Houston Rheumatology Center

Sabeen Najam, MD
Board Certified in Rheumatology

THE PATIENT PORTAL!

The Patient Portal is a secure web portal on our web site home page that gives patient's a new and efficient internet-based method of communicating with their doctor's office. Patients can log on to www.houstonrheumatology.net and click the Patient Portal tab or clink the link provided to you in your email:

Benefits of the Patient Portal include:

- Send and receive secure and confidential messages with our office
- Request Appointments
- Request Prescription Refills
- View Upcoming Appointments for which you will also receive a reminder email
- Able to View and Print Lab Results published by the Doctor
- Update your Personal Information
- Receive material relevant to your condition
- View your Medical Records
- View Current and Past Statements (unable to pay bills on line)

It's simple and easy to access your PATIENT PORTAL

1. When you come in for your visit, we will confirm your email address. We will send an email to the email address you provided to the office which will have a link to the Patient Portal and will also have your log on name and password.
2. Clink on the link in the email and register as an existing patient, NOT as a new patient. You will NOT NEED to Pre-Register. Just enter the log on name and password at the top of the page and click on the login tab. Once you are logged in, it will prompt you to change your password.
3. If you have problems or forget your password, please call our office and we will reset your password.
4. Log in and follow the directions.

If you experience any difficulty when registering or have any questions, please call our office at **(281) 422-7179** during normal business hours for assistance.

Keep this for your records!

Baytown: 1610 W. Baker Rd, Suite C, Baytown, TX 77521
Sugar Land: 17510 W. Grand Parkway South, Ste 460, Sugar Land, TX 77479
Tel: (281) 4227179 Fax: (281) 4227177 Email: info@hrcclinic.com www.houstonrheumatology.net

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PLEASE GIVE YOUR CURRENT INSURANCE CARDS AND ID TO THE RECEPTIONIST

Please Print

Patient Name: _____SS #:_____-_____-_____

Mailing Address: _____

City: _____State: _____Zip Code: _____-_____

Home #: (_____)_____-_____Work#: (_____)_____-_____Cell#: (_____)_____-_____

Date of Birth: _____-_____-_____ Age: _____Sex: M / F Marital Status: Single Married Divorced Widowed
Race: White Black/African American Hispanic Other Prefer not to answer
Ethnicity: Hispanic /Latino Not Hispanic /Latino Prefer not to answer
Language: English Spanish Vietnamese Other_____
Your Employer: _____
Employer Address: _____Telephone #:(_____)_____-_____
Spouse's Name: _____
Spouse's Employer: _____Telephone#: (_____)_____-_____
Address: _____
Emergency Contact (not in same household): _____Relationship:_____
Telephone #: (_____)_____-_____ Address: _____
Your Primary Care Physician: _____Telephone#: (_____)_____-_____
Who referred you to *Dr Najam*?: _____Telephone#: (_____)_____-_____

Pharmacy Name: _____ Telephone#: (_____)_____-_____
Your Email address: _____

Assignment of Benefits:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to ***Houston Rheumatology Center.*** *I understand that I am financially responsible for all non-covered services. I also authorize* ***Houston Rheumatology Center*** *to release any information required to process my claims.*

Signed: _____Date: _____

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Payment is due prior to services rendered unless prior arrangements have been made.

We at Houston Rheumatology Center welcome you to our practice. Our philosophy is to provide comprehensive rheumatologic care, while treating every patient with dignity and respect.

Houston Rheumatology Center Office hours: Monday – Thursday 8:30am– 5:00pm
Friday 9:00am – 3:00pm
We are closed for Lunch from 12:00 – 1:00

Insurance Cards/ID Card:

Please ensure you bring copy of current Insurance cards and Picture ID with you to each office visit. If you're Insurance plan changes please contact our office to have your information updated, to avoid any delay in your appointments.

Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call **Houston Rheumatology Center** promptly if you are unable to attend an appointment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance, and calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

No-Show Policy:

A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. Failure to present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". If three (3) appointments are missed, you will no longer be considered a patient of this practice. After your third missed appointment, you will be notified by mail to find another Rheumatologist. We will continue to care for you over the next 30 days for emergencies only. **There will be a $25 charge for all NO SHOWS. Please be courteous and cancel the appointment 24 hours ahead of your scheduled appointment time to avoid this charge.**

Diagnostic Testing Policy:

Diagnostic lab work will usually be performed on your initial visit. Lab work to follow your disease or to monitor your medications may also be performed on your follow up visits. ***All New Patients will be scheduled for a follow up visit to discuss labs in detail***. ***Initial lab results will not be given over the phone.*** Medications that are prescribed can have toxic side effects, and guidelines exist for monitoring these medications. These guidelines will be discussed on an individual basis. We reserve the right to deny refills on your medications if compliance with these labs is not achieved. Lab/test results for established patients will be available through the Patient Portal once they are reviewed by the doctor.

Medication Refills/Prior Authorizations:

If you are requesting a medication refill, please contact your pharmacy and have them fax our office a refill request. Please allow 24 hours for requests to be reviewed and sent back to the pharmacy. **Medications that require a Prior Authorization from the insurance company require 48-72 business hours for approval.**

Doctor Call Backs:

All calls that are referred to **the Physicians** regarding labs, medications, etc…will be returned within 24 hours. Most calls are returned after clinic is finished for that day. Please ensure that you provide a good call back number to ensure that **the Physicians** can reach you during her call back time. In order to be respectful of other patients needs please allow this time before calling again.

Insurance/Payments:

Houston Rheumatology Center is contract with several insurance carriers. As part of our contract with the insurance companies we are legally required by the terms of the contract to collect any ***co-pays or deductibles from you at the time of service***. Patients who do not have insurance coverage will be expected to pay at the time of service. *For your convenience we accept Cash, Debit Cards & Credit Cards.* ***(Checks are not accepted).***

*Failure to update **Houston Rheumatology Center** with your new Insurance Information upon any given visit will result in the patient being responsible for billed charges.*

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Patient Assistance with High Cost Drugs/Infusions:
Houston Rheumatology Center has several resources available to assist patients with Copays/Deductibles/Coinsurance. Please feel free to inquire regarding these programs for possible assistance.

Referrals/Authorizations:
If you are required by your Insurance Carrier to provide a Referral/Authorization for any services, you are responsible for presenting at time of visit. ***Failure to provide referral will and can result in patient rescheduling appointment for a future date.***

Denied Charges:
Charges that may be denied by your Insurance Carrier as non-covered/Pre-existing conditions or unauthorized will be the patient's responsibility.

Disability Forms/Paperwork and Medical Records:
There is a charge for all paperwork that is required to be filled out by Dr. Najam. Please inquire as the cost my vary depending on the detail involved in completing. You may also be required to have an extensive evaluation to complete the forms. Please allow Dr. Najam a minimum of 3 business days to complete. You will be contacted by our staff if additional time or evaluation is required. Payment is due prior to picking up the paperwork.

Other Charges for Diagnostic Testing:
You may incur other charges from the Lab; we do not do the billing for the Lab. Also if you are having an MRI done in our office it is possible that you will receive a bill for the Reading of the MRI. Please contact the company directly regarding the charges/bills.

All patients will be responsible for filling out and signing new paper work at the first of each year.

You may contact our office by email: info@hrcclinic.com

I have read and agree to assume the responsibilities as stated above.

Patient Signature: _____Date: _____

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NOTICE TO ALL PATIENTS WITH AFFORDABLE CARE ACT (ACA) PLANS

Due to the complexities & costs associated with ACA plans, it is the policy of Houston Rheumatology Center for all patients with ACA plans, whether purchased through the Federal Exchange or directly from the insurance carrier that you provide proof of active coverage and that your current premiums are paid prior to being seen for ***EACH*** visit to our office. Failure to provide these items may result in your appointment being cancelled or rescheduled.
Proof of active coverage and current premium payment could include:

- Receipt showing premium payment to insurance carrier for month being seen. This receipt must include your name and policy number.
- Email confirming premium payment received by the insurance carrier for month being seen. The email must include your name and policy number.
- Copy of your bank statement or online print out showing the auto debit from your account must have your name on it. You can white out of account number and other transaction information.
- ***Note:*** A copy of your bill/statement is not acceptable, we must confirm the actual premium payment has been paid and accepted.

In the event that your premiums are 100% subsidized (meaning you do not pay anything out of pocket for your insurance premiums), you must bring written documentation confirming the information prior to being seen. If your AC is plan is provided through an empire you do not need to provide proof of premium payment this information will be provided to us been verified your coverage.Our office has made a commitment to promote the health of our members, and to provide education regarding preventive health measures that you can take to maintain a healthy lifestyle.

Our records indicate that your Health Insurance plan is through the **AFFORDABLE CARE ACT EXCHANGE PLAN.**

Also known as Health Market Place . At each visit is your responsivity to bring copy of your paid receipt to confirm payment has been made for the month you are being seen.

If for any reason that my premium is unpaid with the Health Exchange I will be responsible for Total Billed Charges for all services rendered during that period.

_____	_____	_____
Patient Name (Print)	Date	Patient Signature

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HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted by law. It also describes your rights to access and control your protected health information. "Protected Health Information '' is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved In your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use as required by law.

Treatment: We will use and disclose your protected information to provide, coordinate, and manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary Information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital stay.

Healthcare Operations: We may use or disclose, as needed, your protected health information in orders to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training medical students, licensing, and conducting or arranging for other business activities, For example, we may disclose your protected health information to medical students that see patients in our office. In addition, 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 the physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: As Required by Law, Public Health issues as regarded by law, Communicable Diseases, Health Oversight, Abuse Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Active and National Security, Workers' Compensation, Inmates, 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 requirements of Section 164.50

Other Permitted Required Uses and Disclosures: Will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at anytime, in writing, except to the extent that your physician of the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You're Rights: Following is a statement of your rights with respect to your protected health information.

You Have the Right to Inspect and Copy Your Protected Health Information: This means you may ask us not disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations, You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health Information, your protected health information will not be restricted. You then have the right to use another healthier professional.

You Have the Right to Request to Receive Confidential Communications from us by Alternative means or at an Alternative location. You Have the Right to Obtain a Paper Copy of This Notice from Us, Upon Request even if you have agreed to Accept This Notice Alternatively, i.e. electronically.

You May Have the Right to Have Your Physician Amend Your Protected Health Information: If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You Have the Right to Receive an Accounting of Certain Disorders We have Made, if any, of Your Protected Health Information. We reserve the right to make any changes to this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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 by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Signature below is only an acknowledgement that you have received this Notice of Privacy Practices.

Print Name: _____ Signature: _____ Date: _____

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AVOIDING BREACHES OF CONFIDENTIALITY
THE ANSWERING MACHINE/VOICE MAIL
OR
SPOUSE/IMMEDIATE FAMILY MEMBER

If you have an Answering machine/Voice mail System, staff may have the opportunity to leave a message for you. These messages may contain confidential information regarding your condition or the fact that you are a patient of Houston Rheumatology Center. People other than you may hear these messages.

_____ Yes, Houston Rheumatology Center may leave a message on my answering machine/voice mail.

_____ No, No messages are to be left.

There may be times when your spouse and or immediate family member will call to request test results, or ask questions regarding your health.

_____ Yes, Houston Rheumatology Center may discuss my medical conditions with the names listed below.

_____ _____
Name **Relationship** **Contact Number**

_____ _____
Name **Relationship** **Contact Number**

_____ No, do not discuss my medical condition with anyone.

_____ _____
Patient Name **Signature**

_____
Date

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

" I hereby authorize this practice to make use and disclosure of my protected Health Information to provide, coordinate, or manage my health care and related services. This includes the coordination or management of my health care with a Third Party. (Information about me in my MEDICAL RECORDS and/or FINANCIAL RECORDS) as Indicated below." This information is to be disclosed to:

Houston Rheumatology Center
Sabeen Najam, MD, PA
1610 W. Baker Road Suite C
Baytown, TX 77521
(281)422-7179 Fax (281)422-7177

Patient's Name: _____ Date of Birth:_____

Previous Name: _____ Social Security #: _____

Healthcare information relating to the following treatment, condition, or dates: _____

_____

All healthcare information for the continuation of care.

TO BE READ AND SIGNED BY PATIENT

I UNDERSTAND THE FOLLOWING:

a) I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY PROVIDING WRITTEN NOTICE TO THIS PRACTICE.
b) I MAY NOT BE ABLE TO REVOKE THIS AUTHORIZATION IF THE PRACTICE HAS ALREADY TAKEN ACTION UTILIZING THIS AUTHORIZATION OR IF THE AUTHORIZIION OR IF THE AUTHORIZATION WAS OBTAINED AS A CONDITION OF OBTAINING INSURANCE COVERAGE.
c) THE PRACTICE WILL NOT CONDITION TREATMENT OR PAYMENT BASED ON MY SIGNING THIS AUTHORIZATION.
d) I AM SIGNING THIS AUTHORIAZATION FREELY.
e) NO ONE HAS PRESSURED ME TO SIGN THIS AUTHORIZATION.
f) THE INFORMATION DISCLOSED IN THIS AUTHORIZAION MAY BE SUBJECT TO REDISCLOSURE BY THE PRACTICE AND NO LONGER PROTECTED UNDER FEDERAL LAW.
g) I ACKNOWLEDGE THAT I HAVE HAD AN OPPORTUNITY TO REVIEW THIS AUTHORIZATION AND UNDERSTAND THE INTENT AND THE USE.
h) IF REQUESTED, I WILL RECEIVE A COPY OF THIS AUTHORIZAION.

Patient Signature: _____ Date signed: _____

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UNLESS REVOKED IN WRITING THIS AUTHORIZATION WILL REMAIN IN EFFECT INDEFINATELY

Patient Health Questionnaire

Patient's Name: _____**Date of Birth**: _____

Drug / Food Allergies: Please list any and all allergies you have pertaining to medications and food, along with the reaction._____

_____

Current Medical Conditions/ Diagnosis: _____

_____

Current Medications: Please list any medications that you take regularly. Include dosage, how often you take them.
(If you have a list of Medications please give to Receptionist)

Name	Dose	Date Started

Last DXA Scan/Bone Density date: _____

Facility: _____

Results: Normal/ Osteopenia/ Osteoporosis (please circle one)

Signed: _____Date: _____

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MEMORIAL HERMANN INFORMATION EXCHANGE "MHiE"
PATIENT CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose: The MHiE is a health information exchange network developed by Memorial Hermann Healthcare System. Exchange Members include hospitals, physicians and other healthcare providers. Exchange Members are able to share electronically medical and other individually identifiable health information about patients for treatment, payment and healthcare operation purposes. We are an Exchange Member of the MHiE and we seek your permission to share your health information with other Exchange Members via the MHiE. By executing this form, you consent to our use and electronic disclosure of your health information to other MHiE Exchange Members for treatment, payment and healthcare operation purposes. We will not deny you treatment or care if you decline to sign this Consent, but we will not be able to electronically share your health information with your healthcare providers that participate in the MHiE as Exchange Members if you do not sign this Consent.

Instructions: If you agree to allow us to disclose your health information with other MHiE Exchange Members please complete the relevant portions of and sign this Consent.

Patient Name (Last, First, Middle)	Date of Birth

Information that will be Disclosed; Purpose of the Consent for Disclosure

I, _____[Patient Name], hereby consent to the disclosure of my medical, health and encounter information by any and all Memorial Hermann Healthcare System providers (collectively the "Provider") to other participating providers in the MHiE (Exchange Members) who may request such information for treatment, payment or healthcare operation purposes. I understand the information to be disclosed includes medical and billing records used to make decisions about me.

I HEREBY SPECIFICALLY AUTHORIZE PROVIDER TO RELEASE ALL TYPES AND CATEGORIES OF PROTECTED HEALTH INFORMATION TO OTHER HEALTHCARE PROVIDERS THAT PARTICIPATE IN THE MHiE FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION PURPOSES, [INCLUDING BUT NOT LIMITED TO, YOUR ALCOHOL AND TREATMENT RECORDS, YOUR DRUG ABUSE TREATMENT RECORDS, YOUR MENTAL HEALTH RECORDS, AND YOUR HIV/ACQUIRED IMMUNE DEFICIENCY SYNDROME RECORDS, AS APPLICABLE].

No Conditions: This Consent is voluntary. We will not condition your treatment on receiving this Consent. **HOWEVER, IF YOU DO NOT SIGN [AND INITIAL] THIS CONSENT, WHERE REQUIRED, YOU CANNOT PARTICIPATE IN THE MHIE.**

Effect of Granting this Consent: This Consent permits all MHiE Exchange Members to access your health information. Exchange Members of the MHiE are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Term and Revocation

This Consent will remain in effect until you revoke it. You may revoke this Consent at any time by completing the MHiE notice of revocation. The MHiE notice of revocation is available by calling 713-456-MHiE (6443). Revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your notice of revocation. Revocation of this Consent will also have no effect on your personal health information made available to Exchange Members during the timeframe in which your Consent was active.

INDIVIDUAL'S SIGNATURE

I have had full opportunity to read and consider the contents of this Consent. I understand that, by signing this Consent, I am confirming my consent and authorization of the use and/or disclosure of my personal health information, as described herein.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include this Consent in the individual's records.

Official Use Only:

MHiE
Memorial Hermann
Information Exchange

HAQ-II (Health Assessment Questionnaire-II)

Houston Rheumatology Center
Sabeen Najam, MD

We are interested in learning how your illness affects your ability to function in daily life. Place an X in the box which best describes your usual abilities **OVER THE PAST WEEK**. *Are you able to:*

	Without any difficulty (0)	With some difficulty (1)	With much difficulty (2)	Unable (3)
Get on and off the toilet?	☐	☐	☐	☐
Open car doors?	☐	☐	☐	☐
Stand up from a straight chair?	☐	☐	☐	☐
Walk outdoors on flat ground?	☐	☐	☐	☐
Wait in a line for 15 minutes?	☐	☐	☐	☐
Reach and get down a 5-pound object (such as a bag of sugar) from just above your head?	☐	☐	☐	☐
Go up 2 or more flights of stairs?	☐	☐	☐	☐
Do outside work (such as yard work)?	☐	☐	☐	☐
Lift heavy objects?	☐	☐	☐	☐
Move heavy objects?	☐	☐	☐	☐

How much **PAIN** have you had because of your illness in the **PAST WEEK**?

No Pain ☐(0)—☐(1)—☐(2)—☐(3)—☐(4)—☐(5)—☐(6)—☐(7)—☐(8)—☐(9)—☐(10) Very Severe Pain

How much of a **PROBLEM** has **UNUSUAL FATIGUE or TIREDNESS** been for you **OVER THE PAST WEEK**?

Fatigue is no Problem ☐(0)—☐(1)—☐(2)—☐(3)—☐(4)—☐(5)—☐(6)—☐(7)—☐(8)—☐(9)—☐(10) Fatigue is a Severe Problem

How much of a **PROBLEM** has **SLEEPING** been for you **OVER THE PAST WEEK**?

Sleep is no problem ☐(0)—☐(1)—☐(2)—☐(3)—☐(4)—☐(5)—☐(6)—☐(7)—☐(8)—☐(9)—☐(10) Sleep is a Severe Problem

How **ACTIVE** has your **ARTHRITIS** been in the **LAST 24 HOURS**?

Not Active ☐(0)—☐(1)—☐(2)—☐(3)—☐(4)—☐(5)—☐(6)—☐(7)—☐(8)—☐(9)—☐(10) Very Active

When you get up in the **MORNING** do you feel **STIFF**? ☐ YES ☐ NO

If you answer YES, please write the number of minutes: _____, OR number of hours:_____ until you are as limber as you will be for the day?