COHEN
MEDICAL CENTERS

566 Saint Charles Dr. Thousand Oaks, CA 91360
www.cohencenters.com
Phone: (805) 449-8781
Fax: (805) 449-4224

Dear Patient,

Thank you for choosing Cohen Medical Centers for your Rheumatology and Regenerative medicine care. Please review and complete all enclosed documents prior to your appointment to expedite your check-in process. Please remember to bring your completed forms, insurance cards, driver's license, and **COPIES** of any recent labs or imaging reports. If it is easier for you, you may have them faxed to our office before your scheduled appointment.

Our office will usually confirm each appointment the day before so please make sure to provide accurate contact information and report any changes as soon as possible. Each appointment time is scheduled for one patient in an effort to provide appropriate attention and care. Please provide our office with at least a 24-hour notice should you need to cancel or reschedule your appointment. If you miss an appointment without giving advanced notice, you will be charged $75 for each missed appointment.

Co-payment amount, if applicable, will be collected at the beginning of each visit. Our office accepts cash, check, Visa, MasterCard, American Express, Discover, Apple Pay and Google Pay. Please note that a $25 fee will be charged for any bounced or cancelled checks.

Our providers will not be able to provide care for any patient who declines to sign the Medical Services Agreement and Privacy Practices Form.

We look forward to meeting you and assisting you with your medical needs. Please contact our office should you have any further questions or concerns.

Sincerely,
Cohen Medical Centers

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OFFICE HOURS

- **Monday- Friday**: 8:00 am to 5:00 pm
- We are **CLOSED** for lunch from 12:00 pm to 1:00 pm
- Phones are open from 8:00 am to 12:00pm and 1:00 pm to 5:00 pm

SCHEDULING APPOINTMENTS

- Call our office during normal phone hours to make an appointment.
- Any patient 15 minutes (or more) late will forfeit their appointment and will need to reschedule for a late date.
- There is a $75 charge for missed appointments and appointments not cancelled at least 24 hours in advance.

PRESCRIPTION

- For any new prescriptions, please call the office with medication name, dosage, directions and your pharmacy's name and phone number.
- For all refills, have the pharmacy fax over a refill request form.
- For any controlled substance prescriptions, please give a 72 hour notice before the fill date.

MEDICAL RECORDS AND FORMS

- All requests for medical records made by another healthcare provider will be faxed to the requesting provider free of charge.
- Patient requests for medical records will incur a $25 charge.
- Disability forms may be completed for a fee of $25 charge.

BILLING

- For all billing-related questions, please call our front office.
- We accept cash, check, Visa, MasterCard, American Express, Discover, Apple Pay and Google Pay.
- All copays and balances are due at the time of service.

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NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. At Shariar Cohen, MD, A Medical Corporation, we will always keep your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice, and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, reviews of your file by a doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may share your medical information with our business associates, such as our billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. We may also call and remind you of your appointments. If you are not home we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner. We may also create and distribute de-identified health information by moving all references to individually identifiable information.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we do not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any use or disclosure we make with your health information beyond the above normal uses.

You have the right to transfer charts and reports to another practice. There may be a fee associated with this transfer. You have the right to request an amendment or change to your health information. You must make this request in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make changes you request, but we will be happy to include your statement in your file. If we agree on amendment or change, we will not remove nor alter earlier documents, but will add new information.

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I acknowledge that I have received, read, and understand the NOTICE OF PRIVACY PRACTICES governed by the Health Insurance Portability and Accountability Act (HIPAA).

Name: .....

Signature: ..... Date: .....

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Privacy Practices Notice, but could not obtain it for the following reason:

_____ 1. Individual refused to sign.
_____ 2. Communication barriers prohibited acknowledgement.
_____ 3. An emergency situation prevented us from obtaining acknowledgement.
_____ 4. Other (please specify): .....

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MEDICAL SERVICES AGREEMENT

1. **MEDICAL CONSENT:** I consent to any medical treatments or procedures which may be performed on an outpatient basis (including emergency treatment or services), which may include, but are not limited to, medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the physicians, staff, or other health care providers of SHARIAR COHEN, MD, A Medical Corporation (herein referred to as "SHARIAR COHEN, MD") assisting my care.

2. **FINANCIAL AGREEMENT: I understand that all charges are due at the time of service.** I agree to pay SHARIAR COHEN, MD for all charges for healthcare services and professional services provided to me by physicians and other healthcare professionals. Acceptable forms of payment include cash, check, Visa, MasterCard, and debit card. If I am a non-insured patient, I agree to pay for my visit in full at the time of service. If SHARIAR COHEN, MD is a participating provider with my insurance company I understand that my co-pay, coinsurance, deductible and/or any outstanding balances are due at the time of service.

I understand that my insurance policy is a contract between myself and my insurance company; SHARIAR COHEN, MD is not involved. In order for SHARIAR COHEN, MD to file claims and accept payments from my insurance company, I understand that I must present current insurance information at each visit and that SHARIAR COHEN, MD will need to verify my health insurance coverage. In the event that SHARIAR COHEN, MD is not able to verify my insurance eligibility and benefits before my visit, I agree to pay for my visit in full at the time of service. A refund will be issued if my insurance pays for the visit. I also understand that I am financially responsible for any services not covered by my insurance company. When my spouse or a financial guarantor signs this agreement, the spouse or the financial guarantor shall be jointly and individually liable with me. Should my account(s) be referred to an attorney or a collection agency for the collection, the undersigned shall pay the actual attorney's fees (including costs) and collections expenses incurred in addition to the other amounts due. Unpaid accounts referred to outside agencies for collection shall bear interest at the current rate per year from the date of referral.

3. **INSURANCE AUTHORIZATION AND RELEASE:** I request that payment of authorized benefits, including Medicare, and any other government sponsored program, private insurance, and any other health plans be made to SHARIAR COHEN, MD for any services furnished by that provider. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize SHARIAR COHEN, MD to disclose portions of or all of my records to any person or corporation which is or may be liable for all or any portion of SHARIAR COHEN, MD's charges, including but not limited to insurance companies, health care service plans, government agencies, or worker's compensation carriers. I authorize SHARIAR COHEN, MD to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance

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MEDICAL SERVICES AGREEMENT

4. **RELEASE OF MEDICAL INFORMATION:** I hereby authorize SHARIAR COHEN, MD to release any information in my chart to any practitioner, doctor, hospital, or medical institution to whom I may be referred to assist in my care. Additionally, I authorize any request for medical information from any medical practitioner, doctor, hospital, or medical institution to assist in my care.

5. **PERSONAL VALUABLES:** SHARIAR COHEN, MD shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs, or other articles of unusual value and shall not be liable for loss or damage to any personal property. SHARIAR COHEN, MD, A Medical Corporation and the patient or the patient's representative, hereby enters into this agreement. The undersigned certifies that he/she has read and agreed to the foregoing, received a copy, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Patient Name

Signature of Patient

Date

or Signature of Patient's Representative & Relationship

Date

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PATIENT INFORMATION SHEET

Last Name	First Name	M.I.	Date of Birth

Address	City	State	Zip

Primary Phone Number	Secondary Phone Number

Email Address	Social Security Number

Driver's License Number:	Issuing State

Employer	Occupation

Emergency Contacts

Name	Relationship	Phone Number
Name	Relationship	Phone Number

Primary Care Physician

Name	Phone Number

Preferred Pharmacy

Name	Phone Number

Primary Insurance Coverage

Company	Effective Date	Group Number

Policy Number	Phone Number

Secondary Insurance Coverage

Company	Effective Date	Group Number

Policy Number	Phone Number

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** If you are covered under the policy of a spouse, partner, parent or legal guardian, please complete the following information:			
Last Name First Name M.I.			Date of Birth
Address	City	State	Zip
Primary Number	Primary Number		
Email Address	Social Security Number		
Employer	Social Security Number		

Please give a brief Rheumatologic history including your chief complaint, the onset, current symptoms, any triggers to those symptoms, and any alleviations.

Please provide a brief previous medical history including previous diagnoses, major surgeries or major illnesses along with the dates and treatments (if possible).	
1.	2.
3.	4.
5.	6.

Please list any hospitalizations you have had along with the reason, date, and treatments.	
1.	2.
3.	4.
5.	6.

Please list any drug **ALLERGIES** that you have and the reaction that occurred:	
1.	2.
3.	4.

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Please check the box with the following medications that you have tried in the past

Biologics/DMARDs:	
Actemra	
Arava/Leflunomide	
Benlysta	
Cellcept	
Cimzia	
Cosentyx	
Cyclosporine	
Cytoxan	
Enbrel	
Gold Injection	
Humira	
Imuran/Azathioprine	
Kineret	
Krystexxa	
Methotrexate	
Orencia	
Otezla	
Plaquenil	
Prednisone	
Remicade	
Rituxan	
Simponi	
Stelara	
Sulfasalazine	
Xeljanz	

Anti-Infam/Pain:	
Arthrotec	
Aspirin	
Celebrex	
Duexis	
Etodolac	
Feldene	
Ibuprofen (Advil/Motrin)	
Indocin	
Mobic	
Naprelan/Naproxen	
Norco	
Tramadol	
Tylenol	
Vicodin	
Vimovo	
Voltaren/Diclofenac	

Fibromyalgia:	
Cymbalta	
Elavil/ Amitriptyline	
Flexeril/Cyclobenzaprine	
Gabapentin	
Savella	

Osteoporosis:	
Actonel	
Atelvia	
Boniva	
Evista	
Forteo	
Fosamax	
Prolia	
Reclast	

Gout:	
Allopurinol	
Colcrys/Colchicine	
Uloric	

GERD/Heartburn:	
Dexilant	
Nexium	
Pepcid	
Prevacid	

Joint Injections:	
Cortisone	
Location	
Euflexxa	
Hyalgan	
Orthovisc	
Supartz	
Synvisc	

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Please provide any family history of Rheumatic disease

Relative: ..... Diagnosis: .....
Relative: ..... Diagnosis: .....
Relative: ..... Diagnosis: .....
Relative: ..... Diagnosis: .....
Relative: ..... Diagnosis: .....

Social History:

	YES	NO	
Do you exercise?	☐	☐	What type and how often? .....
Do you consume alcohol?	☐	☐	If yes, how much per week? .....
Do you smoke?	☐	☐	If yes, how many per week? .....
Do you use any other drugs?	☐	☐	**If yes, what kind, how often, how many years?** .....

.....

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Please **circle YES or NO** if you *have ever experienced or are currently experiencing* any of the following conditions or symptoms. Please specify where applicable.

Head and Neck System:

Severe dry eyes (diagnosed by ophthalmologist, requiring prescription eye drops) or dry mouth? Yes / No
Uveitis, Iritis, Scleritis, or other inflammatory eye conditions? Yes / No
Recurrent oral or nasal ulcers every 6 weeks? Yes / No
Patchy/focal hair loss? Yes / No
Fixed facial rash different from rosacea or acne? Yes / No
Severe rash when exposed to UV light (sunlight)? Yes / No

Cardiovascular System:

Pericarditis / fluid around heart? Yes / No
Heart attack(s)? Yes / No
Pericardial Effusion? Yes / No
Cardiac stents? Yes / No
If so, how many: .....
Acute heart failure? Yes / No
Pulmonary Hypertension? Yes / No
Myocarditis? Yes / No
Cardiomyopathy? Yes / No
Atrial Fibrillation or an abnormal heart rhythm? Yes / No
Valvular heart disease (e.g., Endocarditis, Mitral or Aortic valve disease, or valve replacement)? Yes / No

Pulmonary System:

Interstitial Lung Disease? Yes / No
Frequent cases of Pleurisy? Yes / No
Pleural Effusion? Yes / No
COPD? Yes / No
Chronic cough? Yes / No
Recurrent Pneumonia? Yes / No
Pulmonary Embolism? Yes / No
Positive TB test? Yes / No
Chronic lung infections (e.g., valley fever, MAC, bronchiectasis)? Yes / No
If so, please specify: .....

Vascular system

Deep Vein Thrombosis (DVT) or blood clots? Yes / No
Vasculitis/angiitis? Yes / No
Blood disorders (e.g., anemia)? Yes / No
If so, please specify: .....

Gastrointestinal System:

GERD? Yes / No
Gastritis? Yes / No
Gastric ulcer? Yes / No
Barrett's Esophagus? Yes / No
Gastroparesis? Yes / No
Difficulty swallowing? Yes / No
Irritable Bowel Syndrome? Yes / No
If so, please specify constipation, diarrhea, or both: .....
Recurrent Diverticulitis? Yes / No
SIBOe? Yes / No
Chronic diarrhea (>4 weeks)? Yes / No
Colitis (e.g., Crohn's, Ulcerative Colitis, Collagenous Colitis)? Yes / No
If so, please specify: .....
Fatty liver? Yes / No
Gallbladder disease? Yes / No
Recurrent Pancreatitis? Yes / No
Malabsorption? Yes / No
Hepatitis B or C? Yes / No

Musculoskeletal System

Prolonged morning stiffness improving with stretching and time? Yes / No
Joint pain that improves throughout the day? Yes / No
OR joint pain that worsens throughout the day? Yes / No
Recurrent joint swelling? Yes / No
Generalized muscle aches? Yes / No
Recurrent Achilles Yes / No
Tendinitis? Yes / No
Plantar Fasciitis? Yes / No
Rotator Cuff Tear? Yes / No
Meniscus Tear? Yes / No
Bursitis (e.g., GT bursitis in hips, SA bursitis in shoulders)? Yes / No
If so, please specify: .....
Do you have Tendinitis? Yes / No
If so, where? .....
Joint replacements? Yes / No
If so, please specify: .....
Gout or Pseudogout/CPPD? Yes / No

Psychiatric System:

Severe anxiety? Yes / No
Moderate to severe depression? Yes / No
Bipolar Disorder? Yes / No
Psychosis? Yes / No
ADHD? Yes / No
Restless Leg Syndrome? Yes / No

Genitourinary System:

Frequent UTIs? Yes / No
Interstitial Cystitis? Yes / No
Blood in your urine? Yes / No
Urethritis? Yes / No
Recurrent Prostatitis? Yes / No
Enlarged prostate? Yes / No
Recurrent kidney stones? Yes / No
Urinary incontinence? Yes / No
Abnormal protein in your urine? Yes / No

Neurologic System:

Migraines? Yes / No
TIA or stroke? Yes / No
If so, how many: .....
Neuropathy? Yes / No
Memory loss that has been diagnosed by a neurologist? Yes / No
Multiple Sclerosis? Yes / No
Tremors? Yes / No
Muscle disorder? Yes / No
If so, how many: .....
Carpal Tunnel Syndrome? Yes / No
Cubital Tunnel Syndrome? Yes / No

Dermatology System:

Psoriasis that has been diagnosed by a healthcare provider? Yes / No
Eczema? Yes / No
Atopic Dermatitis? Yes / No
Raynaud's or finger discolorations (purple or white) in cold weather?
Finger ulcerations? Yes / No
Nail pitting, nail ridges, or other nail changes? Yes / No

Other:

Hashimoto's? Yes / No
Unintentional weight loss? Yes / No
Recurrent miscarriages? Yes / No
Cancer? Yes / No
If so, please specify: .....

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Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facitily/entity listed below.

Patient Name: ..... Date of Birth: .....
(mm/dd/yyy)

The information you may release subject to the signed release form is as follows:					
	Completion Records		History & Physical		Progress Notes
	Care Plan		Lab Reports		Radiology Reports
	Pathology Reports		Treatment Record		Operative Reports
	Hospital Reports		Medication Record		
	Other (please Specify):				

Authorization

I hereby Authorize: .....
Physician/Healthcare Facitily

To: .....
Name

.....
Address

....
City State Zip Code

....
Signature of patient or legal/personal Representative of patient
Relationship if other than Patient

....
Patient's Name (Print)
Date

IMPORTANT WARNING: This transmission is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is **STRICTLY PROHIBITED.** If you have received this communication in error, please immediately notify us by telephone and return this original message or destroy it.