# Elyse Rubenstein, M.D., F.A.C.R.

A Professional Corporation

*Diplomate American Boards Internal Medicine and Rheumatology*

1328 16th Street • Santa Monica, California 90404

Phone: (310) 256-2425 • Fax: (310) 395-3218


Patient Name_____Date of Birth_____
Street Address_____
City_____State_____Zip Code_____
Phone Number_____SS#_____
Email_____Sex M○ F○

Referring Physician_____
Address/Phone_____
Primary Care Physician_____
Address/Phone_____

Employer_____Occupation_____
Employer Address_____
Work/Cell Phone Number_____

Marital Status _____
Spouse's Name_____Date of Birth_____
Spouse's Employer/Occupation_____
Phone Number_____

Emergency Contact Name_____Relation_____
Address_____
Phone Number_____

Billing Name (if other than patient)_____
Billing Address_____

Primary Insurance_____Phone Number_____
Address_____
Name of Insured_____Relation to Patient_____

Additional Insurance_____Phone Number_____
Address_____
Name of Insured_____Relation to Patient_____

Medicare #_____Medicaid #_____

Patient Name (print)_____

Signature of Insured_____Date_____

Elyse Rubenstein, M.D., F.A.C.R.
A Professional Corporation

**Authorization to Release Information**

I hereby authorize Elyse Rubenstein, MD A Professional Corporation to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company.

Signature_____Date_____

**Assignment of Insurance Benefits**

I hereby authorize direct payment of insurance benefits directly to Elyse Rubenstein, MD A Professional Corporation for any services rendered under her and her supervision. I understand that I am financially responsible for any balance not covered by my insurance plan.

Signature_____Date_____

**Open Payments Database**

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

Signature_____Date_____

**Medicare/Medicaid**

I request that payment of authorized Medicare benefits be made on my behalf. I authorize release of all information to the Centers for Medicare and Medicaid Services on request. A photocopy of these assignments shall be valid as the original.

Signature_____Date_____

# Elyse Rubenstein, M.D., F.A.C.R.

A Professional Corporation

Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree on this restriction, but if we do, we shall honor that agreement.

By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment or health operations

The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.

The Practice reserves the right to change the Notice of Privacy Policies

The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.

The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by _____

Print Name

_____

Signature

Relationship to patient (if other than patient) _____

Date_____

In front of _____

Practice Representative

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# Release of Medical Records Authorization

Date_____

Patient Name:_____
DOB:_____

To_____
_____
_____
_____

The above named patient is currently under my care. The purpose of the release is for continuity of care. Please forward pertinent medical records including laboratory and x-ray reports to:

Elyse Rubenstein, M.D., F.A.C.R.
1328 16th Street
Santa Monica, CA 90404

Or

Fax: (310) 395-3218

Thank you,

Elyse Rubenstein, M.D., F.A.C.R

_____ _____
Patient Signature of Authorization Patient Name

# Elyse Rubenstein, M.D., F.A.C.R.

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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**
**PLEASE REVIEW CAREFULLY.**

This notice describes our privacy practices. All above entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

## Our Pledge Regarding Health Information

We understand that information about you, your health, and your health care is personal. We are committed to protecting your personal health information (PHI).

We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by this health care practice, whether made by your personal physician or others working in this office. This notice will tell you about the ways in which we may use and disclose your PHI. We also describe your rights to the PHI we keep about you, and describe certain obligations we have regarding the use and disclosure of your PHI.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to your PHI
- Follow the terms of the notice that is currently in effect

## How We May Use and Disclose Your PHI

The following categories describe different ways that we use and disclose health information. We also provide some examples. All the ways we are permitted to use and disclose information will fall within one of the categories. However, the list of examples is not exhaustive and so not every use or disclosure possible in a category is listed.

**For Treatment:** We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to physicians, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our offices; at the hospital if you are hospitalized under our supervision; or at another physician's office, lab, pharmacy, or other health care provider where we may have referred you for x-rays, laboratory tests, prescriptions, or other treatment purposes. We may also disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

**For Payment:** We may use and disclose information about treatment and services we provided to you for billing purposes. These fees may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about your office visit so that your health plan will pay us or reimburse you for the visit. We may also tell your health plan about a treatment before you receive it so that we can obtain prior approval or determine if your plan will cover the treatment.

**For Health Care Operations:** We may use and disclose health information about you for the operation of our health care practice. These uses and disclosures are necessary to run our practice and to make sure that all our patients receive quality care. For example, we may use health information in a general review of our treatments and services or, more specifically, to evaluate the performance of our staff in caring for you. We may also combine the health information of many patients to decide what improvement we could make, what additional services we should offer, what services are not needed, or whether certain new treatments are effective. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

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**Appointment Reminders:** We may use and disclose health information to contact you as a reminder that you have an appointment or that you missed an appointment and should contact us to reschedule. Please let us know if you do not wish to have us contact you for this purpose or if you wish us to use a different address to contact you for this purpose.

**Health-Related Services and Treatment Alternatives:** We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. Please let us know if you do not wish us to send you this information or if you wish us to use a different address to send this information to you.

**Fundraising Activities:** We may use your health information to contact you in an effort to raise money for our not-for-profit operations. We may disclose health information to a business associate so that they may contact you in raising money for our practice. We only will release contact information, such as your name, address, and phone number, and the dates you received treatment or services from us. Please let us know if you do not want us to contact you for such fundraising efforts.

**Research:** Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another medication for the same condition. The Quality Assurance Committee of the Board of Directors must approve all research projects. This committee evaluates all potential projects and selects those that will be of direct or indirect benefit to our patients and/or community. Their review process also evaluates a proposed research project's use of health information, trying to balance the needs of the research community with patients' need for privacy. We will obtain your written authorization to use your PHI for research purposes *except* when our Quality Assurance Committee has determined that:

- The use or disclosure involves no more than a minimal risk to your privacy based on the following:
  - An adequate plan to protect the identifying information from improper use and disclosure;
  - An adequate plan to destroy the identifying information 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
  - Adequate written assurances that the PHI will not be reused 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);
- The research could not practically be conducted without the waiver; and
- The research could not practically be conducted without access to and use of the PHI.

Before we use or disclose health information for research, the project will have been approved through our research approval process. However, we may disclose health information about you to people preparing to conduct a research project. For example, we may help potential researchers look for patients with specific health needs, as long as the health information they review does not leave our facility.

**Organ and Tissue Donation:** If you are an organ donor, we may release health information to an organ donation bank or to organizations that handle organ procurement or organ, eye, or tissue transplantation, as necessary to facilitate organ or tissue donation and transplantation.

**As Required by Law:** We will disclose health information about you when required to do so by federal, state, or local law.

**To Avert a Serious Threat to Health or Safety:** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

**Military and Veterans:** If you are a member of the armed forces or separated or discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans' Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

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**Workers' Compensation:** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks:** We may disclose health information about you for public health activities. These activities generally include the following:

- The prevention or control of disease, injury, or disability
- The reporting of births and deaths
- The reporting of child abuse or neglect
- The reporting of reactions to medications or problems with products
- The notification of people about recalls of products they may be using
- The notification of a person or organization required to receive information on Food and Drug Administration–regulated products
- The notification of a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- The notification of the appropriate government authority, if we believe a patient has been the victim of abuse, neglect, or domestic violence (we will only make this disclosure if you agree or when required or authorized by law)

**Health Oversight Activities:** We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose your health information in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement:** We may release health information if asked to do so by a law enforcement official:

- In reporting certain injuries, as required by law: gunshot wounds, burns, dog bites, and injuries to perpetrators of crime
- In response to a court order, subpoena, warrant, summons, or similar process
- To identify or locate a suspect, fugitive, material witness, or missing person (name and address, date of birth or place of birth, social security number, blood type or Rh factor, type of injury, date and time of treatment and/or death, if applicable, and a description of distinguishing physical characteristics)
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of criminal conduct
- About criminal conduct at our facility
- In emergency circumstances to report a crime; the location of a crime or victims; or the identity, description, or location of a person who committed a crime

**Coroners, Health Examiners, and Funeral Directors:** We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

**National Security and Intelligence Activities:** We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**Protective Services for the President and Others:** We may disclose health information about you to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons, or foreign heads of state.

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**Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

## Your Rights Regarding Health Information About You

You have the following rights regarding health information we maintain about you:

**Right to Inspect and Copy:** You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records.

To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed

**Right to Amend:** If you believe that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing. You must include information supporting and the reasons for your request.

We may deny your request for an amendment if it is not in writing or does not include a reason for the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the health information kept by or for our practice
- Is not part of the information that you would be permitted to inspect and copy
- Is accurate and complete

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

**Right to an Accounting of Disclosures**: You have the right to request a list of the disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

To request this list of disclosures, you must submit your request in writing. Your request must state a time period that may not be longer than 6 years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures in writing within 30 days of your request. If we are unable to provide you with this information within 30 days, we will notify you of that fact and inform you of the date by which we can supply the list. This date will not be more than 60 days from the date you made the request.

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**Right to Request Restrictions**: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we withhold your information from a specified nurse or that we not disclose information to your spouse about a surgery you had.

We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively affect the care we provide you.

If we do agree, we will comply with your request, unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request in writing. In your request, you must tell us what information you want to limit and to whom you want the limits to apply.

**Right to Request Confidential Communications:** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish us to contact you.

**Right to a Paper Copy of This Notice:** You have the right to obtain a paper copy of this notice at any time.

## Changes to This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, at the top, the effective date. You may request a copy of our most current notice at any time.

## Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services in Washington, DC. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

## Other Uses of Health Information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

## Acknowledgment of Receipt of This Notice

We will request that you sign a separate form acknowledging that you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign his or her name and date. This acknowledgment will be filed with your records.