

*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, ask questions, and perform an examination.

If you cannot keep your appointment, we require at least **TWO FULL BUSINESS DAYS' NOTICE**. Please note we are closed Fridays, so notice on Thursday of a Monday cancellation is not considered full notice. *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.

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](http://www.ashlandrheum.com)

# Yasmin Maldonado-Stitt, MD

Board Certified Rheumatology

420 Williamson Way

Ashland, OR. 97520

541-535-5523 Phone

541-535-5368 Fax

## APPT DATE AND TIME:

Welcome to our practice! We have scheduled an appointment for you, at the date and time listed above.

- Please complete and bring the enclosed forms or fill them out via Asante MyChart online (no need to do both).
- We do not treat illness or injury arising from Motor Vehicle Accident or Work Comp claims.
- Also, please remember to bring VALID ID, your insurance card(s), prescription card and medication list with you.
- Please bring your COMPLETED paperwork with you, or we will not be able to see you at that time and will need to reschedule your appointment.
- We are a non-narcotic office. This means that we do not prescribe narcotics.
- We do not do disability evaluations nor do we fill out disability forms, nor do we communicate with lawyers. However, our notes will be available should you need them.

Our office hours are Monday-Thursday between the hours of 9:00 a.m. and 12:00 p.m., and from 1:00 p.m. and 5:00 p.m., closed on Fridays.

Sincerely,

The Staff

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.

Atención: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**PAST MEDICAL HISTORY:** If you have had any of the following problems, circle it and write the date you were first told you had that problem.

Diabetes \_\_\_\_\_ Heart attack \_\_\_\_\_ Hepatitis \_\_\_\_\_

High blood pressure \_\_\_\_\_ Angina (chest pains) \_\_\_\_\_ High cholesterol \_\_\_\_\_

Rheumatic fever \_\_\_\_\_ Heart murmur \_\_\_\_\_ AIDS \_\_\_\_\_

**Other Medical Problems (Please List):** \_\_\_\_\_

\_\_\_\_\_

Surgeries (list and give approximate dates): \_\_\_\_\_

\_\_\_\_\_

**HABITS:**

SMOKING- *I am a current smoker*  *I am a non-smoker:*   
Pack(s) per day \_\_\_\_\_ Yrs smoked? \_\_\_\_\_ Yr. Quit: \_\_\_\_\_

ALCOHOL- *I currently drink alcohol*  *I do not drink alcohol*   
Average alcohol use: \_\_\_\_\_

COFFEE- *I currently drink coffee*  *I do not drink coffee*   
Daily coffee use: \_\_\_\_\_

RECREATIONAL DRUGS- *I am a current drug user*  *I do not use drugs*   
Current drug use: \_\_\_\_\_

List any vitamins or supplements you may be taking.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you seen another Rheumatologist? If so, who: \_\_\_\_\_

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

# MEDICATION LIST

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

PHARMACY: \_\_\_\_\_ Date: \_\_\_\_\_

MEDICATION	HOW MANY MILLIGRAMS	HOW OFTEN YOU TAKE IT

**PATIENT INFORMATION**  
**FORM MUST BE FILLED OUT COMPLETELY**  
**OR WE CAN NOT BILL YOUR INSURANCE**

Legal Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell # \_\_\_\_\_ Home # \_\_\_\_\_

Ok to leave a message on home phone?  yes  no

Social Security \_\_\_\_\_ Email address \_\_\_\_\_

Present Employer \_\_\_\_\_ Work Number \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widow \_\_\_\_\_ Domestic Partner \_\_\_\_\_

Primary Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact/relationship \_\_\_\_\_ Phone \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Phone \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_

Insured's name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address if different from above: \_\_\_\_\_

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to Insured: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to Insured: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_

**SIGNATURE** \_\_\_\_\_ **Date** \_\_\_\_\_

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION PERSUANT TO HIPAA**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_

The health information that relates to dates of service from \_\_\_\_\_ to \_\_\_\_\_

may be released and may include (circle all that apply): Entire medical record, History & Physicals, Lab reports, Radiology reports, Treatment records, Pathology reports, Billing records, Insurance records, Medication records or Other:

\_\_\_\_\_ (specify)

For the purpose of:

\_\_\_\_\_

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Signature of Patient or representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of representative and relationship

• 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).

**AUTHORIZATION FOR MEDICAL TREATMENT AND  
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 that it is my responsibility to complete all tests (i.e. blood work, x-ray, MRI, 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 referral 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 unpaid balances after 90 days. I accept financial responsibility for all charges that are not paid by my health insurance company. I understand that any copay and deductible will be due at the 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.**

**Responsible Party Signature \_\_\_\_\_ Will sign electronic version at visit \_\_\_\_\_**

***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.***

Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_

**RELEASE OF INFORMATION MEDICAL AND BILLING (OPTIONAL)**

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 and billing information to the people listed below.

Examples include: spouse, caregiver or facility, family, transportation, etc.

Name:	Phone Number:	Relationship:
Name:	Phone Number:	Relationship:
Name:	Phone Number:	Relationship:

**This information is valid until revoked by the patient**

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature (or printed name and signature of representative)

# ACKNOWLEDGMENT 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.**

By: \_\_\_\_\_ *Will sign electronic version at visit* \_\_\_\_\_

# 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 for anything
- *Please note that we are closed on Fridays--a cancellation on Friday for a Monday appointment is not sufficient notice.*
- **We charge a \$50.00 fee** for an appointment not canceled within **TWO FULL BUSINESS DAYS** of the appointment time.

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.*

Signature \_\_\_\_\_ *Will sign electronic version at visit*

## DIRECTIONS

### Coming from North

Take I-5 South to Ashland Exit 19. Make a Right at the stop sign and follow to OR-99/S Pacific Hwy. Take a left on OR-99/S Pacific Hwy. Follow toward Ashland for 1.6 miles. Take a Left on Hersey St. (just after Big Al's restaurant). Follow Hersey St. for 0.8 miles (through 3 stop signs). One block after the third stop sign make a Right on Williamson Way. We are on the left side next door to the corner building at 420 Williamson Way.

### Coming from South

Take I-5 North to Ashland Exit 14 for OR-66. Turn Right onto OR-66/Ashland St. Take a sharp Left onto E Main St. Follow for 2.3 miles. Turn right onto N. Mountain Ave. and follow for 0.5 miles. Turn left on E. Hersey St. (at bottom of the hill). Turn Left on Williamson Way. We are on the left side next door to the corner building at 420 Williamson Way.

For Your Convenience  
We now accept  
MasterCard, Visa, and Discover

*Your co-pay, if applicable, is due at time of service. We will not bill you for your co-pay amount.*

Thank you for your cooperation,

The Staff of Yasmin Maldonado-Stitt, MD