

Dr. Elvira Lindwall

Phone: (805) 370-1965

Fax: (805) 370-1984

2190 Lynn Rd. Suite 240

Thousand Oaks, CA 91360

Billing: (951)800-8148

Dear Patient:

Thank you for choosing Dr. Lindwall for your Rheumatology care. In order to expedite the check in process, please review and complete all enclosed documents prior to your appointment. Please bring your completed forms, insurance cards, driver's license, and copies of any recent laboratory tests or imaging reports. You may, if easier for you, have them faxed to our office before your scheduled appointment.

You will receive a confirmation call from our office for each appointment the day before so please make sure to provide accurate contact information and report any changes as soon as possible. Each appointment time is scheduled for one patient in an effort to provide appropriate attention and care. Please provide our office with at least a 24-hour notice should you need to cancel or reschedule your appointment. If you miss an appointment without giving advanced notice, you will be charged up to \$50 for each missed appointment.

If you have an insurance policy that requires an authorization or referral from your primary care physician, it is your responsibility to obtain one. Please make sure you have a valid referral for each visit.

Co-payment amount, if applicable, will be collected at the beginning of each visit. We accept cash, check, Visa and MasterCard. Please note that a \$25 fee will be charged for any bounced or cancelled checks.

Our provider will not be able to provide care for any patient who declines to sign the Medical Services Agreement and Privacy Practices Form.

We look forward to meeting you and assisting you with your medical needs. Please contact our office should you have any further questions or concerns.

Sincerely,

Dr. Lindwall and staff

Dr. Elvira Lindwall

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OFFICE HOURS

Monday – Thursday: 8:30 am to 5:00 pm

Friday: 8:30am to 12:00pm

We are CLOSED for lunch from 12:00 pm to 1:30 pm

Phones are open from 8:30 am to 12:00pm and 1:30 pm to 5:00 pm

SCHEDULING APPOINTMENTS

Call our office during normal phone hours to make an appointment.

Any patient 15 minutes (or more) late will forfeit their appointment and will need to reschedule for a later date.

There is a \$50 charge for missed appointments and appointments not cancelled at least 24 hours in advance.

PRESCRIPTIONS

For any **new** prescriptions, please call the office with medication name, dosage, directions and your pharmacy's name and phone number.

For all refills, have the pharmacy send us an electronic request.

For any controlled substance prescriptions, please give a 72 hour notice before the fill date.

MEDICAL RECORDS AND FORMS

All requests for medical records made by another healthcare provider will be faxed to the requesting provider free of charge.

Patient requests for medical records will incur a \$25 charge.

Disability forms may be completed (at the discretion of Dr. Lindwall) for a fee of \$25-\$50.

BILLING

For all billing---related questions, please call 951-800-8148.

We accept cash, check, Visa, and MasterCard.

All copays are due at the time of service.

For self-paid patients, all balances are due at the time of service.

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MEDICAL SERVICES AGREEMENT

Patient's Name: _____

1. **MEDICAL CONSENT:** I consent to any medical treatments or procedures which may be performed on an outpatient basis (including emergency treatment or services), which may include, but are not limited to, medications, injections, taking of medical photographs, laboratory procedures, and/or x---ray examinations provided to me under the general and special instructions of the physician, staff, or other health care providers of Dr. Lindwall MD a Medical Corporation (Dr. Lindwall) assisting my care.

2. **FINANCIAL AGREEMENT:** I understand that all charges are due at the time of service. I agree to pay for all charges for healthcare services and professional services provided to me by physicians and other healthcare professionals. If I am a non---insured patient, I agree to pay for my visit in full at the time of service. If the provider is a participating provider with my insurance company I understand that my co---pay, coinsurance, deductible and/or any outstanding balances are due at the time of service.

I understand that my insurance policy is a contract between myself and my insurance company; Dr. Lindwall is not involved. In order for Dr. Lindwall to file claims and accept payments from my insurance company, I understand that I must present current insurance information at each visit and that Dr. Lindwall will need to verify my health insurance coverage. In the event that Dr. Lindwall is not able to verify my insurance eligibility and benefits before my visit, I agree to pay for my visit in full at the time of service. A refund will be issued if my insurance pays for the visit. I also understand that I am financially responsible for any services not covered by my insurance company. When my spouse or a financial guarantor signs this agreement, the spouse or the financial guarantor shall be jointly and individually liable with me. Should my account(s) be referred to an attorney or a collection agency for the collection, the undersigned shall pay the actual attorney's fees (including costs) and collections expenses incurred in addition to the other amounts due. Unpaid accounts referred to outside agencies for collection shall bear interest at the current rate per year from the date of referral.

3. **INSURANCE AUTHORIZATION AND RELEASE:** I request that payment of authorized benefits, including Medicare, and any other government sponsored program, private insurance, and any other health plans be made to Elvira Lindwall M.D. a Medical Corporation for any services furnished by that provider. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize Dr. Lindwall to disclose portions of or all of my records to any person or corporation which is or may be liable for all or any portion of Dr. Lindwall's charges, including but not limited to insurance companies, health care service plans, government agencies, or worker's compensation carriers. I authorize Dr. Lindwall to act as my agent to help me obtain any required pre---certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give Dr. Lindwall any information required to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

4. **RELEASE OF MEDICAL INFORMATION:** I hereby authorize Dr. Lindwall to release any information in my chart to any practitioner, doctor, hospital, or medical institution to whom I may be referred to assist in my care. Additionally, I authorize any request for medical information from any medical practitioner, doctor, hospital, or medical institution to assist in my care.

5. **PERSONAL VALUABLES:** Dr. Lindwall shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs, or other articles of unusual value and shall not be liable for loss or damage to any personal property. Elvira Lindwall M.D. a Medical Corporation and the patient or the patient's representative, hereby enters into this agreement. The undersigned certifies that he/she has read and agreed to the foregoing, received a copy, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Signature of Patient

Date

or Signature of Patient's Representative & Relationship Date

Office Representative Signature

Date

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Patient Registration

Last Name: _____ First Name: _____ MI: _____
DOB: _____ Social Security #: _____
Address: _____ City: _____ State: _____ Zip: _____
Primary Phone Number: _____ Secondary Phone Number: _____
Driver's License Number: _____ Issuing State: _____
Employer: _____ Occupation: _____
Email Address: _____

Emergency Contacts:

1. Name: _____ Relationship: _____ Phone Number: _____
2. Name: _____ Relationship: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

Who referred you to Dr. Lindwall? _____

Primary Insurance Coverage:

Company: _____ Effective Date: _____ Group Number: _____
Policy Number: _____ Phone Number: _____

Secondary Insurance Coverage:

Company: _____ Effective Date: _____ Group Number: _____
Policy Number: _____ Phone Number: _____

If you are covered under the policy of a spouse, partner, parent or legal guardian, please complete the following information:

Last Name: _____ First Name: _____ MI: _____
DOB: _____ Social Security #: _____
Address: _____ City: _____ State: _____ Zip: _____
Primary Phone Number: _____ Secondary Phone Number: _____
Employer: _____ Occupation: _____

Assignment of Insurance Benefits and Authorizations for Release of Information.

I request that payment of authorized Medicare and/or other insurance benefits be made on my behalf to Elvira Lindwall M.D. a Medical Corporation for any services furnished to me. I authorize any holder of medical information needed to release to the Health Care Financing Administration, its agents and/or other insurer any information needed to determine these benefits or the benefits payable for related services. This authorization shall continue until such time as I revoke it in writing.

Signature of Patient

Date

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RHEUMATOLOGY PATIENT HISTORY FORM

Date: ____/____/____

NAME: _____ Birthdate: ____/____/____
Last First M. I.

Age: _____ Sex: ☐ F ☐ M

Marital status: ☐ Never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered/significant other

Whom do we thank for referring you here? _____

Name of your primary care physician: _____

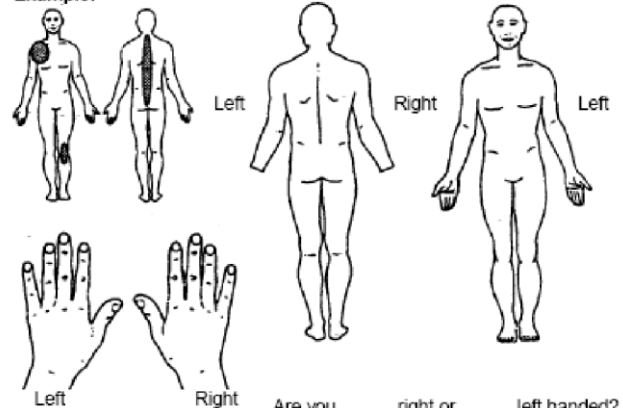
Describe briefly your present symptoms:

When did your symptoms start?

What diagnosis have you been given, if any?

Please shade all the locations of your pain over the past week on the body figures and hands.

Example:



Are you ____ right or ____ left handed?
(Which hand do you sign your name with?)

Please list the names of other practitioners you have seen for this problem:

Previous treatment for this problem (include physical therapy, surgery, and injections; medications to be listed later):

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RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

	Yourself	Relative	→	Name/relationship
Arthritis (type unknown)	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Gout	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Lupus or "SLE"	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Ankylosing spondylitis	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Childhood arthritis	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Sjogren's syndrome	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Psoriasis/psoriatic arthritis	<input type="checkbox"/>	<input type="checkbox"/>	→	_____

PAST MEDICAL HISTORY

Do you now or have you ever had: (check if "yes")

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Pulmonary embolism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach or peptic ulcer |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Kidney stones | |

Other significant illnesses (please list): _____

Previous Operations

Type	Year	Reason
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____

Any previous fractures? ☐ No ☐ Yes : Describe _____Any other serious injuries? ☐ No ☐ Yes : Describe _____Do you drink alcohol? ☐ No ☐ Yes : Usual drink: _____ How much: _____Do you smoke? ☐ No ☐ Yes : In the past – How long ago?: _____Has anyone ever told you to cut down on your drinking? ☐ Yes ☐ NoDo you use drugs for reasons that are not medical? ☐ No ☐ Yes If yes, please list: _____Do you get enough sleep at night? ☐ Yes ☐ No

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Do you wake up feeling rested? ☐ Yes ☐ No

MEDICATIONS

Drug allergies: ☐ No ☐ Yes To what? _____

Please list any medications that you are now taking. Include non-prescription medications, such as aspirin, vitamins, glucosamine, laxatives, calcium, etc.

Name of drug

Dose (include strength and number of pills per day)

1.	_____
2.	_____
3.	_____
4.	_____
5.	_____
6.	_____
7.	_____
8.	_____
9.	_____
10.	_____
11.	_____
12.	_____

PERSONAL HISTORY

What is your highest educational level? ☐ High school ☐ Some college courses ☐ College graduate
☐ Advanced degree

What is your current or past occupation? _____

Are you currently working? : ☐ Yes ☐ No If yes, hours/week _____ If not, are you ☐ retired ☐ disabled ☐ sick leave?

Do you receive disability or SSI? ☐ Yes ☐ No If yes, for what disability? _____

What date did this disability begin? _____

With whom do you currently live? _____

How much exercise do you get each week? _____ What kind of exercise? _____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at death	Cause
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____

Number of siblings: _____ Number living _____

Number of children _____ Number living _____ List ages of each _____

Health of children: _____

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SYSTEMS REVIEW

Date of last eye exam _____ Date of last chest x-ray _____

Date of last bone density test _____

Result of last TB (PPD) test: ☐ Never done ☐ Negative ☐ Positive

Date test performed: _____

GENERAL

- ☐ Recent weight gain; how much _____
- ☐ Recent weight loss; how much _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Night sweats

MUSCLE/JOINTS/BONES

- ☐ Morning stiffness
 - Lasting how long _____ Minutes
 - _____ Hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Joint swelling
- List joints affected in the last 6 months

EARS

- ☐ Ringing in ears
- ☐ Loss of hearing

EYES

- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye

MOUTH

- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness
- ☐ Recent increase in tooth cavities

NOSE

- ☐ Nosebleeds
- ☐ Loss of smell

THROAT

- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing
- ☐ Pain in jaw while chewing

NECK

- ☐ Swollen glands
- ☐ Tender glands

HEART AND LUNGS

- ☐ Pain in chest
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat
- ☐ Shortness of breath
- ☐ Difficulty in breathing at night
- ☐ Swollen legs or feet

- ☐ Cough
- ☐ Coughing up blood

STOMACH AND INTESTINES

- ☐ Nausea
- ☐ Heartburn
- ☐ Stomach pain relieved by food
- ☐ Vomiting of blood/"coffee grounds"
- ☐ Yellow jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools

KIDNEY/URINE/BLADDER

- ☐ Difficult urination
- ☐ Pain or burning on urination
- ☐ Blood in urine
- ☐ Cloudy, "smoky" urine
- ☐ Pus in urine
- ☐ Discharge from penis/vagina
- ☐ Frequent urination
- ☐ Getting up at night to pass urine
- ☐ Vaginal dryness
- ☐ Rash/ulcers
- ☐ Sexual difficulties
- ☐ Prostate trouble

BLOOD

- ☐ Anemia
- ☐ Bleeding tendency

SKIN

- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive
- ☐ Skin tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet in the cold (Raynaud's)

NERVOUS SYSTEM

- ☐ Fainting or loss of consciousness
- ☐ Numbness or tingling in hands/feet
- ☐ Memory loss
- ☐ Muscle weakness

PSYCHIATRIC

- ☐ Depression
- ☐ Excessive worries
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

For women only:

Age when periods began: _____

Number of pregnancies: _____

Number of miscarriages: _____

Have you reached menopause?

☐ No ☐ Yes If yes, at what age: _____

Date of last Pap smear: _____

Date of last mammogram: _____

If you are still having periods:

Are they regular? ☐ Yes ☐ No

How many days apart? _____

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Please circle all medications that you are currently taking, or have taken in the past.

<i>Biologics/DMARDs</i>	<i>Anti-Inflammatory /Pain</i>	<i>Fibromyalgia</i>	<i>Osteoporosis</i>	<i>Gout</i>	<i>GERD/Heartburn</i>	<i>Joint Injections</i>
Actemra	Arthrotec	Cymbalta	Actonel	Allopurinol	Dexilant	Euflexxa
Arava/Leflunomide	Aspirin	Elavil/ Amitriptyline	Atelvia	Colcrys/ Colchicine	Nexium	Hyalgan
Benlysta	Celebrex	Flexeril/ Cyclobenzaprine	Boniva	Uloric	Pepcid	Orthovisc
Cellcept	Duexis	Gabapentin	Evista		Prevacid	Supartz
Cimzia	Etodolac	Savella	Forteo		Prilosec	Synvisc
Cosentyx	Feldene		Fosamax			Cortisone List Joints Below
Cyclosporine	Ibuprofen		Prolia			
Cytosan	Advil / Motrin		Reclast			
Enbrel	Indocin					
Gold Injection	Mobic					
Humira	Naprelan / Naproxen					
Imuran/Azathioprine	Norco					
Kineret	Tramadol					
Krystexxa	Tylenol					
Methotrexate	Vicodin					
Orencia	Vimovo					
Otezla	Voltaren / Diclofenac					
Plaquenil						
Prednisone						
Remicade						
Rituxan						
Simponi						
Stelara						
Sulfasalazine						
Xeljanz						

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Authorization for Disclosure of Confidential information

Patient Name: _____

DOB: _____

Address: _____

I, _____ authorize the release of my protected health information including results of my laboratory tests, X-rays and /or other test results to the following designated representative(s)

Patient Initials

_____ My Spouse (Name) _____

_____ My Child (Name) _____

_____ Others (Name) _____

_____ May be left on my answering machine at home

_____ May be left on my answering machine at work

_____ May be left on my cell phone at: _____

_____ **May not be given to anyone other than myself**

(Date)

(Signature of Participant)

(Date)

(Witness)

This authorization shall be valid for one year from the date of signature above unless revoked in writing by the patient prior to that expiration. As a patient, you have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization or, if applicable, during contestability period. In order for revocation of this authorization to be effective, Elvira Lindwall MD a Medical corporation must receive the revocation in writing. The Revocation must include 1) the patient's name, address, and date of birth. 2) Patient's desire to revoke the authorization. 3) Date of revocation and the patient signature. All revocation must be sent in writing to the attention of Elvira Lindwall MD a Medical Corporation Privacy officer at 2190 Lynn Rd. Suite 240 Thousand Oaks, CA 91360. Phone: (805) 370-1965 and Fax: (805) 370-1984.

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Patient Electronic Communication Consent

Elvira Lindwall MD a Medical Corporation is dedicated to keeping your medical record information confidential. To better serve our patients, our office has established a patient portal for some forms of electronic communication. Despite our best efforts, due to the nature of the patient portal and email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email and internet usage corporate property and your messages and internet usage may be monitored. Even when emailing from home, you may feel that access to your email and internet usage is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to your physician, the staff and/or colleagues would have access to this information.

When sending mail, please put the subject of your message so we can process it more efficiently. Also, include your name and return telephone number in the message. We also ask that you acknowledge receipt of emails coming from this office by using the auto reply feature.

Communications relating to diagnosis and treatment will be filed in your medical record.

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.

I understand and agree to the above electronic communication policy.

By signing below, I am agreeing that Elvira Lindwall a Medical Corporation may send medical related correspondence to me via electronic communication, and that we may respond to your electronic communication to us via electronic communication.

Patient Signature

Witness (optional)

Patient Name

Date of Birth

Date

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CONSENT TO RELEASE MEDICAL RECORDS

Patient name: _____ Home Number: _____

Date of birth: _____ Cell Number: _____

I hereby authorize and request that _____
Name of facility/individual

Address City/State/Zip

Release information from my records to the following:

Name of the Facility/individual: Dr. Elvira Lindwall Fax Number, if applicable (805) 370-1984
2190 Lynn Rd. Suite 240 Thousand Oaks, CA 91360
Address City/State/Zip

Please be specific regarding record and dates requested information to be released

- ☐ Diagnosis and record of treatment _____
Specific date / dates requested
- ☐ Laboratory and/or X-ray reports _____
Specific date / dates requested
- ☐ Entire file (excluding confidential and psychiatric records, if any)
- ☐ Other _____

BE ADVISED THAT IF YOU ARE REQUESTING A COPY OF YOUR MEDICAL RECORD, A COPYING FEE MAY APPLY. IT IS PROHIBITED BY LAW TO RELEASE/DISCLOSE THE ATTACHED/ENCLOSED INFORMATION TO ANYONE EXCEPT THOSE SPECIFIED ABOVE. I UNDERSTAND THAT THIS AUTHORIZATION ALONE MAY NOT AUTHORIZE RELEASE OF PSYCHIATRIC OR HIV INFORMATION.

► In signing, I am aware that this Authorization is valid for 30 calendar days after today.

► Signature: _____ Date: _____

If a minor; signature, name and date of parent/guardian: Signature: _____

Date: _____ Name: _____