



RHEUMATOLOGY PARTNERS OF
HOUSTON, LLC

129 Vision Park Blvd., Ste. 206, Shenandoah, TX 77384
4747 Bellaire Blvd., Ste. 150, Bellaire, TX 77401
O: 281-315-8130 F: 281-315-8131 & 281-315-8132

Welcome to Rheumatology Partners of Houston

www.RPHdocs.com

Dear Patient,

We are happy that you've chosen us for your rheumatologic care. Our team is committed to providing you with compassionate, expert care in a comfortable and professional environment.

To help ensure your visit goes smoothly, please review the following important information:

Arrival Time

- New Patients: Please arrive at least **30 minutes** prior to your scheduled appointment to allow sufficient time for processing paperwork.
- Established Patients: Please arrive 15 minutes before your appointment time.

To help expedite the check-in process, we strongly encourage you to complete your paperwork prior to your appointment. This will help us serve you more efficiently and keep appointment times on track.

What to Bring

When you arrive, please be prepared to present:

- A valid form of identification (such as a current driver's license)
- Your insurance card

If your insurance plan requires a referral, you must contact your primary care physician and have them send the referral to our office before your appointment. Unfortunately, we may not be able to see you without a referral on file.

No-Show and Cancellation Policy - We understand that circumstances can change, but please note our cancellation policy:

1. Appointments must be canceled at least 24 hours in advance.
2. A \$50 no-show fee will apply for appointments canceled less than 24 hours before the scheduled time or missed without notice. This fee must be paid before your next appointment can be scheduled.

We accept the following forms of payment:

- Cash
- American Express, Visa, MasterCard, Discover
- Personal Checks

For additional details about our practice and services, please visit us at www.RPHdocs.com.

We look forward to partnering with you in your healthcare journey and thank you for trusting us with your care.

Rheumatology Partners of Houston



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.

Rheumatology Partners of Houston LLC (RPH) is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at RPH please contact us at 281-315-8130.

How RPH may Use or Disclose Your Health Information:

RPH collects health information from you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of **RPH**, but the information in the medical record belongs to you. **RPH** protects the privacy of your health information. The law permits **RPH** to use or disclose your health information for the following purposes:

1. Treatment. We may disclose your health care information to other healthcare professionals for the purpose of treatment, Payment or healthcare operations. Example: Reviews of your file by a doctor whom we may involve in your care.
2. Payment: We may disclose your health information to your insurance provider for the purpose of payment or health care operations. Example: "As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to **RPH** for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing statement to you for your insurance company for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received"
3. Regular Health Care Operations - We may disclose your health information to a staff member in order that they may process paperwork, input computer information, fill out report forms, for copying or faxing whereby your medical condition, diagnosis and treatment may be visible to them in their day-to-day work. "If a staff member is asked to copy records that are to be sent to another doctor at your request."
4. Notification and communication with family - We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
5. Required by law - As required by law, we may use and disclose your health information.
6. Public health - As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.
7. Health oversight activities - We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.
8. Law enforcement/Judicial and administrative proceedings - We may disclose your health information in the course of any administrative or judicial proceeding. We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.
9. Deceased person information/ Organ donation - We may disclose your health information to coroners, medical examiners and funeral directors. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
10. Research - We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.



HIPAA Notice of Privacy Practices *continued*

11. Public safety - We may disclose your health information to appropriate person(s) in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
12. Worker's compensation - We may disclose your health information as necessary to comply with worker's compensation laws.
13. Reminders - We may contact you to provide appointment reminders or to give you information about other treatments or health-related benefits and services that may be of interest to you.
14. Charitable Causes - We may contact you to participate in fund-raising activities for blood drives, food bank raising donations or other charitable entities that we may be involved with to benefit those in need.
15. Change of Ownership - In the event that RPH is sold or merged with another organization, your health information/record will become the property of the new owner.
16. Emergencies - We may disclose your health information, to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Rheumatology Partners of Houston May Not Use or Disclose Your Health Information Except as described in this Notice of Privacy Practices, **RPH** will not use or disclose your health information without your written authorization. If you do authorize **RPH** to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Your Health Information Rights

1. You have the right to request restrictions on certain uses and disclosures of your health information. **RPH** is not required to agree to the restriction that you requested.
2. You have the right to receive your health information through a reasonable alternative means or at an alternative location.
3. You have the right to inspect and copy your health information.
4. You have a right to request that **RPH** amend your health information that is incorrect or incomplete. **RPH** is not required to change your health information and will provide you with information about **RPH** denial and how you can disagree with the denial.
5. You have a right to receive an accounting of disclosures of your health information made by **RPH**, except that **RPH** does not have to account for the disclosures described in parts (treatment), (payment), (health care operations), (information provided to you), (directory listings) and (certain government functions) of section I of this Notice of Privacy Practices.
6. You have a right to a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please circle the areas of concern and return this to the receptionist for review.

Changes to this Notice of Privacy Practices

RPH reserves the right to amend this Notice of Privacy Practices at any time in the future, and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendment. Until such amendment is made, **RPH** is required by law to comply with this Notice. Revised notices will be posted in the office and given to each new patient as they come in for care.

Complaints

If you have any questions about this notice, please ask the receptionist to speak to our Practice Administrator. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to U.S. Department of Health and Human Services (DHHS); we will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.

**These privacy practices are currently in effect and will remain in effect until further notice.*



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Patient Written Authorization Request Regarding Release of Health Information

(Friends & Family – not physicians)

Patient Name (Print): _____ Date of Birth: _____

Phone Number: _____ Email: _____

In accordance with HIPAA regulations, I authorize **Rheumatology Partners of Houston, PLLC** to discuss and release information regarding my medical condition, appointments, billing, and treatment to the individuals listed below. Authorized Contacts:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

☐ I do not wish to give access to my Protected Health Information to anyone besides myself regarding my medical condition. How to contact me: _____

Patient Signature: _____ Date: _____

Legal Representative

If the patient has a legal representative who will be signing forms for them, please fill out the information below:

Legal Representative Name (Print)

Legal Representative Email

Legal Representative Signature

Legal Representative Contact (cellphone)



Rheumatology Policies

No show & Cancellation policy

If you are unable to make your appointment, we ask that you call our office promptly to cancel as soon as possible so that we can meet the medical needs of our community.

Once cancelled, your appointment time will then be offered to another patient who is in urgent need of treatment.

If it is necessary to cancel your scheduled appointment, we require an advanced notice of at least 24 business hours. For example, if your appointment is scheduled for Tuesday at 3 PM, please call prior to 3 PM on Monday. Monday appointments should be cancelled by 12:00 PM the Friday prior if possible. Appointments are in high demand, so it is very helpful to use every appointment time for a patient in need.

Late Cancellations and Same day cancellations are considered as a "No Show" appointment

Our physicians appreciate your help to make this possible.

How to cancel your appointment:

To cancel your appointment, please call 281-315-8130.

No Show

A "No Show" is a patient who misses an appointment without cancelling it 24 business hours in advance of the scheduled appointment. Failure to be present at the time of scheduled appointment, or to call 24 hours in advance to cancel, will be recorded in your chart as "No Show". A fee will be applied to your account as follows:

- First No-show: \$50.00
- Subsequent No-show: \$75.00

These fees cover the administrative tasks associated with your appointment, which still occur even when you have not seen your provider. Payment of this fee is required before scheduling any further appointments. A patient with a third no show in a 12-month period will be considered for discharge from the practice.

Forms Completion Policy

At Rheumatology Partners of Houston, we understand that patients may require documentation for medical leave or disability purposes. Completing these forms requires time, attention to detail, and a thorough review of your medical history and current condition to ensure accurate and complete responses.

To accommodate these requests while maintaining high standards of care, the following fees will apply:

- FMLA (Family and Medical Leave Act) Forms: \$25.00
- Disability Forms (Short-term, Long-term, or other disability-related documentation): \$50.00

These fees cover the time and resources required to review your chart, assess your condition, and complete the forms accurately and professionally.

Please note:

- Fees must be paid prior to completion.
- Allow up to 7-10 business days for form processing.
- Forms will not be completed during office visits; requests must be submitted separately.

If you have any questions regarding this policy, please contact our office staff for assistance.

Thank you for your understanding and cooperation.

Patient Name (print): _____ Today's Date: _____

Patient Signature: _____



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Patient Portal

Rheumatology Partners of Houston offers a Patient Portal you can access online; portal access is free to all **RPH** patients.

Why Enroll in the Patient Portal?

The Patient Portal is a secure and convenient online tool that allows you to easily view and update portions of your health and clinical information. It's designed to help you stay informed and more engaged in your care. In the coming months, we will be rolling out additional features that will make managing your health even easier, including:

- Appointment requests
- Visit reminders
- Prescription refill requests
- Secure messaging for non-emergent questions

Please note: The Patient Portal is not intended for emergency concerns or any issue requiring a same-day response. For urgent matters, please contact the office directly at 281-315-8130.

To get started, we just need your email address to enroll you in the portal. Please complete the section below:

☐ I would like to be enrolled in the Rheumatology Partners of Houston Patient Portal

My email address is (please print): _____

☐ I **DO NOT** wish to enroll in the Rheumatology Partners of Houston Patient Portal because:

(Please check one):

☐ I do not have an email address

☐ I decline enrollment and do not want to provide my email address

Other: _____

Patient Name (print): _____ Today's Date: _____

Patient Signature: _____



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PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Contact: _____

I hereby authorize _____ to release the following information from my health record covering the period from/to _____, if I do not specify a period, I am authorizing the release of records for the entire duration of care with the provider. (**check all boxes that apply below**).

Provider Name, Address, Phone and Fax number:

Complete Medical Record (includes information regarding insurance, demographic, referral documents, and medical records). If this box is checked, do not check any additional boxes.			
Progress/Office Visit Notes	Radiology/Imaging Reports	Chemo/Infusion Records	
Lab Reports	Pathology Reports	Billing/Payment Records	
Other:			

Information is to be released to: **Rheumatology Partners of Houston, LLC**

Office # 281-315-8130

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Dr. Carmen Perez-Masuelli

Dr. Kalpita Hatti

Dr. Leslie Wilson

The information being released for the following purposes:

Continued Treatment	Disability	Attorney/Litigation	Other
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I understand that this authorization will remain in effect until I revoke it in writing. I understand that according to applicable state and/or Federal laws (Texas Medical Practice Act or Health Insurance Portability and Accountability Act), a re-disclosure could be made of records received from another physician or other health care provider involved in my care or treatment.

Print Patient/Legal Representative Name

Signature of Patient/Legal Representative

Date

REVOKE/CANCEL THIS AUTHORIZATION

Signature of Patient/Legal Representative

Date



General Consent For Treatment & Acknowledgement – Initial each section

_____ **Medical consent:** I consent to receive medical care, treatment, tests, imaging, and procedures as deemed necessary by the providers at **Rheumatology Partners of Houston, LLC (RPH)**, including physicians, physician assistants, and their clinical staff. This includes the use of medications, blood products, pathology, radiology, and other services recommended for my care. I understand that no guarantees have been made regarding treatment outcomes. I also authorize the examination, use, storage, or proper disposal of any tissue or fluid removed during my care. In the event of accidental exposure of my blood or bodily fluids to healthcare personnel, and if I am unable to provide timely consent, I authorize limited testing for hepatitis A, B, C, and HIV to protect those involved in my care.

_____ **Right to refuse treatment:** I understand that I have the right to make informed decisions regarding all my care and treatments, and that I should ask my health care professional to further clarify or explain anything I do not understand. This right includes the right to refuse any treatment that I do not want.

_____ **Acknowledgement of receipt of patient rights & notice of privacy practices:** I acknowledge both notices, Notice of Patient Rights/Responsibilities and Notice of Privacy Practices are available to be either in the office,

_____ **Release of medical information:** I authorize **RPH** to release any information necessary to facilitate healthcare processing of claims, and audit of payments related to my care/treatment from **RPH**. I also consent to the release of any information as needed for my care to other facilities, agencies, or healthcare providers as I direct or as required by law. This order will remain in effect until revoked by me in writing.

_____ **Assignment of insurance benefits:** I hereby assign all applicable medical and major medical benefits to which I am entitled to **RPH**. I authorize and direct my insurance carrier(s) - including Medicare, Medigap, Medicare Advantage, private insurance, and any other health or medical benefit plan to issue payment directly to **RPH** for services provided to me. I understand that I am financially responsible for any charges not covered by my insurance.

_____ **Medicare certification:** I certify that the information I have provided for Medicare payment is accurate. I authorize the release of medical or other relevant information to the Social Security Administration and its agents as needed to process this or related Medicare claims. I request that authorized benefits be paid on my behalf. *(Applies only if Medicare coverage is in effect.)*

_____ **Consent to obtain external prescription history:** I hereby authorize **RPH** and its providers to access my external prescription history through our charting software. I understand that this may include prescription information provided by other healthcare providers, insurance companies, and pharmacy benefit managers not affiliated with **RPH**. I acknowledge that this history may include medications prescribed over the past several years and may be reviewed by my providers and their authorized staff for the purpose of providing safe and effective care.



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General Consent For Treatment & Acknowledgement *continued*

_____ **Financial agreement:** I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists. I understand I am financially responsible to **RPH** for charges not paid under this agreement. I am responsible for all charges for services which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan. **RPH** will make every attempt to notify me in advance if a service is not covered. I am responsible for and agree to pay all co-pays, deductibles, and patient responsibility balance(s) at the time of service unless other arrangements have been made in advance.

_____ **Insurances requiring referrals:** I am presenting my insurance information for my appointment with Dr. _____ at **RPH**. I understand that it is my responsibility to ensure that a valid referral, if one is required, has been submitted to my insurance company by my current primary care provider for my visit today. ** If a referral has not been obtained, I will be responsible for all charges incurred at today's visit, including lab and x-ray if applicable. **

Receipt of Notice of Privacy Practices

_____ I acknowledge that I have received a copy of the **HIPAA Notice of Privacy Practice**, which describes how my health information may be used and disclosed, and how I can access this information. I understand that the Notice of Privacy Practices may be amended as allowed by law, and that a current copy will always be available upon request and on the practice's website at www.RPHdocs.com.

Patient Name (print): _____ Today's Date: _____

Patient Signature: _____



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NEW PATIENT QUESTIONNAIRE – RHEUMATOLOGY

Please complete this questionnaire by answering each question as accurately as possible.

GENERAL INFORMATION

Patient Name: _____ Date of Birth: _____ SS#: _____
Phone: _____ Cell: _____ Address: _____
Primary Care Provider: _____ Referring Provider: _____
Marital Status: ____ Married ____ Single ____ Divorced ____ Widow ____ Other _____
Employer: _____ Occupation: _____
Emergency Contact Name & #: _____ Relation: _____

INSURANCE & GUARANTOR INFORMATION

Primary Insurance Company: _____ ID# _____ Group# _____
Secondary Insurance Company: _____ ID# _____ Group# _____
Who is the guarantor (the person financially responsible for this account)? Name: _____
Relation to the patient: _____ Phone #: _____

CHIEF COMPLAINT / REASON FOR VISIT

What is the reason for your visit today? _____

Are you experiencing any pain? (circle one) **NO** **YES** If yes, where? _____
If you circled YES, please indicate on the scale of 1 to 10 (with 10 being the highest), what is your level of pain? _____

MEDICATIONS

Please list all prescriptions and over-the-counter medication you take on a regular basis. If you have a list readily available, please give a copy to the front desk or the medical assistant.

Medication Name	Dose (e.g., 50 mg)	Frequency (e.g., once a day)	Reason for Taking

ALLERGIES

Are you allergic to any medications? ____ YES ____ NO If yes please list: _____
Are you allergic to IV contrast? ____ YES ____ NO If yes list reaction: _____
Any other allergies? Incl. Latex ____ YES ____ NO If yes please list: _____

PHARMACY INFORMATION

Name, address and phone number of **local** pharmacy:

Name and phone number of **mail order** pharmacy (if known):



RHEUMATOLOGY NEW PATIENT MEDICAL QUESTIONNAIRE

PERSONAL HEALTH HISTORY

1) Do you or have you ever used tobacco products? (circle one) YES or NO If yes, proceed to 1A & 1B, if no skip to 2.

1a. Select all that apply:

☐	Current smoker	☐	Current smoker, some days	☐	Smoker, status unknown
☐	Light tobacco smoker	☐	Heavy tobacco smoker	☐	Former smoker

1b. Select all that apply:

☐	Cigarettes	Amount per day:	☐	Cigars	Amount per day:
☐	Smokeless	Amount per day:	☐	Pipe	Amount per day:

2) Have you had exposure to secondhand smoke (circle one)? YES NO

3) Do you drink alcoholic beverages (circle one)? YES NO If yes, how often? _____

FAMILY MEDICAL HISTORY

IF LIVING			IF DECEASED			
Year of Birth		Health	Age at Death	Cause		
Father						
Mother						
	Sister(s) how many?		Living?		Deceased?	
	Brother(s) how many?		Living?		Deceased?	
Child(ren)						
	Daughter(s) how many?		Living?		Deceased?	
	Son(s) how many?		Living?		Deceased?	
Health of child(ren)?						

Circle all the conditions you have or have had in the past

Anemia	Crohn's/ Ulcerative Colitis	High Cholesterol	Pacemaker
Anxiety	COPD	Irregular Heartbeat	Psoriasis
Arthritis	Depression	Kidney Disease	Steroid Use in eyes
Asthma	Diabetes	Liver Disease	Stomach Ulcer
Bleeding Disorder	Emphysema	High Blood Pressure	Stroke
Blood clot/DVT	Glaucoma	Migraine Headaches	Tuberculosis
Blood transfusion	Heartburn/reflux	Heart Disease	Multiple Sclerosis
Bone Marrow problems		Osteoporosis	
Cataracts	Heart attack/MI	Cancer (type: _____)	
Hepatitis (type: _____)			



RHEUMATOLOGY NEW PATIENT MEDICAL QUESTIONNAIRE

REVIEW OF SYSTEMS

Check the symptoms you currently have or have had in the past year. Please check all that apply.

<u>GENERAL</u> ___ Fever ___ Chills ___ Fatigue ___ Weight Loss ___ Weight Gain	<u>GASTROINTESTINAL</u> ___ Heartburn ___ Abdominal Pain ___ Nausea ___ Vomiting ___ Diarrhea / Loose Stools ___ Constipation ___ Blood in Stool ___ Trouble Swallowing	<u>SKIN</u> ___ Color changes to the fingertips ___ New or changing skin lesions ___ Photosensitivity ___ Rashes ___ Edema
<u>EYE, EAR, NOSE & THROAT</u> ___ Visual Changes ___ Eye Pain or Redness ___ Eye Discharge ___ Dry eyes ___ Dry mouth ___ Oral Ulcers ___ Enlarged neck glands	<u>URINARY</u> ___ Increased urinary frequency ___ Loss of bladder control ___ Pain with Urination	<u>NEURO/PSYCH</u> ___ Headaches ___ Numbness ___ Tingling ___ Dizziness ___ Fainting ___ Seizures ___ Anxiety ___ Depression ___ Sleep Problems
<u>CARDIOVASCULAR/PULMONARY</u> ___ Chest Pain ___ Chest Tightness ___ Palpitations ___ Cough ___ Shortness of Breath ___ Wheezing	<u>MUSCULOSKELETAL</u> ___ Weakness ___ Muscle Pain ___ Neck Pain ___ Back Pain ___ Joint Pain ___ Joint Swelling	<u>ENDOCRINE</u> ___ Heat Intolerance ___ Cold Intolerance ___ Night-time sweating

DEPRESSION SCREEN

Over the last 2 weeks , how often have you been bothered by the following problems:	0 Not at All	1 Several Days	2 More than half the days	3 Nearly everyday
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				



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RHEUMATOLOGY NEW PATIENT MEDICAL QUESTIONNAIRE

PAST MEDICAL HISTORY

1) Have you been hospitalized in the last 6 months? _____ YES _____ NO
If yes, when _____ Why? _____

2) Please list any additional information about your medical history that your provider should know:

PAST SURGICAL HISTORY

Please list all surgeries and dates:

_____	_____
_____	_____
_____	_____

Please list any other information about your medical history that the physician should know:

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my provider if I have a change in health.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Relationship to Patient