Tri-City Rheumatology
Sabiha Rasheed M.D., F.A.C.R
734 Mowry Avenue
Fremont, CA 94536

Acknowledgement of Receipt of Notice of Privacy Practices
Advanced Beneficiary Notice

I acknowledge that I have received and read Tri-City Rheumatology *Notice of Privacy Practices* with the effective date of April 14, 2003. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

_____ _____
Signature of patient/patient representative Date

_____
Relationship to the Patient

I request the following restrictions to the use or disclosure of my health information:

Medical information can be discussed with:
Patient only _____
Family member of friend_____
Other Physicians_____
Other_____

Detailed messages regarding test results can be left on answering machine
yes no Phone number_____

Other restrictions _____

Dear Patient,
Medicare and/or your insurance will only pay for services that they determine to be "reasonable and necessary". These are examinations and treatment performed for specific illnesses, symptoms, complaints or injuries. Routine physical examination and some screening procedures along with laboratory studies and imaging may not be covered by Medicare and my not be covered by your insurance.

I have read the above statement and agree to pay for the services rendered to me that are "not covered" by Medicare or my insurances company, while I am a patient with Tri-City Rheumatology.

Patient Signature_____

Patient Name (Please print) _____

Date: _____