CENTER FOR RHEUMATOLOGY

Solutions for diseases of joints, muscles, bones and arthritis

Welcome to Center for Rheumatology! We are pleased to have you as a new patient. Please review and complete the required attachments and sign where indicated.

- Patient Information
- Health History
- Patient Consent
- Office Policies *(please do not alter or change)*
- Notice of Privacy Practices
- Patient Activity Scale
- Medical Record Release

Let us know if you have any questions.

Thank you for your time!

Arash A. Horizon, M.D., F.A.C.R.
Dmitry Karayev, M.D., F.A.C.R.
Benjamin Kretzmann, M.D., F.A.C.R.

CENTER FOR RHEUMATOLOGY MEDICAL CORPORATION
8640 West Third Street, Suite 300, Los Angeles, CA 90048 (310) 659-7878
www.CenterForRheumatology.com

Patient Name ____
LAST FIRST MIDDLE

Address____City/State/Zip: ______________________________

Social Sec.# _______-______ -________ Birth Date _____ /_____ /______ Driver's License: ________________________
MONTH DAY YEAR

Home Phone (_____) ______-_______ Cell Phone (_____) _______ - _______ Email: ________________________

Check √ [ ] Male [ ] Female [ ] Minor [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed [ ] Partner

Patient or Parent's Employer ____ Work Phone (______) ________ - _________

Employers Address ______________________________________ City/State/Zip: ___________________________

Spouse or Parent's Name ____ Contact # (______) _______ - ________

Emergency Contact Person: ____ Contact# (______) _______ - _________
NAME RELATIONSHIP

Whom shall we thank for referring you?____

- **RESPONSIBLE PARTY**

Person responsible for account ____ Contact # (______) _______ - ________
NAME RELATIONSHIP

Address: ____City/State/Zip: ______________________________

- **INSURANCE INFORMATION - PRIMARY**

Insured Name ____ Relationship to Patient ____________________

Social Sec.# _______-______ -________ Birth Date _____ /_____ /______ Driver's License: ________________________
MONTH DAY YR

Insurance Company ____ Phone (______) ________ - _________
Claims Address: ____City/State/Zip: ____________________________
Policy Number ___________________________________ Group Number ______________________________
Do you have a deductible? [ ] No [ ] Yes, how much $___________ Do you have a co-pay [ ] No [ ] Yes, how much $____________

Do you have additional insurance? No [ ] [ ] Yes, please fill in information below

- **INSURANCE INFORMATION - SECONDARY**

Insured Name ____ Relationship to Patient ____________________

Social Sec.# _______-______ -________ Birth Date _____ /_____ /______ Driver's License: ________________________
MONTH DAY YR

Insurance Company ____ Phone (______) ________ - _________
Claims Address: ______________________________________City/State/Zip: ______________________________
Policy Number ________________________________ Group Number _________________________________
Do you have a deductible? [ ] No [ ] Yes, how much $___________ Do you have a co-pay [ ] No [ ] Yes, how much $____________

AUTHORIZATION AND RELEASE

I hereby authorize payment directly to the doctor for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance and for all services rendered on my behalf or my dependents. I authorize Center For Rheumatology Medical Group and or any supplier of service in this office to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

SIGNATURE OF RESPONSIBLE PARTY: ____ Date ______ /_______ /______

For Office Use Only- **Doctor:** ___________________________ **Acct #:** _________________

CENTER FOR RHEUMATOLOGY
Solutions for diseases of joints, muscles, bones and arthritis

HEALTH HISTORY
(Confidential)

Name ____ Birthdate _____________ Age _______ Date _____________

Date of last physical examination ____________What is your reason for the visit _________________________________

SYMPTOMS: Check (ç) symptoms you currently have or have had in the past year

General
- ☐Chills
- ☐Depression
- ☐Dizziness
- ☐Fainting
- ☐Fever
- ☐Forgetfulness
- ☐Headache
- ☐Loss of Sleep
- ☐Loss of Weight
- ☐Nervousness
- ☐Numbness
- ☐Sweats

Muscle/Joint/Bone
- ☐Arms ☐Hips
- ☐Back ☐Legs
- ☐Feet ☐Neck
- ☐Hands ☐Shoulders

Genito-Urinary
- ☐Blood in Urine
- ☐Frequent Urination
- ☐Lack of Bladder
- ☐Control
- ☐Painful Urination

Gastrointestinal
- ☐Poor Appetite
- ☐Bloating
- ☐Bowel Changes
- ☐Constipation
- ☐Diarrhea
- ☐Excessive Hunger
- ☐Excessive Thirst
- ☐Gas
- ☐Hemorrhoids
- ☐Indigestion
- ☐Nausea
- ☐Rectal Bleeding
- ☐Stomach Pain
- ☐Vomiting
- ☐Vomiting Blood

Cardiovascular
- ☐Chest Pain
- ☐High Blood Pressure
- ☐Irregular Heart Beat
- ☐Low Blood Pressure
- ☐Poor Circulation
- ☐Rapid Heart Beat
- ☐Swelling of Ankles
- ☐Varicose Veins

Eye, Ear, Nose & Throat
- ☐Bleeding Gums
- ☐Blurred Vision
- ☐Crossed Eyes
- ☐Difficulty Swallowing
- ☐Double Vision
- ☐Earache
- ☐Ear Discharge
- ☐Hay Fever
- ☐Hoarseness
- ☐Loss of Hearing
- ☐Nosebleed
- ☐Persistent Cough
- ☐Ringing in ears
- ☐Sinus Problems
- ☐Vision-Flashes
- ☐Vision-Halos

Skin
- ☐Bruise Easily
- ☐Hives
- ☐Itching
- ☐Change in Moles
- ☐Rash
- ☐Scars
- ☐Sore(s) that wonøt heal

Men Only
- ☐Breast Lump
- ☐Erection Difficulties
- ☐Lump in Testicles
- ☐Penis Discharge
- ☐Sore(s) on Penis
- ☐Other:_________________

Women Only
- ☐Abnormal Pap Smear
- ☐Bleeding between periods
- ☐Breast Lump
- ☐Extreme Menstrual Pain
- ☐Hot Flashes
- ☐Nipple Discharge
- ☐Painful Intercourse
- ☐Vaginal Discharge
- ☐Other: _________________

Date of last Menstrual period:_______________
Date of last Pap Smear: ___________________
Have you had a Mammogram? _______________
Are you pregnant? _____________
Number of Children: ____________

CONDITIONS: Check (ç) conditions you have or have had in the past.

AIDS	Cancer	Heart Disease	Mononucleosis	Suicide Attempt
Alcoholism	Cataracts	Hepatitis	Multiple Sclerosis	Thyroid Problems
Anemia	Chemical Dependency	Hernia	Mumps	Tonsillitis
Anorexia	Chicken Pox	Herpes	Pacemaker	Tuberculosis
Appendicitis	Diabetes	High Cholesterol	Pneumonia	Typhoid Fever
Arthritis	Emphysema	HIV Positive	Polio	Ulcers
Asthma	Epilepsy	Kidney Disease	Prostrate Problem	Vaginal Infections
Bleeding Disorders	Glaucoma	Liver Disease	Psychiatric Care	Venereal Disease
Breast Lump	Goiter	Measles	Rheumatic Fever	
Bronchitis	Gonorrhea	Migraine Headaches	Scarlet Fever	
Bulimia	Gout	Miscarriage	Stroke	

MEDICATIONS: List medications you are currently taking			**ALLERGIES:** Medications or substances
Pharmacy Name:		Phone Number:	

FAMILY HISTORY: Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death	Check (ç) if, your blood relatives had any of the following:		
Father						Disease	Relationship to you
Mother						Arthritis/Gout	
Brother (s)						Asthma/Hay Fever	
						Cancer	
						Chemical Dependency	
						Diabetes	
Sister (s)						Heart Disease/Stroke	
						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other:	

HOSPITALIZATIONS/SURGERIES: Year Outcome	Hospital	Reason for Hosp./Surgery	**Pregnancy History:** Year of Birth	Sex of Birth	Complications if any:

HEALTH HABITS: Check (ç) which substances you use and describe how much you use

(ç)	**Substance**	**Quantity/Frequency**
	Caffeine	
	Tobacco	
	Drugs	
	Other:	

OCCUPATIONAL CONCERNS: Check (ç) if your work exposes you to the following

	Stress
	Hazardous Substances
	Heavy Lifting
	Other
Your Occupation:	

Have you ever had a blood transfusion? Yes No
If yes, please give approximate dates:

Serious Injury	**Date**	**Outcome**

I certify that the above information is correct to the best of my knowledge. I will not hold the doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form

Signature ____________________ Date ____________________

Reviewed by ____________________ Date ____________________

Name: ______________________ **Acct#:** _________________ **Date:** _______________

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PATIENT CONSENT

PATIENT CONSENT FOR SERVICES: I hereby consent to and authorize the performance of all treatments, surgery and medical services by the staff of Center for Rheumatology Medical Corporation ("Center for Rheumatology") which Center for Rheumatology may deem advisable. I hereby authorize my insurance benefits to be paid directly to Center for Rheumatology. Specific services will be reviewed with me in advance.

FINANCIAL RESPONSIBIITY FOR SERVICES: I hereby authorize my insurance benefits to be paid directly to Center for Rheumatology. I understand that I may be responsible for the entire amount or a portion of the charges for services rendered and will remit appropriate payment at the time of service. These charges may include payments for services which are not covered by my insurance, such as non-participating providers or out of network providers, and/or co-payments for office visits. (I understand I am ultimately responsible for all services rendered and failure of the insurance carrier to pay any claim does not negate my duty to pay for any unpaid claims or services.)

Balances are due within 30 days of when the bill is issued. Statements will be issued after the insurance carrier pays its portion of the bill. I understand that if the balance remains unpaid 60 days after statements are sent, a late charge of $30.00 per month will be applied to the account. (Also, accounts without any activity for 60 days may be forwarded for further collection action. I understand if my account is referred to a collection agency or attorney, I will be responsible for all costs incurred in the process including finance charges, court costs, collection agency, attorney bills, etc. Furthermore, I understand I will be at a risk of being dismissed from the care of Center for Rheumatology.)

To avoid any unpaid balances that could result in further collection actions, finance charges, and/or dismissal from the clinic, I give Center for Rheumatology permission to place any unpaid claims or payments that I may owe on a current credit card kept on file if they have not been paid for any reason within 60 days from date of service. I understand I will be notified immediately prior to doing so and Center for Rheumatology will provide me with a receipt of all payments made with the credit card. I also understand Center for Rheumatology will keep my credit card information in a secure location and only limited personnel will be allowed access to it. In the event my insurance carrier pays Center for Rheumatology for any unpaid claims or payments after my credit card is charged, I understand I will be fully reimbursed for the paid amounts.

Name: ______________________ **Acct#:** _________________ **Date:** _______________

CO-PAYMENT POLICY: I understand and agree that all necessary co-payments will be paid at the time of service. I also understand and agree that if my co-payment is not paid at the time of service, Center for Rheumatology will assess my account a $5.00 late fee and my appointment may be cancelled.

INSURANCE COVERAGE: I understand and agree that I am required to provide my insurance card(s): at my first appointment as a new patient, my first visit of every New Year, and any time my insurance information has changed. I understand that outdated cards with incorrect information can cause unnecessary delays in the payment of my claims.

RELEASE OF INFORMATION: I authorize the release of my medical records or other information necessary to provide proper health care, to process my medical claims, and for any other purposes that are related to the health care operations. I understand that Center for Rheumatology may share information with Cedars-Sinai Medical Center and its affiliated ancillary departments (e.g., laboratory and imaging). Additional information is provided in the Center for Rheumatology's Notice of Privacy Practices

DISCLAIMER TO ALL PATIENTS: Center for Rheumatology does not consider an individual a patient until the patient has actually completed a preliminary in-person assessment in the office.

I certify that I have read and fully understand the above sections on patient consent, financial responsibility for services, co-payment policy, insurance coverage, and release of information. Any additional questions I have will be referred to the staff at Center for Rheumatology.

X ______________________

Name: ______________________ **Acct#:** _________________ **Date:** _______________

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OFFICE POLICIES

ON-TIME ARRIVAL POLICY: We ask that all patients arrive at least 15 minutes before their scheduled appointment so that they may have an adequate amount of time to complete any necessary documents and/or forms. Patients that arrive late for their scheduled appointment may have to reschedule their appointment for another day and time since our physicians make a strong effort to adhere to their pre-arranged schedule at all times. However, please note that sometimes we have unexpected delays due to the urgent or complex needs of other patients and will make every effort to get you seen by a physician within a timely manner.

REFERRAL/AUTHORIZATION: Some medical insurance companies require a referral from a patient's provider in order to see a specialist. Therefore, if a patient chooses to access specialty services without prior authorization from their provider, or elects to use a Point of Service option, or fails to notify Center for Rheumatology that their insurance plan requires specific outside vendors, such as laboratories, to perform referred services, the patient may be financially responsible for the services rendered and needs to be aware that their insurance my not cover the costs of these additional medical services.

MESSAGES: By signing this document, patients consent that Center for Rheumatology is authorized to leave messages on their voicemails with non-confidential information. This consent also allows Center for Rheumatology to communicate with you using any email address that you provide to Center for Rheumatology, and/or any email address that you send communications to Center for Rheumatology.

ANCILLARY SERVICES: Patients may be billed separately for services such as laboratory, imaging, or other ancillary services depending on their individual medical insurance.

SPECIAL LETTERS AND FORM COMPLETION: Center for Rheumatology charges fees for any forms/letters describing any medical conditions and/or treatments for their patients. This fee is based to the length and complexity of the form or requested letter.

FEE FOR MEDICAL RECORDS: A signed medical release form (which is valid for 30 days) will be required for any copies of patient medical records. Furthermore, Center for Rheumatology charges a fee for all copies of patient medical records, whether they are copied, faxed (if applicable), mailed or picked up from the medical office. This fee is based on the size of the chart, the amount of time it takes to be copied, and any additional forms or documents that

Name: ______________________ Acct#: _________________ Date: _______________

are required to be filed out for the medical records. The fee must be paid in full before any records will be released. Please be aware that X-rays cannot be mailed and must be picked up at the office and that it may take up to 72 business hours to have a patient's medical records prepared.

CANCELLED APPOINTMENTS: It is our office policy that patients must cancel their appointment at least 24 hours in advance. If a patient does not cancel their appointment within the prescribed cancellation period, the patient will be charged a $75 cancellation fee.

MISSED APPOINTMENTS: Center for Rheumatology charges a fee of $75 for any missed appointments. In addition, a patient who misses three or more consecutive appointments without any type of notification, will be discharged from the practice.

MEDICATION REFILLS: Medication refills may take up to 48 business hours to be completed. Please have the patient's pharmacy fax the request to Center for Rheumatology. Please be aware that Center for Rheumatology does not call individual pharmacies. In addition, if a patient's prescription requires a prior authorization, Center for Rheumatology may require up to 72 business hours to complete this request. Furthermore, please note that some prescriptions will not be authorized by a patient's insurance company and it is the patient's responsibility to know what medications are covered under their pharmacy benefits and to file any necessary appeals. Lastly, in order to best serve the patient's medical needs, please ensure that Center for Rheumatology has the patient's most current pharmacy information on file.

PATIENT PHOTOGRAPH: Center for Rheumatology is deeply committed to your safety and identity protection. Please allow us to take your picture at the time of your visit to upload into your electronic medical chart. We use your photograph to protect you from identity theft, ensure patient safety and to further personalize our service to you. Your picture helps us confirm that all members of the care team are accessing the correct medical record and brings us closer by putting a “face with the name”.

I certify that I have read and fully understand the above sections on cancelling appointments, on-time arrival policy, special letter and form completion, fee for medical records, referrals, ancillary services, phone messages, medication refills, and patient photographs. Any additional questions I have will be referred to the staff at Center for Rheumatology.

X ____________________

Name: ______________________ Acct#: _________________ Date: _______________

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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received (either on the website or in person) a copy of Center for Rheumatology Medical Corp.'s Notice of Privacy Practices. I further acknowledged that I will be offered a copy of any amended Notice of Privacy Practices at each appointment. If I have questions, I can contact Center for Rheumatology's Privacy Officer at:

PRIVACY OFFICER
CENTER FOR RHUEMATOLOGY MEDICAL CORPORATION
8640 WEST THIRD STREET SUITE 300
LOS ANGELES, CA 90048
(310) 659-7878

X ________________________

If not signed by the patient please indicate:

Relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

NOTICE OF PRIVACY PRACTICES

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), 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.

A. WHO WILL FOLLOW THIS NOTICE

This Notice describes the privacy practices relating to protected health information ("PHI") followed by the doctors, including but not limited to: Arash Horizon M.D., Dmitry Karayev M.D., and Benjamin Kretzmann M.D., and all of the employees and staff. The doctors, the office employees and staff may share your medical information with each other for treatment, payment of health care operations purposes described in this Notice.

B. UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a physician, hospital or other healthcare provider, a record of your visit is typically made. This record generally contains your symptoms, examinations and test results, diagnosis, treatment and plan for future care or treatment. This information serves as a basis for planning your care and treatment; a means of communication among the doctors and other healthcare providers that are involved in your care; a medical-legal document describing the care you have received; a means by which you or a third-party can verify that services billed were actually provided; a source of data for medical research, education and data collection; a source of information for public health officials charged with improving community health and other healthcare operations.

C. OUR POLICY REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health ("PHI") is personal. Our commitment to you is to protect medical information about you. Our office creates a record describing the care and services you receive at our office. This record is necessary in order to provide medical care to you and to comply with certain legal requirements. This notice applies to all of the records created in our office in connection with your care and treatment, whether made by the doctor and/or the employees and staff.

If you have any questions about this notice, please contact our Privacy Officer/Contact Person at (310) 659-7878.

Patient Activity Scale (PAS)

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**	**With Some Difficulty**	**With Much Difficulty**	**Unable To Do**
Dress yourself, including shoelaces and buttons?	☐	☐	☐	☐
Shampoo your hair?	☐	☐	☐	☐
Stand up from a straight chair?	☐	☐	☐	☐
Get in and out of bed?	☐	☐	☐	☐
Cut your meat?	☐	☐	☐	☐
Lift a full cup or glass to your mouth?	☐	☐	☐	☐
Open a new milk carton?	☐	☐	☐	☐
Walk outdoors on flat ground?	☐	☐	☐	☐
Climb up five steps?	☐	☐	☐	☐

Please place an X in the box beside any aids or devices that you usually use for any of the above activities:

☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ Built up or special utensils ☐ Special or built up chair

☐ Devices used for dressing (button hook, zipper pull, long handled shoe horn) ☐ Other (please specify) ____________

Place an X in the box beside any categories for which you usually need HELP FROM ANOTHER PERSON:

☐ Dressing and Grooming ☐ Arising ☐ Eating ☐ Walking

Place an X in the box which best describes your usual abilities OVER THE PAST WEEK:

Are you able to:	**Without Any Difficulty**	**With Some Difficulty**	**With Much Difficulty**	**Unable To Do**
Wash and dry your body?	☐	☐	☐	☐
Take a tub bath?	☐	☐	☐	☐
Get on and off the toilet?	☐	☐	☐	☐
Reach and get down a 5 pound object (such as a bag of sugar) from just above your head?	☐	☐	☐	☐
Bend down to pick up clothing from the floor?	☐	☐	☐	☐
Open car doors?	☐	☐	☐	☐
Open jars which have been previously opened?	☐	☐	☐	☐
Turn faucets on and off?	☐	☐	☐	☐
Run errands and shop?	☐	☐	☐	☐
Get in and out of a car?	☐	☐	☐	☐
Do chores such as vacuuming or yard work?	☐	☐	☐	☐

Please place an X in the box beside any AIDS or DEVICES that you usually use for any of the above activities:

☐ Bathtub bar ☐ Raised toilet seat ☐ Jar opener for jars previously opened ☐ Long-handled appliances for reach

☐ Long-handled appliances in bathroom ☐ Other (please specify) ____________

Please place an X in the box beside any categories for which you usually need HELP FROM ANOTHER PERSON:

☐ Hygiene ☐ Reach ☐ Gripping and Opening Things ☐ Errands and Chores

Draft

We are also interested in learning whether or not you are affected by pain because of your illness.

How much pain have you had because of your illness in the past week? Place an X in the box that best describes the severity of your pain on a scale of 0-10.

	0																				**10**	
NO PAIN	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	SEVERE PAIN

Considering ALL THE WAYS THAT YOUR ILLNESS AFFECTS YOU, RATE HOW YOU ARE DOING on the following scale. Place an X in the box below that best describes how you are doing on a scale of 0-10.

	0																				**10**	
VERY WELL	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	VERY POOR

Draft

Name: **Acct#:** **Date:**

CONSENT For Research on Leftover Specimens

DESCRIPTION: You are invited to participate in a research study on Rheumatology/Autoimmune diseases.

PROCEDURES: You are scheduled to see a physician at Center for Rheumatology Medical Center. After we complete our initial tests, we would like to save the leftover specimens for future research on rheumatology/autoimmune research. The specimens will be frozen and will be stored with a number assigned to it instead of your name. The number will be linked to your name, which means you can withdraw from this study at any time. The collection and study will not change your medical treatment.

The future use of your specimen(s) may result in new products, tests or discoveries which may have potential commercial value. Donors of specimens do not retain any property rights to the materials. As such, you would not share in any financial benefits from these products, tests or discoveries.

The results of the study of your specimens will be used for research purposes only and you will not be told the results of the tests.

x______________

I consent to my samples being saved for future research

x______________

I do not consent to my samples being saved for future research

RISKS AND BENEFITS: There are no anticipated risks associated with this study. As this is not a treatment study, you will not receive any direct benefit from your participation.

TIME INVOLVEMENT: Your participation will not require any extra time from you, other than for the initial visit where the collection of specimens is explained to you.

PAYMENTS: You will not be paid for the leftover specimens or to participate in any research or study.

PARTICIPANT'S RIGHTS: If you have read this form and have decided to participate in this project, please understand your participation is voluntary and you have the right to withdraw your consent or discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled.
The results of any research study may be presented at scientific or professional meetings or published in scientific journals. However, your identity will not be disclosed**.** If applicable: You have the right to refuse to answer particular questions.

Name: **Acct#:** **Date:**

Authorization to Use Your Health Information for Research Purposes

Because information about you and your health is personal and private, it generally cannot be used in a research study without your written authorization. If you sign this form, it will provide that authorization. The form is intended to inform you about how your health information will be used or disclosed in a study. Your information will only be used in accordance with this authorization form and the informed consent form and as required or allowed by law. Please read it carefully before signing it.

What is the purpose of this research study and how will my health information be utilized in the study?
Your specimens will be frozen and stored for future research on rheumatology/autoimmune diseases.

Do I have to sign this authorization form?
You do not have to sign this authorization form. But if you do not, you will not be able to participate in collection of specimens and possible future research studies.

If I sign, can I revoke it or withdraw from the research later?
If you decide to participate, you are free to withdraw your authorization regarding the use and disclosure of your health information (and to discontinue any other participation in the study) at any time. After any revocation, your health information will no longer be used or disclosed in the study, except to the extent that the law allows us to continue using your information (e.g., necessary to maintain integrity of research). If you wish to revoke your authorization for the research use or disclosure of your health information in this study, you must write to: Center for Rheumatology Medical Center, P.O. Box 5762, Beverly Hills, California 90209.

What Personal Information Will Be Used or Disclosed?
Health information about you obtained from studying your specimens.

Who May Use or Disclose the Information?
The following parties are authorized to use and/or disclose your health information in connection with this research study:

- Center for Rheumatology Medical Center may use and/or disclose your health information to research partners or storage facilities that will house the specimens.

Who May Receive or Use the Information?
The parties listed in the preceding paragraph may disclose your health information to the following persons and organizations for their use in connection with this research study:

- Rheumatology/Autoimmune research studies sponsored by private and governmental institutions.

Your information may be re-disclosed by the recipients described above, if they are not required by law to protect the privacy of the information.

When will my authorization expire?
Your authorization for the use and/or disclosure of your health information will end on December 31, 2050 or when collection or any research project ends, whichever is earlier.

SIGNATURE BY PARTICIPANT:

X ______________________

SIGNATURE BY THE SUBJECT'S PARENT/GUARDIAN (If applicable)

X ______________________

SIGNATURE BY THE INVESTIGATOR:
I attest that all the elements of informed consent described in this form have been discussed fully in non-technical terms with the subject. I further attest that all questions asked by the subject were answered to the best of my knowledge. The subject has been provided with the Experimental Subject's Bill of Rights.

X ______________________

SIGNATURE BY THE WITNESS/TRANSLATOR (If applicable)

(The signature of the witness below attests that the translator has presented the elements of consent to the subject, orally and in his/her preferred language, and that a summary of the oral presentation, in a language the subject can understand, has been given to the participant.)

X ______________________

Name: **Acct#:** **Date:**

EXPERIMENTAL SUBJECT'S BILL OF RIGHTS

In accordance with California Health and Safety Code 24172, any person who is required to consent to participate as a subject in a research study involving a medical experiment or who is requested to consent on behalf of another has the right to:

1. Be informed of the nature and purpose of the experiment.

2. Be given an explanation of the procedures to be followed in the medical experiment, and any drug or device to be utilized.

3. Be given a description of any attendant discomforts and risks to the subject reasonably to be expected from the experiment.

4. Be given an explanation of any benefits to the subject reasonably to be expected from the experiment, if applicable.

5. Be given a disclosure of any appropriate alternative procedures, drugs or devices that might be advantageous to the subject, and their relative risks and benefits.

6. Be informed of the avenues of medical treatment, if any, available to the subject after the experiment if complications should arise.

7. Be given an opportunity to ask any questions concerning the experiment or the procedure involved.

8. Be instructed that consent to participate in the medical experiment may be withdrawn at any time and the subject may discontinue participation in the medical experiment without prejudice.

9. Be given a copy of any signed and dated written consent form used in relation to the experiment.

10. Be given the opportunity to decide to consent or not to consent to a medical experiment without the intervention of any element of force, fraud, deceit, duress, coercion, or undue influence on the subject's decision.

X ______________________________

CONTACT INFORMATION:
Questions, Concerns, or Complaints: If you have any questions, concerns or complaints about this specimen collection, its procedures, or risks and benefits, you should ask a physician at Center for Rheumatology Medical Center, (310) 659-7878.

Arash A. Horizon, M.D., F.A.C.R.
Dmitry Karayev, M.D., F.A.C.R.
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Telephone (310) 659-7878
Facsimile (310) 659-7117

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize ____
Name of facility/individual

____
Address City/State/Zip

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: ____
Name
____
Address
______________________ __________ __________
City State Zip Code

The medical information/records will be used for the following purpose: ______________________
This authorization is:
[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information: ______________________________

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse ________(initial) HIV Diagnosis/Treatment ________(initial)

Psychiatric/Mental Health ________(initial) Genetic Information ________(initial)

Tests for Antibodies to HIV ________(initial)

DURATION This authorization shall be effective immediately and remain in effect until ____________
Date

RESTRICTIONS: Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

______________________________ ______________________________
Signature of patient *or legal/personal representative* Relationship *if other than patient*

______________________________ ______________________________
Patient's Name (PRINT) *Date*

______________________________ ______________________________
Patient's Social Security Number Patient's Date of Birth

______________________________ ______________________________
Witness name Witness signature