a continuous basis, I will be referred back to my Primary Care Physician or a Certified Pain Management Physician.

Prior Authorizations – I understand that some medications I may take will require a prior authorization. The authorization process can take up to 2 weeks and may be longer if the insurance denies and an appeal is needed. There is a fee of $40 per authorization. If multiple appeals are needed, charges may apply. I understand that a prescription card may be requested from me and may help with the authorization process.

Our doctors and staff truly appreciate your compliance and understanding to these policies so that we can continue to provide excellent medical care.

Print _____

Signature _____

Date _____

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Patient Consent to notice of privacy practices

In Accordance with the Health Insurance Portability and Accountability Act (HIPAA), you have been provided with our Notice of Privacy Practices that provides information about how we may use and disclose protected health information ("PHI") about you. The notice provides a more complete description of information uses and disclosures.

As part of your healthcare, we maintain health records that describe your health history, symptoms, examinations and test results, diagnosis, treatment and plans for future care or treatment. This information serves as a basis for planning your care and treatment; a means of communication among other health professionals who contribute to your care; a source of information for applying your diagnosis and healthcare information to bill third parties; a means by which a third-party payer can verify that services billed were actually provided; and a toll for routine healthcare operations such as assessing quality and reviewing the delivery of medical services.

You have the right to review our Notice before signing this consent. As provided in our Notice, the terms of our notice and/or privacy practices may change. If we change our Notice and/or privacy practices, we will provide you with a revised copy by mailing it to your then-current address.

You have the right to object to the use of disclosure of your health information. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment and health care operations in accordance with the Notice of Privacy Practices. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Initial {___} I request the following restrictions to the use or disclosure of my health information:

You have the right to review our Notice before signing this consent. As provided in our Notice, the terms of our notice and/or privacy practices may change. If we change our Notice and/or privacy practices, we will provide you with a revised copy by mailing it to your then-current address.

Signature _____

Date _____

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