Arthritis and Rheumatology Clinical Center of Northern Virginia, PLLC

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PATIENT WELCOME FORM

Dear New Patient,

Welcome to our office, where we strive to provide you with outstanding and state of the art care, in a compassionate and patient-centered environment. To help streamline your first visit, please familiarize yourself with this packet, including our office and financial policies. To begin building our partnership with you, please read and sign the forms below and answer all personal history questions as accurately as possible. If you have any questions, feel free to contact us at: **703-734-2222.**

We extend to you the invitation to **sign up** on our secure **patient portal**, which is a complimentary service. Here, you can actively help us provide you with the best quality of care, resulting in more efficient office visits. Once your account is established, you may request or reschedule appointments, request medication refills, view lab results, receive secure messages from your rheumatologist and much more. All on-line and at your convenience.

We recommend filling out the new patient welcome packet including the patient history form, in advance of your appointment. **If you are unable to do so, please arrive 20 minutes earlier for your appointment so that you may complete the forms in our waiting room.** Please make sure you bring the following with you to your first appointment:

1. List (or actual bottles) of **ALL MEDICATIONS**, including dosing instructions and pharmacy name and phone/fax numbers

2. Name of your **referring physician and PCP.**

3. If your insurance policy requires a referral, please bring the **referral** with you, otherwise you may not be seen due to insurance limitations

4. Please bring any pertinent MEDICAL RECORDS, these include but are not limited to lab tests, imaging (i.e. reports of X-rays, MRI's, CT scans, nerve conduction tests, bone density scans etc.) which may be related to your condition. It is best if you ask your PCP, referring physician or prior rheumatologist to fax us this information before the visit.

5. **INSURANCE CARD(S)** and **PHOTO ID** such as driver's license

6. **CO-PAY**, as this is collected upon check-in

We look forward to meeting you and establishing a solid medical partnership with you.

Most Sincerely,

Arthritis and Rheumatology Clinical Center of Northern Virginia 2

PATIENT INFORMATION

Patient Full Name: _____ DOB: _____

Address: _____City: _____ State: _____ Zip: _____

Home #: _____ Work#: _____ Cell#: _____

SS #: _____ □ Male □ Female Marital Status: S M D W

Email Address: _____

Preferred Language: _____ Race: _____ Ethnicity: Hispanic Not Hispanic

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Primary Care Physician: _____ City, State: _____

Phone #: _____ **Fax Number:** _____

Referring Physician: _____ City, State: _____

Phone #: _____ **Fax Number**: _____

Preferred Pharmacy: _____ Location: _____

Phone Number: _____ Fax: _____

Do you have a living will? □ Yes □ No

Primary Insurance Information:

Ins Name: _____ ID# _____ Group #_____

Policy Holder Name: _____ Relation to Pt: _____ Holders DOB: _____

Secondary Insurance Information:

Ins Name: _____ ID# _____ Group #_____

Policy Holder Name: _____ Relation to Pt: _____ Holders DOB: _____

I authorize the Arthritis & Rheumatology Clinic to disclose my protected health information to:

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

HIPAA Release Form

Patient Name _____

Date of Birth_____

Release of Information

I authorize the release of medical and financial information rendered to me by ARCC. This information may be released to:

- My spouse
- My children
- Other _____(please enter name and relationship to patient)
- Do not release this information to anyone

******This Release of Information will remain in effect until terminated by me in writing *******

Messages

I authorize you to leave a message on:

- Home phone
- Work phone
- Mobile phone

If unable to reach me:

- You may leave a detailed message
- Leave a message asking for a return call
- Do not leave a message

_____ _____

Patient Signature Date

HIPAA CONSENT

Arthritis and Rheumatology Clinical Center of Northern Virginia, PLLC

Acknowledgement of Receipt & Review of Notice of Privacy Practices:

Arthritis and Rheumatology Clinical Center of Northern Virginia, PLLC, is committed to the protection of your privacy and ensuring that your health information is appropriately used and disclosed. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our organization and outlines your rights with regard to your health information and how you can obtain access to this information. Please sign below to acknowledge that you have received our Notice of Privacy Practices.

I hereby permit **Arthritis and Rheumatology Clinical Center of Northern Virginia** to **release** my healthcare information for the purposes of treatment, payment or healthcare operations. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation. If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicare claim.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Arthritis and Rheumatology Clinical Center of Northern Virginia, PLLC and authorize the release of information.

Name: _____

Signature: _____

Name of personal Representative: _____

Signature of personal Representative: _____

Relationship to patient: _____

Date: _____

Arthritis and Rheumatology Clinical Center of Northern Virginia

Consent for Non-Face-to-face "Virtual" Visits

Patient Name: _____ Date of Birth: _____

Social Security No.: _____ Today's Date: _____ Time: _____ am / pm

I, _____ hereby voluntarily consent to receive "virtual" care.
Examples of the virtual services offered here are:

Virtual check-ins – You and your treating provider may have a brief phone call to determine whether or not an in-person visit or other appropriate treatment is needed. Charges apply.

E-visits/ Portal Communication – You may communicate with your treating provider through our patient portal or secure email. Charges apply.

Telehealth visits: You and your treating provider can use real-time interactive audio and video communication that permits real-time communication to conduct a visit while you are home. Charges apply.

I understand that this consent form will be valid and remain in effect as long as I receive medical care at Arthritis and Rheumatology Clinical Center of Northern Virginia.

"Virtual Visits" mean that you may be evaluated and treated by a health care provider or specialist from a distant location via electronic communication. Since this may be different than the type of consultation with which you are familiar, it is important you understand and agree to the following statements:

- Your provider will make the ultimate decision regarding which type of communication they choose to utilize for your care.
- Your treating provider will be at a different location from you. Additional medical or registration personnel may also be present in the room with the Provider. _____ (initials)
- I understand that my voice and image may be recorded in order to assist in my treatment and I consent *to any such* audio and video recording. _____ (initials)
- I understand there are potential risks to this technology, including, but not limited to, interruptions, unauthorized access, technical difficulties, and call termination. I understand there are alternatives and limitations to this type of care. I understand that my health care provider or I can discontinue the telemedicine consultation/visit if it is felt that the videoconferencing connections are not adequate for my situation. _____ (initials)
- I understand that I may be disconnected before all my medical problems are known or treated and it is my responsibility to make such conditions or symptoms known to the medical personnel as well as to make arrangements for follow-up care. _____ (initials)
- I understand that standard charges/rates apply to all the above services. This may or may not be covered by your health plan. I consent to Virtual Treatment _____ (initials)

This form has been explained to me and I fully understand this **Consent for Non-Face-to-face "Virtual" Visits** and agree to its contents.

Signature of Patient or Person Authorized to consent for patient:

_____ _____
Name Date

***FINANCIAL POLICY*:**

1. All charges are due and payable at the time of services unless other arrangements have been made in advance by yourself or your health coverage carrier. For your convenience, we accept ALL major credit cards as well as check. Refunds from services charged on a credit card will be returned to the same credit card. **There will be a $30.00 fee charged directly to the patient for any returned checks.**

2. Arthritis and Rheumatology Clinical Center of Northern Virginia will bill insurance plans as a courtesy to their patients if the patient provides the required insurance information at the time of service and signs the financial policy. Please note: Any balances not paid within **45 days** will become the responsibility of the patient. ***Not all services are covered benefits in all contracts. There can be significant variations amongst health plans and their coverage. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered.***

3. It is the patient's responsibility to provide our office with the most recent up to date insurance information. Failure to update insurance information may result in services charged directly to the patient.

4. It is the patient's responsibility to determine whether a referral is required, the referral can be requested from your primary care physician. If we have not received an authorization prior to your arrival at the office and you are unable to obtain the referral you will have the option of paying for your visit under non-covered services or rescheduling your appointment

5. Prior to providing services, payment of prior outstanding accounts will be requested and should be received. Any account balance that is not paid may be referred to a collection agency. Patients will be responsible for any and all costs and fees, including legal fees relating to the collection of the patients debt.

6. For ***Workman's Compensation claims,*** please provide out office with your active claim number, carrier name, adjustor's name, phone number and pre-authorization. If for any reason the provided worker's compensation carrier denies payment for services rendered to the patient, the patient agrees to accept full responsibility for any balances due.

I, the patient/patient legal representative, understand and agree to abide by the financial policy set forth.

_____ _____ _____

Signature of Patient/Legal Patient Name Date

OFFICE POLICIES:

In our efforts to remain a modern medical practice, we strongly urge you to sign up for our patient portal. Through the portal, you can view lab results, send your physician messages, request or reschedule appointments and request medication refills. We provide this service to all of our patients with the ultimate goal of enhancing your safety, security and communication with your provider.

1. PRESCRIPTION REFILL POLICY

All refills should be requested through your pharmacy, this is the most efficient way. Alternatively, you may request a refill via the patient portal. **Please allow up to a 72- hour turnaround time.**

Please note that most medications cannot be renewed if we have not seen you in more than **3 months**. This is primarily due to the fact that medications carry with them a significant risk of side effects and we must monitor your blood work before prescribing.

Medications will not be filled on weekends and we are unable to refill narcotics over the phone.

Please monitor your medications and contact us ***BEFORE*** you run out, so there are no interruptions to your regimen.

2. LABS & IMAGING RESULTS: Please allow 72 hours for any general telephone or patient portal related questions. It is the responsibility of the patient to follow up and ensure they receive their lab results and imaging results within 10 days.

3. APPOINTMENTS & CANCELLATION POLICY: Office hours are by appointment only. Our physicians make every effort to accommodate urgent add on requests. Please inform us of your cancellation/rescheduling request at least **48 hours** before your appointment. This will allow us to accommodate other patients who need to be seen earlier. ***A cancellation with less than 48 hour notice and/or a NO SHOW appointment will incur a $50 cancellation fee***. Patients arriving more than **15 minutes** late for their appointment may need to be rescheduled. We accommodate all of our patients with disabilities to the best of our ability. If we have accommodated you for example, by hiring an interpreter, and you cancel less than 48 hours prior to your appointment, then you will be responsible for the interpreter fee as well.

TERMINATION POLICY: We value our patient relationships and believe in protecting your rights. Reasons for termination from the practice may include; repeatedly missing appointments, refusing to adhere to medical care, being hostile or abusive to staff or not paying bills in a timely manner.

AFTER-HOURS: Our office phone lines are open from 8:00AM-4:30PM, Monday-Friday. We cannot guarantee that any phone call after 8:00 pm will be urgently answered, therefore we ask you to dial 911 or go to the nearest emergency room if you think you have any kind of emergency. Please note there is a $10 fee for any after hour phone calls.

I, the patient/patient legal representative, understand and agree to abide by the financial and office policies set forth.

_____ _____ _____

Signature Patient Name Date