Cabrillo Infusion

Phone#: 619-334-4818 Fax#: 619-334-4940
New Patient Referral

Chula Vista:	Mission Valley:	La Jolla:	La Mesa:
296 H Street, Suite 304 Chula Vista, CA 91910	5030 Camino De La Siesta, Suite 106 San Diego, CA 92108	4180 La Jolla Village Drive, Suite 240 San Diego, CA 92037	6280 Jackson Drive, Suite B San Diego, CA 92119

El Centro:	Poway:	San Marcos:
1420 Ocotillo Drive, Suite B, El Centro, CA 92243	15525 Pomerado Road, Suite E6 Poway, CA 92064	338 Via Vera Cruz, Suite 230 San Marcos, CA 92078

Patient Information:

Patient name: _____

Address: _____

Telephone #: _____ Email: _____

Referring Physician Information:

Physician: _____ NPI: _____

Address: _____

Telephone #: _____ Fax#: _____

POC: _____ Email: _____

Please include the following:

- Demographics (insurance card(s))
- Approved prior authorization
- Medical Records (most recent encounter note with physician, labs, imaging, etc.)
- Infusion order (if applicable)

Cost of Filling Out Forms and Generating Letters:

Cabrillo Center for Rheumatic Disease charges for forms to be filled out by our office that are not pertinent to direct daily patient care paperwork (i.e. lab orders, x-ray orders, prescriptions, and medical records) as these forms create extra work that is not covered by your insurance. These forms are not considered a standard part of patient medical care. Below is an updated list of various forms not covered by insurance and their costs:

$0	Excuse note for work, school, or jury duty (Completed on a prescription pad paper note- no letterhead)
$20	Form requiring Signature only
$25	Department of Motor Vehicle parking placard form, Family Medical Leave Act form
$30/page	Letters requiring letterhead that are not disability related
$50/page	Disability forms and disability letters (separate appt may need to be made)
$0.50/page	Chart copies (if more than just a single lab or x-ray report or office note), but we can fax copies to any doctor at no cost.

Policy Statement

Privacy Practices: I understand that this medical office reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by requesting it in writing (either by mail or at my next appointment) and a revised copy may be sent in the mail or will be provided to me at the time of my next appointment. _____ (INITIAL)
Please indicate whether you should like a copy of the Notice of Privacy Practices. _____ YES _____NO

Confidentiality: Professional ethics and California state law specifies that communications to medical staff are confidential and privileged, and cannot be released or shared without the express written permission of the patient, except as noted above. However, there exist a few instances that are mandated by law to report certain information. These include, but are not limited to abuse of a minor, or if you express the intent of bringing harm to yourself or another person. In such circumstances, the provider is required to inform potential victim(s) and legal authorities. _____(INITIAL)

Cancellation: Your appointment time has been reserved exclusively for you. I agree that if I fail to cancel my appointment within at least 24 hours notice, I will be billed a $25 cancellation fee. I understand that this fee is the patient's responsibility, as missed appointments are not covered by insurance. _____(INITIAL)

No-Show Policy: Patients are subject to a $50 charge for missing their scheduled appointment. This fee is the patient's responsibility, as it is not covered by insurance. _____(INITIAL)
If you do not show for your appointment three(3) times you may be discharged from the clinic _____(INITIAL)

Late Fee Policy: Patients that arrive _____ minutes after their scheduled appointment time are not guaranteed to be seen the same day. Patients may reschedule for another day. _____(INITIAL)

Insurance: This office will submit your insurance claims to you carrier at no cost to you. However, we are not in a position to guarantee payment from your insurance company because the claim is based upon arrangements between you and the insurer. Please be aware that it is common for insurance companies to subcontract certain benefits to another company. In these instances, we may not bill your insurance company; we may be required to bill your medical group or a third party payer. I understand that it is my responsibility to know if this is true. _____(INITIAL)

Prior Authorization: Prior authorization may be required before your first visit. Please be aware that it is your responsibility to know if this is true for your insurance coverage(s), and to get the necessary authorization(s). _____(INITIAL)

Medical Records: I understand that CCRD will retain my medical records for seven years as per legal requirements. Copies of records can be transferred to other health care providers upon receipt of a valid written consent. I understand that this office requires at least 72 hours notice prior to medical records being made available to the authorized party. _____(INITIAL)

Medications: I understand that medical refills will be considered during office hours only. This is so the office can conform with California Pharmacy statutes, and to prevent the possibility of other persons from acting or posing as patients of CCRD, or obtaining medication illegally. I further understand that if I need to have a prescription refilled that I should contact my pharmacy 1-2 days prior to needing the medication or the medication may not be available to me the same day. I understand refills for any medication will not be performed unless I have been seen within the last 6 months. _____(INITIAL)

Agreements: I have reviewed the preceding information and I certify that this information is accurate. I further understand that I am responsible for any financial loss due to incomplete or inaccurate information provided by myself. _____(INITIAL)

I hereby authorize payment directly to this medical provider any insurance benefits that would otherwise be payable to me for services rendered. _____(INITIAL)

In instances where insurance does not pay any benefits, I agree to pay for those services. If payment is not received within 90 days from the date the claim was submitted, I agree that I will become responsible for the full amount for the balance on my account._____(INITIAL)

Should I break the financial arrangements as detailed above, I agree that my name may be released for collection purposes. I understand that no treatment related information will accompany this disclosure. I also agree that if any legal action is taken to enforce the provisions of this Policy Statement that the prevailing party shall be entitled to reasonable attorney's fees and costs. _____ (INITIAL)

Please sign below to indicate that you have read the Policy Statement and agree to the terms as stated

Signature:_____ Date: _____

Coordination of Care:

Rheumatic diseases can affect many different body systems, which therefore can require communication between doctors of different specialties. In order to provide you with the most well-rounded care possible, your provider may request to see records/results of your visits with other providers. The following page is a form that will allow your other healthcare providers to share your health information with your provider at CCRD. This release is 100% voluntary, and can be revoked at any time.