PATIENT INFORMATION (PLEASE PRINT CLEARLY)

Date	Social Security #	Birthdate
Name (Last Name) (First Name) (Middle Initial)		Sex ☐ M ☐ F ☐ Transgender / Age
Address (City) (State) (Zip Code)		
Home Phone	Cell Phone	Email

☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered

Race	Ethnicity	Preferred Language	Preferred method of contact *(Check all that apply)*
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian ☐ White ☐ Other Pacific Islander ☐ Other	☐ Hispanic ☐ Non-Hispanic		☐ Home Phone ☐ Work Phone ☐ Cell Phone / SMS (text) ☐ Email ☐ patient portal

Patient Employer / School	Occupation
Employer / School Address	Employer / School Phone
In case of emergency, who should be notified?	Phone Number
Name of Primary Care Physician	Name of Referring Physician *(if different from PCP)*

PRIMARY INSURANCE (If this is not filled out you will be billed for all visits)

Insurance Company	
Subscriber #	Group #
Person Responsible for Account (Last Name) (First Name) (Middle Initial)	
Relationship to Patient / Birthdate / Social Security #	
Address (if different from patient) (City) (State) (Zip Code)	Phone
Person Responsible – Employed by	Occupation
Business Address (City) (State) (Zip Code)	Business Phone
Names of other dependents covered under this plan	Copay $

SECONDARY OR ADDITIONAL INSURANCE

Insurance Company		
Subscriber #	Group #	
Person Responsible for Account (Last Name) (First Name) (Middle Initial)		
Relationship to Patient	Birthdate	Social Security #

ASSIGNMENT AND RELEASE

I certify that I and my dependents have insurance coverage with _____ and assign directly to Center for Rheumatic
Name of Insurance Company
Diseases and Osteoporosis, P.A. all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature of all insurance admissions. The Center for Rheumatic Diseases and Osteoporosis, P.A. may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent includes my authorization to release medical information to my primary care physician and/or consulting physicians to assist with continuity of my healthcare. This release will remain in effect until I cancel this release in writing.

Signature of Patient, Parent, Guardian, or Personal Representative	**Date**
Please print name:	**Relationship to Patient:**

Center for Rheumatic Diseases & Osteoporosis

PATIENT HISTORY FORM

Date of first appointment:	Month	Day	Year	Time of appointment:		Birthplace:	

Patient Name:	LAST	FIRST	M.I	Birthdate:	Month	Day	Year

Age:	Sex: ☐F ☐M	Telephone: (H)	(C)	(W)

Address: _____
Street City Apt# State Zip Code

Referred by: *(Check one)* ☐Self ☐Family ☐Friend ☐Physician ☐Other Health Professional:

Name of Person Making Referral:

Name of Primary Care Physician:

WHAT BRINGS YOU TO THE DOCTOR?

Problem onset	
Present symptoms	

DRUG ALLERGIES: ☐No ☐Yes If Yes, to what?	
Type of reaction:	

PRESENT MEDICATIONS (List any medications you are taking, including such items as aspirin, vitamins, laxatives, calcium, and other supplements)

NAME OF DRUG	Dose	No. of pills and how often?	How long have you taken this medication?	Please check ✓: Helped?		
				A Lot	Some	Not at all
1.				☐	☐	☐
2.				☐	☐	☐
3.				☐	☐	☐
4.				☐	☐	☐
5.				☐	☐	☐
6.				☐	☐	☐
7.				☐	☐	☐
8.				☐	☐	☐
9.				☐	☐	☐
10.				☐	☐	☐

PAST MEDICAL HISTORY: Do you now or ever had: **Please mark "X" if Yes**

☐	Cancer type _____	☐	Heart attack	☐	Thyroid Problems	☐	Colitis
☐	Goiter	☐	Angina	☐	Lung Problems type_____	☐	Psoriasis
☐	Depression/Anxiety	☐	Heart Failure	☐	Anemia	☐	Tuberculosis
☐	Nervous Breakdown	☐	Diabetes	☐	Cholesterol	☐	Other significant illnesses (please list)
☐	High Blood Pressure	☐	Stomach Ulcers	☐	HIV/AIDS		
☐	Stroke	☐	Liver Problems	☐	Glaucoma		
☐	Asthma	☐	Kidney Problems	☐	Hepatitis		
☐	Leukemia	☐	Osteoarthritis	☐	Ankylosing Spondylitis		
☐	Rheumatic Fever	☐	Gout	☐	Scleroderma		
☐	Bleeding Tendency	☐	Childhood Arthritis	☐	Lupus or "SLE"		
☐	Alcoholism	☐	Psoriatic Arthritis	☐	Rheumatoid Arthritis		
☐	Epilepsy	☐	Osteoporosis	☐	Arthritis (unknown type)		

SURGERIES: Place an "X" if YES

☐	Total knee replacement
☐	Total hip replacement
☐	Back Surgery
☐	Hysterectomy
☐	Prostate
☐	Other:

FAMILY HISTORY:

☐ LIVING ☐ DECEASED

	Age	Health	Age at death	Cause
Father				
Mother				

At any time, has a blood relative had any of the following? (Give relationship):

	Relative Relationship		Relative Relationship
Arthritis (unknown type)		Cancer	
Osteoarthritis		Leukemia	
Gout		Stroke	
Childhood Arthritis		Colitis	
Lupus or "SLE"		Heart Disease	
Rheumatoid Arthritis		High Blood Pressure	
Ankylosing Spondylitis		Bleeding Tendency	
Osteoporosis		Alcoholism	
Psoriatic Arthritis		Asthma	
Scleroderma		Epilepsy	
Rheumatic Fever		Diabetes	
Other Arthritis Conditions:		Goiter	

SOCIAL HISTORY:

Primary language spoken: _____

Occupation: _____ No. of hours worked/average per week _____

Employer: _____ Retired, _____ Date _____

MARITAL STATUS: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Do you smoke? ☐No ☐Yes ☐ Past – How long ago? _____ Packs a day_____ Number of Years _____

Do you drink alcohol? ☐No ☐Yes Number per week _____

Activity level: ☐Sedentary_____ ☐ Moderate_____ ☐ Vigorous_____

Type of Exercise: ☐Gym ☐Golf ☐ Jogging ☐Skiing ☐Swimming ☐Walking ☐Yoga ☐Other_____

Exercise Frequency: _____ times/week_____

Recent Travel: Out of State:_____

International:_____

PAST MEDICATIONS:

NAME OF DRUG *NonSteroidal/Anti-Inflammatory Drugs (NSAIDS)*	Length of time	Please mark "X" : Helped?			Reactions
		A Lot	Some	Not at all	
Arthrotec (diclofenac + misoprostil)					
Aspirin (including coated aspirin)					
Celebrex (celecoxib)					
Indocin (indomethacin)					
Lodine (etodolac)					
Motrin/Rufen (ibuprofen)					
Naprosyn (naproxen)					
Voltaren (diclofenac)					
Other:					
Other:					
Other:					
PAIN RELIEVERS	**Length of time**	**Please mark "X" : Helped?**			**Reactions**
		A Lot	**Some**	**Not at all**	
Acetaminophen (Tylenol)					
Oxycodone, Percocet, Oxycontin					
Propoxyphene (Darvon/Darvocet)					
Other:					
DISEASE MODIFYING ANTIRHEUMATIC DRUGS *(DMARDS)*	**Length of time**	**Please mark "X" : Helped?**			**Reactions**
		A Lot	**Some**	**Not at all**	
Hydroxychloroquine (Plaquinil)					
Methotrexate (Rheumatrex)					
Azathioprine (Imuran)					
Sulfasalazine (Azulfidine)					
DISEASE MODIFYING ANTIRHEUMATIC DRUGS *(BIOLOGICS)*	**Length of time**	**Please mark "X" : Helped?**			**Reactions**
		A Lot	**Some**	**Not at all**	
Infliximab (Remicade)					
Adalimumab (Humira)					
Rituximab (Rituxan)					
Abatacept (Orencia)					
Enbrel					
Cimzia					
Xeljanz					
Simponi					
Actemra					
Other:					
DISEASE MODIFYING ANTIRHEUMATIC DRUGS *(BIOLOGICS)*	**Length of time**	**Please mark "X" : Helped?**			**Reactions**
		A Lot	**Some**	**Not at all**	
Estrogen (Premarin, etc.)					
Alendronate (Fosamax)					
Raloxifene (Evista)					
Calcitronin injection or nasal (Miacalcin, Calcimar)					
Residronate (Actonel)					
Boniva					
Reclast					
Prolia					
Forteo					
Estrogen (Premarin, etc.)					

RAPID3
ROUTINE ASSESSMENT OF PATIENT INDEX DATA

The RAPID3 includes a subset of core variables found in the Multi-dimensional HAQ (MD-HAQ). Page 1 of the MD-HAQ, shown here, includes an assessment of physical function (section 1), a patient global assessment (PGA) for pain (section 2), and a PGA for global health (section 3). RAPID3 scores are quickly tallied by adding subsets of the MD-HAQ as follows:

1. PLEASE CHECK THE ONE BEST ANSWER FOR YOUR ABILITIES AT THIS TIME:

OVER THE LAST WEEK, WERE YOU ABLE TO:	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
a. Dress yourself, including tying shoelaces and doing buttons?	☐ 0	☐ 1	☐ 2	☐ 3
b. Get in and out of bed?	☐ 0	☐ 1	☐ 2	☐ 3
c. Lift a full cup or glass to your mouth?	☐ 0	☐ 1	☐ 2	☐ 3
d. Walk outdoors on flat ground?	☐ 0	☐ 1	☐ 2	☐ 3
e. Wash and dry your entire body?	☐ 0	☐ 1	☐ 2	☐ 3
f. Bend down to pick up clothing from the floor?	☐ 0	☐ 1	☐ 2	☐ 3
g. Turn regular faucets on and off?	☐ 0	☐ 1	☐ 2	☐ 3
h. Get in and out of a car, bus, train, or airplane?	☐ 0	☐ 1	☐ 2	☐ 3
i. Walk two miles or three kilometers, if you wish?	☐ 0	☐ 1	☐ 2	☐ 3
j. Participate in recreational activities and sports as you would like, if you wish?	☐ 0	☐ 1	☐ 2	☐ 3
k. Get a good night's sleep?	☐ 0	☐ 1.1	☐ 2.2	☐ 3.3
l. Deal with feelings of anxiety or being nervous?	☐ 0	☐ 1.1	☐ 2.2	☐ 3.3
m. Deal with feelings of depression or feeling blue?	☐ 0	☐ 1.1	☐ 2.2	☐ 3.3

1. a-j FN (0-10):

1=0.3	16=5.3
2=0.7	17=5.7
3=1.0	18=6.0
4=1.3	19=6.3
5=1.7	20=6.7
6=2.0	21=7.0
7=2.3	22=7.3
8=2.7	23=7.7
9=3.0	24=8.0
10=3.3	25=8.3
11=3.7	26=8.7
12=4.0	27=9.0
13=4.3	28=9.3
14=4.7	29=9.7
15=5.0	30=10

2. PN (0-10):

3. PTGE (0-10):

RAPID3 (0-30)

2. HOW MUCH PAIN HAVE YOU HAD BECAUSE OF YOUR CONDITION OVER THE PAST WEEK? PLEASE INDICATE BELOW HOW SEVERE YOUR PAIN HAS BEEN:

NO PAIN — PAIN AS BAD AS IT COULD BE

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

3. CONSIDERING ALL THE WAYS IN WHICH ILLNESS AND HEALTH CONDITIONS MAY AFFECT YOU AT THIS TIME, PLEASE INDICATE BELOW HOW YOU ARE DOING:

VERY WELL — VERY POORLY

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

CONVERSION TABLE

Near Remission (NR): 1=0.3; 2=0.7; 3=1.0
Low Severity (LS): 4=1.3; 5=1.7; 6=2.0
Moderate Severity (MS): 7=2.3; 8=2.7; 9=3.0; 10=3.3; 11=3.7; 12=4.0
High Severity (HS): 13=4.3; 14=4.7; 15=5.0; 16=5.3; 17=5.7; 18=6.0; 19=6.3; 20=6.7; 21=7.0; 22=7.3; 23=7.7; 24=8.0; 25=8.3; 26=8.7; 27=9.0; 28=9.3; 29=9.7; 30=10.0

HOW TO CALCULATE RAPID 3 SCORES

1. Ask the patient to complete questions 1, 2, and 3 while in the waiting room prior to his/her visit.

2. For question 1, add up the scores in questions A-J only (questions K-M have been found to be informative, but are not scored formally). Use the formula in the box on the right to calculate the formal score (0-10). For example, a patient whose answers total 19 would score a 6.3. Enter this score as an evaluation of the patient's functional status (FN).

3. For question 2, enter the raw score (0-10) in the box on the right as an evaluation of the patient's pain tolerance (PN).

4. For question 3, enter the raw score (0-10) in the box on the right as an evaluation of the patient's global estimate (PTGE).

5. Add the total score (0-30) from questions 1, 2, and 3 and enter them as the patient's RAPID 3 cumulative score. Use the final conversion table to simplify the patient's weighed RAPID 3 score. For example, a patient who scores 11 on the cumulative RAPID 3 scale would score a weighed 3.7. A patient who scores between 0–1.0 is defined as near remission (NR); 1.3–2.0 as low severity (LS); 2.3–4.0 as moderate severity (MS); and 4.3–10.0 as high severity (HS).

Center for Rheumatic Diseases & Osteoporosis

CONSENTS AND ACKNOWLEDGEMENTS

NOTICE OF PRIVACY NOTICES:

INITIALS:	I acknowledge that I have received and reviewed a copy of The Center for Rheumatic Diseases and Osteoporosis, P.A.'s NOTICE OF PRIVACY NOTICES which describes how medical information about me be used and disclosed.

FINANCIAL POLICY:

INITIALS:	I acknowledge that I have received and reviewed The Center for Rheumatic Diseases and Osteoporosis, P.A.'s FINANCIAL POLICY.

PATIENT PORTAL:

INITIALS:	The Center for Rheumatic Diseases and Osteoporosis, P.A., utilizes a patient portal that enables patients to request appointments, request medications, and correspond with The Center for Rheumatic Diseases and Osteoporosis, P.A.'s physicians and personnel. For you to have access to the portal, The Center for Rheumatic Diseases and Osteoporosis, P.A. will need a current email address as well as a signed consent for usage. This consent has no expiration and will be valid indefinitely until revoked by a written request.

LAST NAME:	FIRST NAME:
EMAIL ADDRESS:	DATE OF BIRTH:

PRESCRIPTION HISTORY:

INITIALS:	In compliance with Meaningful Use (CMS) objectives regarding the utilization of Electronic Health Record (EHR) systems, our providers have the capacity to access limited historical information regarding the medications prescribed for you from other providers. Registry information may include: medication name; dose; instructions; prescribing physician; filling pharmacy; and date filled. By placing your initials and signing below, you consent for the physicians to access and utilize this information in making medical decisions regarding your health.

APPOINTMENT / LATE CANCELLATION / NO SHOW POLICY:

INITIALS:	Our office appointment policy is to be given a 24-hours in advance notice for any appointment change or you will be charged for a broken appointment. **There will be a No Show or Late Cancellation fee if you fail to notify the office 24-hours in advance. For any established patient scheduled with Dr. Sharma and Dr. Goyal who fails to contact our office will incur a $25.00 charge. For any New Patient scheduled with Dr. Sharma and Dr. Goyal who fails to contact our office will incur a $50.00 charge.** If your appointment is scheduled on Monday, we must call or notify the office by the Friday before 3:00p.m. that your appointment needs to be rescheduled or canceled. Please understand your doctor has allotted time for your appointment and without notice given, your doctor will not be able to pass this appointment slot to another patient in need. As a courtesy, our computer system is scheduled to call for reminders. However, should the system fail, it is your responsibility to remember your scheduled appointment. If you are a New Patient, please arrive 20 minutes prior to your appointment time. Any arrival more than 10 minutes late will be rescheduled, and this will be considered as a late cancellation.

REFERRAL & INSURANCE ACKNOWLEDGMENT:

INITIALS:	• I understand that I am required to obtain a referral from my Primary Care Physician (PCP) prior to going to a specialist. My insurance carrier requires an appropriate referral that is necessary for my office visit. • If I do not have a referral on the date of service, I understand and agree that I will be financially responsible for all charges, that are not covered by my insurance company. • I understand in some instances that my PCP may be delayed in sending a referral before my appointment, this referral follow-up is my full responsibility. • I understand that my insurance may not cover all services. I understand that I will be financially liable for any services performed by this office that is not covered by my insurance.

NO INSURANCE INFORMATION: *(Write N/A if you have Insurance)*

INITIALS:	• I elect to be seen without having my insurance information. • I acknowledge that I am **SELF-PAY** at the time of service. • If I provide the CRD billing department with my insurance information within five (5) business days after my date of service, my claim will be submitted to my insurance, and I will be reimbursed when my insurance claims have been paid.

PATIENT'S SIGNATURE / RESPONSIBLE PARTY:	DATE SIGNED:

Center for Rheumatic Diseases & Osteoporosis

FINANCIAL POLICY

Thank you for choosing the CENTER FOR RHEUMATIC DISEASES AND OSTEOPOROSIS, P.A .. We are committed to providing you with the highest quality of care possible. CENTER FOR RHEUMATIC DISEASES AND OSTEOPOROSIS, P.A. is a participating provider for Blue Cross/Blue Shield, Medicare and several other insurance companies, PPO'S, POS'S and some HM O's. A complete list is available at the front desk. Being aware that insurance companies and their plans frequently merge or change their names, however, it is not always possible for our office to ascertain with 100% certainty wlrnther or not CENTER FOR RHEUMATIC DISEASES AND OSTEOPOROSIS, P.A. is a participating provider with your insurance plan. Therefore, even though we will assist you, it is your responsibility to verify that CENTER FOR RHEUMATIC DISEASES AND OSTEOPOROSIS, P.A. is a participating provider with your plan. If we know that CENTER FOR RHEUMATIC DISEASES AND OSTEOPOROSIS, P.A. is not participating provider with your insurance company, full payment is due at the time of service. We accept Visa, MasterCard, Debit card, money orders and checks.

For patients enrolled in the insurance plans in which CENTER FOR RHEUMATIC DISEASES AND OSTEOPOROSIS, P.A. participates, the insurance company's fees for services will be accepted. With m.ost of these plans, patients are still responsible for their co-payment, co-insurance and/or deductible. Certain services may not be covered and will be the patient's responsibility. Therefore we ask that you pay the charge(s) at the time of service.

I understand that I have a personal and a primary obligation to pay for all medical services when due and I agree to pay all bills promptly. I understand that if my insurance plan requires a referral for specialty care services, I am responsible for obtaining that referral prior to my scheduled appointment, and I will present that referral at the time of service. I am aware that if] fail to submit my referral, my insurance company may not pay for these services, and I will be responsible for payment. I further understand that although CENTER FOR RHEUMATIC DISEASES AND OSTEOPOROSIS, P.A. may submit a bill to my insurance company for payment as a service to me, that service does not relieve me of my personal responsibility to ensure that the insurance company makes payment according to the terms ofmy policy.

I further understand that insurance coverage varies widely among insurers and that it is my responsibility to know which services are covered by my policy and which are my responsibility. I am aware that insurance payment/reimbursement may not cover the total balance due for the medical services I received. I agree to pay any outstanding balance on my account when due. I also agree to pay any and all office and legal expenses and fees incurred for the purpose of collecting payment for an outstanding balance on my account if such action is deemed necessary. In addition, I agree to pay interest (at 1 ½ % per month) on my outstanding account balance plus any collection foes and/or costs including court cost incurred in order to collect payments on my account if the balance is outstanding beyond 120 days, including attorney's fees in the amount of 50% the balance due. I waive my right under the Maryland's statute of limitations should reconciliation of my account extend beyond 3 years from the date of service. I certify that the information I have reported with regard to my insurance coverage is correct and promise to update CENTER FOR RHEUMATIC DISEASES AND OSTEOPOROSIS, P.A. with any changes to my insurance company, address, phone number, etc:

ACKNOWLEDGEMENT & UNDERSTANDING OF FINANCIAL POLICY: I have read and understand the financial policy of Center for Rheumatic Diseases and Osteoporosis, P.A.

Patient/Responsible Party Signature	**Print Name**	**Date**

CENTER FOR
Rheumatic Diseases
& Osteoporosis P.A.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USE AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. IT FURTHER DETAILS HOW YOUR PERSONAL REPRESENTATIVE MAY GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

If you have any questions about this Notice please contact our privacy contact, Elizabeth Bernardo - Administrator ("Privacy Contact"), at 301-230-5888. This Notice describes how our practice and our health care professionals, employees, volunteers, trainees and staff may use and disclose your medical information to carry out treatment, payment or health care operations and for other purposes that are described in this Notice. We understand that medical information about you and your health is personal and we are committed to protecting medical information about you. This notice applies to all records of your care generated by this practice.

This Notice also describes your right to access and control your medical information. This information about you includes demographic information that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services. Typically your medical information will include symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment.

We are required by law to protect the privacy of your medical information and to follow the terms of this Notice. We may change the terms of this Notice at anytime. The new Notice will then be effective for all medical information that we maintain at that time and thereafter. We will provide you with any revised Notice if you request a revised copy be sent to you in the mail or if you ask for one when you are in the office.

I. Uses and Disclosures of Protected Health Information

Your medical information may be used and disclosed for purposes of treatment, payment and health care operations. The following are examples of different ways we use and disclose medical information.

These are examples only.

a) Treatment:

We may use and disclose medical information about you to provide, coordinate, or manage your medical treatment or any related services. This includes the coordination or management of you health care with a third party that has already obtained your permission to have access to your medical information. For example, we could disclose your medical information to a home health agency that provides care to you. We may also disclose medical information to other physicians who may be treating you, such as a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your medical information to another physician or health care provider, such as a laboratory.

b) Payment:

We may use and disclose medical information about you to obtain payment for the treatment and services you receive from us. For example, we may need to provide your health insurance plan information about your treatment plan so that they can make a determination of eligibility or to obtain prior approval for a planned treatment. For example, obtaining approval for a hospital stay may require that relevant medical information be disclosed to the health plan to obtain approval for the hospital admission.

c) Healthcare Operations:

We may use or disclose medical information about you in order to support the business activities of our practice. These activities include, but are not limited to, reviewing our treatment of you, employee performance reviews, training of medical students, licensing, marketing and fundraising activities and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your medical information to remind you of your next appointment.

We may share your medical information with third party "business associates" that perform activities on our behalf, such as billing or transcription for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of you medical information, we will have a written contract that contains terms that asks the "business associate" to protect the privacy of your medical information.

We may use or disclose your medical information to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your medical information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact to request that these fundraising materials not be sent to you.

d) Health Information Exchange:

CRD, along with certain other health care providers and practice groups in the area, participate in a health information exchange operated by the Independent Physician Network (the "Exchange"). The Exchange facilitates electronic sharing and exchange of medical and other individually identifiable health information regarding patients among health care providers that participate in the Exchange. Through the Exchange we may electronically disclose demographic, medical, billing and other health-related information about you to other health care providers that participate in the Exchange and request such information for purposes of facilitating or providing treatment, arrangement for payment for health care services or otherwise conducting or administering their health care operations.

I. Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your medical information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your medical information. If you are not present or able to agree or object to the use or disclosure of the medical information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the medical information that is relevant to your health care will be disclosed.

a) Others Involved in Your Healthcare:

Unless you object, we may disclose to a member of your family, a relative or close friend your medical information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information if we determine that it is in your best interest based on our professional judgment. We may use or disclose medical information to notify or assist in notifying a family member or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your medical information to an entity assisting in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

b) Emergencies:

We may use or disclose your medical information for emergency treatment. If this happens, we shall try to obtain your consent as soon as reasonable after the delivery of treatment. If the practice is required by law to treat you and has attempted to obtain your consent but is unable to do so, the practice may still use or disclose your medical information to treat you.

c) Communication Barriers:

We may use and disclose your medical information if the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and, in our professional, judgment, you intended to consent to use or disclosure under the circumstances.

II. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object.

We may use or disclose your medical information in the following situations without your consent or authorization. These situations include:

a) Required By law:

We may use or disclose your medical information when federal, state or local law requires disclosure. You will be notified of any such uses or disclosure.

b) Public Health:

We may disclose your medical information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. This disclosure will be made for the purpose of controlling disease injury or disability.

c) Communicable Diseases:

We may disclose your medical information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

d) Health Oversight:

We may disclose medical information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure. These activities are necessary for the government agencies to oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

e) Abuse or Neglect:

We may disclose your medical information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your medical information to the governmental entity authorized to receive such information if we believe that you have been a victim of abuse, neglect or domestic violence as is consistent with the requirements of applicable federal and state laws.

f) Food and Drug Administration:

We may disclose your medical information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

g) Legal Proceedings:

We may disclose medical information in the course of any judicial or administrative proceeding, when required by a court order or administrative tribunal, and in certain conditions in response to a subpoena, discovery request or other lawful process.

h) Law Enforcement:

We may disclose medical information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include: (i) responding to a court order, subpoena, warrant, summons or otherwise required by law; (ii) identifying or locating a suspect, fugitive, material witness or missing person; (iii) pertaining to victims of a crime; (iv) suspecting that death has occurred as a result of criminal conduct; (v) in the event that a crime occurs on the premises of the practice; and (vi) responding to a medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

i) Coroners, Funeral Directors, and Organ Donors:

We may disclose medical information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose medical information to funeral directors as necessary to carry out their duties.

j) Research:

We may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board ("IRB") or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure: (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate, written assurances that the PHI will be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

k) Criminal Activity:

Consistent with applicable federal and state laws, we may disclose your medical information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose medical information if it is necessary for law enforcement authorities to identify or apprehend an individual.

l) Organ and Tissue Donation:

If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

m) Military Activity and National Security:

If you are a member of the armed forces, we may use or disclose medical information, (i) as required by military command authorities; (ii) for the purpose of determining by the Department of Veterans Affairs of your eligibility for benefits; or (iii) for foreign military personnel to the appropriate foreign military authority. We may also disclose your medical information to authorized federal officials for conducting national security and intelligence activities, including for protective services to the President or others legally authorized.

n) Workers' Compensation:

We may disclose you medical information as authorized to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illness.

o) Inmates:

We may use or disclose your medical information if you are an inmate of a correctional facility and our practice created or received your health information in the course of providing care to you.

p) Required Uses and Disclosures:

Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500, et seq. seq.

IV. The Following Is a Statement of Your Rights with Respect to Your Medical Information and a Brief Description of How You May Exercise These Rights.

a) You have the right to inspect and copy your medical information.

This means you may inspect and obtain a copy of medical information about you that has originated in our practice. We may charge you a reasonable fee for copying and mailing records. To the extent we maintain any portion of your PHI in electronic format; you have the right to receive such PHI from us in an electronic format. We will charge no more than actual labor cost to provide you electronic versions of your PHI that we maintain in electronic format.

After you have made a written request to our Privacy Contact at the following address: 6001 Montrose Road Suite 702 North Bethesda, Maryland 20852, we will have thirty (30) days to satisfy your request. If we deny your request to inspect or copy your medical information, we will provide you with a written explanation of the denial.

You may not have a right to inspect or copy psychotherapy notes. In some circumstances, you may have a right to have the decision to deny you access reviewed. Please contact the Privacy Contact if you have any questions about access to your medical record.

b) You have the right to request a restriction of your medical information.

You may ask us not to use or disclose part of your medical information for the purposes of treatment, payment or healthcare operations. You may also request that part of your medical information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. You must state in writing the specific restriction requested and to whom you want the restriction to apply. You have the right to restrict information sent to your health plan or insurer for products or services that you paid for solely out-of-pocket and for which no claim was made to your health plan or insurer.

c) **CRD is not required to agree to your request.** If we believe it is in your best interest to permit use and disclosure of your medical information, your medical information will not be restricted; provided, however, we must agree to your request to restrict disclosure of your medical information if: (i) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (ii) the information pertains solely to a health care item or service for which you (and not your health plan) have paid us in full. If we do agree to the requested restriction, we may not use or disclose your medical information in violation of that restriction unless it is needed to provide emergency treatment. Your written request must be specific as to what information you want to limit and to whom you want the limits to apply. The request should be sent, in writing, to our Privacy Contact.

d) You have the right to request to receive confidential communications from us at a location other than your primary address.

We will try to accommodate reasonable requests. Please make this request in writing to our Privacy Contact.

e) You may have the right to have CRD amend your medical information.

If you feel that medical information we have about you is incorrect or incomplete, you may request we amend the information. If you wish to request an amendment to your medical information, please contact our Privacy Contact, in writing to request our form *Request to Amend Health Information*. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us.

f) You have the right to receive an accounting of disclosures we have made, if any, of your medical information.

This applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, family members or friends involved in your care, or for notification purposes. To receive information regarding disclosures made for a specific time period no longer than six (6) years and after April 14, 2003, please submit your request in writing to our Privacy Contact. We will notify you in writing of the cost involved in preparing this list. To the extent we maintain your PHI in electronic format; you may request an accounting of all electronic disclosures of your PHI for treatment, payment, or healthcare operations for the preceding three (3) years prior to such request.

g) Uses and Disclosures of Protected Health information Based upon Your Written Authorization.

Other uses and disclosures of your medical information not covered by this Notice or requested by law will be made only with your written authorization. For example, most uses and disclosures of psychotherapy notes; PHI for marketing purposes; that constitute a sale of PHI and other than those described in this Notice, require authorization. You may revoke this authorization at any time, except to the extent that our practice has taken an action in reliance on the use or disclosure indicated in the prior authorization.

h) Right to be Notified of a Breach.

You have the right to be notified in the event that our practice (or a Business Associate of ours) discovers a breach of unsecured protected health information.

i) Complaints:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact, in writing. We will not retaliate against you for filing a complaint.

By signing this form, you acknowledge receiving this Notice and that you were afforded an opportunity to ask questions related to the content herein.

Signature of Patient _____ Date_____

Print Name of Patient _____

CENTER FOR
Rheumatic Diseases
& Osteoporosis P.A.

William W. Mullins, M.D. | Anu Sharma, M.D. | Seema Goyal, M.D.

Discrimination is Against the Law

Center for Rheumatic Diseases and Osteoporosis, P.A. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. **Center for Rheumatic Diseases and Osteoporosis, P.A.** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Center for Rheumatic Diseases and Osteoporosis, P.A.
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact **Elizabeth Bernardo, RN, BSN - Administrator**
If you believe that **Center for Rheumatic Diseases and Osteoporosis, P.A.** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Elizabeth Bernardo, RN, BSN - Administrator
6001 Montrose Road Suite 702
North Bethesda, Maryland 20852
Tel: (301) 230-5888
Fax: (301) 230-2488

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, **Elizabeth Bernardo, RN, BSN - Administrator** is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Barbara Holland, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
150 S. Independence Mall West
Suite 372, Public Ledger Building
Philadelphia, PA 19106-9111
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.