YASMIN MALDONADO-STITT, MD

WELCOME

Welcome to the practice of Yasmin Maldonado-Stitt, MD.

As a new patient, we block out extra time for you so that Dr. Maldonado can do a full evaluation, answer your questions, and perform an examination.
If you cannot keep your appointment, we ask for at least two full business days' notice to allow us time to offer your appointment slot to others who are waiting to establish as a patient. Please note we are closed Fridays.

If you do not show for your first appointment, we will not be able to reschedule you due to our high volume of patients needing appointment spaces.
We may not always do courtesy calls to remind you of your appointment, so please mark your calendar accordingly.

Though we are not an Asante provider, we do use their patient portal. You are welcome to complete your paperwork through Asante's MyChart prior to your visit by doing your pre-check. If you do the online check-in, you do not need to do this paperwork as well. MyChart also can provide reminder texts/emails, if desired.

Further information on our practice, Notice of Privacy Practices, Notice of Non-Discrimination, and access to our Patient Portal can be found on our website at: www.ashlandrheum.com

We look forward to meeting you!

Yasmin Maldonado-Stitt, MD
Ph: 541-535-5523
Fax: 541-535-5368

YASMIN MALDONADO-STITT, MD

Board Certified Rheumatology
420 Williamson Way
Ashland, OR. 97520
541-535-5523

APPT DATE AND TIME:

- Please complete and bring the enclosed forms (or mail them prior to your appointment).
- Please remember to bring VALID ID, your insurance card(s), prescription card (Part D) and medication list with you.
- Co-pay is due at time of service. For your convenience, we accept Visa, MasterCard, Discover, and American Express, as well as cash and check.
- We do not treat illness or injury arising from Motor Vehicle Accident or Workers' Compensation claims.
- We are a non-narcotic office, meaning we do not prescribe narcotics.
- We do not do disability evaluations or fill out disability forms. However, our notes will be available should you need them.

OFFICE HOURS

Monday-Thursday
9:00am - 5:00pm
Closed for lunch from 12:00pm - 1:00pm

Dr. Yasmin Maldonado-Stitt complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Nuestra documentación está disponible en español. Por favor, llámenos al 541-535-5523. Hablmos español.

MEDICAL HISTORY

Date: _____ / _____ / _____

Patient Information

Name: _____ Date of Birth: DD MM YY

Personal Medical History (Check all that apply):

- ☐ Diabetes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Angina (chest pains)
- ☐ AIDS
- ☐ Hepatitis
- ☐ Rheumatic fever

Other Medical History (please list below)

_____

_____

_____

_____

Surgeries:

_____

Allergies (please list below)

_____

Habits

Smoking ☐ Current smoker ☐ Non-smoker

Packs per day: _____ Years: _____ Year Quit: _____

Alcohol ☐ I currently drink alcohol ☐ I do not drink alcohol

Average amount of drinks per week: _____

Caffeine ☐ I currently consume caffeine ☐ I do not consume caffeine

Average amount of caffeine per week: _____

Recreational Drugs ☐ I am a current drug user ☐ I do not use drugs

What drugs and how often:

_____

MEDICATION LIST

Date: _____ / _____ / _____

Patient Information

Name: _____ Date of Birth: DD MM YY

Pharmacy

Pharmacy Name and Location:

_____

Medications

Medication	Amount	How often You Take It

DEMOGRAPHICS

Date: _____ / _____ / _____

Patient Information

Name: _____ Date of Birth: DD MM YY

Address: _____

City: _____ State: _____ Zip: _____

Cell #: _____ Home #: _____

Emergency Contact: _____ Phone #: _____

Primary Doctor: _____ Phone #: _____

Referring Doctor: _____ Phone #: _____

Insurance Information

Primary Insurance: _____

Insured Name: _____ DOB: _____

Address (if different from above): _____

ID #: _____ Group #: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

Secondary Insurance: _____

Insured Name: _____ DOB: _____

Address (if different from above): _____

ID #: _____ Group #: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

OTHERS INVOLVED IN HEALTHCARE

Patient Information

Name: _____ Date of Birth: DD MM YY

Others Involved in Healthcare

This authorization is to release medical information to others in your life who you want to have involved in your care that are **NOT** your medical providers. By signing this form, you are permitting Yasmin Maldonado-Stitt, MD to disclose medical, appointment, and billing information to the people and entities listed below.

Examples: spouse, caregiver, facility, family, friends, transportation, etc.

This authorization remains in effect until revoked in writing by patient.

Name	Phone Number	Relationship

Printed Name _____ Date: _____

Patient Signature _____

Staff only:
Initial and date if this is updating a prior Others Involved in Healthcare form

_____ / _____

YASMIN MALDONADO-STITT, MD

AUTHORIZATION FOR MEDICAL TREATMENT
AGREEMENT OF FINANCIAL RESPONSIBILITY

I, _____ , authorize Dr Maldonado-Stitt and her medical staff to administer treatment as deemed necessary for my benefit. I also authorize the use of any anesthetics and/or medications, with the exception of _____ (allergy or other reason). I acknowledge that no guarantee or assurance has been made to the results that may be obtained.

I also understand it is my responsibility to complete all tests (i.e. blood work, x-ray, MRS, CT, etc.) that Dr Maldonado-Stitt necessarily prescribes. If I do not complete the test for any reason, I release Dr Maldonado-Stitt of all responsibility.

I understand that it is my (the patient) responsibility to verify with my health insurance company that the services being provided to me by Dr Maldonado-Stitt's office are covered and authorized by my insurance company. I understand that it is also my responsibility to have a referral in place, if it is required by my health insurance company. This is to include any referred needed to see any other doctor that Dr Maldonado-Stitt may feel necessary for me to see to help with any of my medical concerns. I understand that it is my responsibility, as well, to verify with my health insurance company that I am covered for tests (such as those referenced in the preceding paragraph) that Dr Maldonado- Stitt may order.

I accept financial responsibility for all charges that are not paid by my health insurance company. I understand there will be a finance charge of 1.5% per month (18% annual percentage rate) assessed to balances after 90 days. I understand that any copay and deductible will be due at time of service.

I hereby certify that I have read, fully understand, and agree to this Authorization for Medical Treatment and Agreement of Financial Responsibility.

No signature required- you will sign electronic version at office

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Yasmin Maldonado-Stitt, MD or insurance company to release any information required to process my claims.

YASMIN MALDONADO-STITT, MD

ACKNOWLEDGEMENT AND CONSENT

I understand that Yasmin Maldonado-Stitt, MD (referred to below as "This Practice") will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility from my health insurance, submit bills, claims and other related information to insurance companies (or others who may be responsible to pay for some or all of my health care;) and
- Perform various office administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I will read the copy of the Notice of Privacy Practices in the office.

No signature required- you will sign electronic version at office

YASMIN MALDONADO-STITT, MD

CANCELLATION POLICY

Please be assured that we value your time and hope that you value ours. We make every reasonable effort to stay on schedule throughout the day, while we remain committed to providing each patient with the highest quality of care.

- If you need to reschedule an appointment, we will be happy to accommodate you, but we do ask for at least TWO FULL BUSINESS DAYS' advance notice barring an emergent need. We have a high volume of referrals and this is to allow us time to fill your new patient slot with another patient who has been waiting to get in.

- Please note that we are closed on Fridays--a cancellation on Friday for a Monday appointment is not considered sufficient notice.

- We charge a $50.00 fee for an appointment not canceled within policy. After the second missed appointment without appropriate notice, we will not reschedule an appointment for you.

- We may not make confirmation calls prior to your appointment. Please mark your calendars accordingly.

I hereby acknowledge receipt of Dr Maldonado-Stitt's Cancellation Policy

No signature required- you will sign electronic version at office

YASMIN MALDONADO-STITT, MD

DIRECTIONS

From I-5 South

- Take Exit 19
- Turn right
- Left at light onto S. Pacific Hwy toward Ashland, follow for 1.6 miles
- Left on Hersey St. (after Big Al's restaurant)
- Follow Hersey for 0.8 miles
- Right on Williamson Way
- End at 420 Williamson Way (next door to corner building)

From I-5 North

- Take Exit 14
- Turn left on OR-66 E/Ashland St
- Take right on Tolman Creek Rd. and follow 0.6 miles
- Take left on E. Main St and follow 1.4 miles
- Take right on Mountain St. and follow 0.5 miles
- Left on Hersey St. (stop sign at bottom of hill) Follow for 0.2 miles
- Left on Williamson Way
- End at 420 Williamson Way (next door to corner building)

** Construction is ongoing through June '26 on Mountain St. and you may be better served following E. Main (turns into Lithia) down to Oak St.
Take right on Oak St.
Right on E. Hersey St.
Left on Williamson Way

RELEASE OF INFORMATION

Name: _____ Date of Birth: DD MM YY

By signing this form, I authorize (name and address of physician/clinic/entitiy)

- ☐ Yasmin Maldonado-Stitt, MD
- ☐ Other: _____

to release confidential health information about me, by releasing a copy of my medical records, to the physician/clinic/entity below (name, address, and fax number)

_____

The health information that relates to the dates of service from _____ to _____ may be released and may include (mark below):

- ☐ Entire medical record
- ☐ Chart Notes
- ☐ Lab reports
- ☐ Radiology reports
- ☐ Treatment records
- ☐ Billing records
- ☐ Insurance records
- ☐ Medication records
- ☐ Other (specify below)

_____

For the purpose of:

_____

- I understand that unless revoked in writing, this authorization is valid for 12 months from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.
- Unless specifically excluded below, this authorization includes release of specially protected information including referral, diagnosis and treatment information related to my health care.
- (Please circle all that apply to EXCLUDE the information from authorization and disclosure):

Substance Abuse Mental Health Conditions Sexually Transmitted Diseases HIV/AIDS

- I understand once my health care information is released, the person or organization that receives it may re-disclose the information and that it may no longer be protected by privacy laws.
- I understand release of my records may take up to 30 days.
- I understand that I do not have to sign an authorization as a condition for receiving treatment or health care benefits (treatment, payment or enrollment).

_____ Printed Name

_____ Signature

_____ Date

_____ Relationship to Patient