PATIENT INFORMATION 2018

(PLEASE PRINT ALL INFORMATION)

LAST NAME _____FIRST NAME_____ MIDDLE INIT____

WHAT FIRST NAME DO YOU PREFER?_____ RACE _____MARITAL STATUS: S M D W

SS # _____DATE OF BIRTH_____AGE:_____

ADDRESS _____ SEX M_____ F_____

CITY _____ STATE _____ZIP _____

HOME # (_____) _____CELL # (_____) _____

EMAIL ADDRESS_____

EMPLOYER _____WORK # (_____) _____

SPOUSE'S NAME_____ EMPLOYER _____

PRIMARY CARE PHYSICIAN_____ PHONE #_____

REFERRING PHYSICIAN_____PHONE #_____

PHARMACY _____PHONE #_____

MAIL OFF PHARMANCY_____PHONE #_____

PRIMARY INSURANCE: FAX #_____

NAME _____ GROUP NAME _____

ADDRESS_____POLICY # _____

CITY _____STATE _____ZIP _____GROUP #_____

PHONE # (_____) _____ FAX # (_____) _____

POLICY HOLDER_____DATE OF BIRTH_____RELATIONSHIP_____

EMPLOYER_____ ADDRESS_____

SECONDARY INSURANCE:

NAME _____GROUP NAME_____

ADDRESS _____POLICY #_____

CITY _____ STATE_____ZIP _____GROUP#_____

POLICY HOLDER_____DATE OF BIRTH_____

CONTACT IN CASE OF EMERGENCY:

NAME _____HOME # _____

RELATIONSHIP _____WORK # _____

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to myself or the providers of Arthritis & Rheumatic Diseases, P.C. for professional services rendered.

Signature _____ Date _____

RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process this claim.

Signature _____ Date _____

ARTHRITIS & RHEUMATIC DISEASES, P.C.

329/331 McLaws Circle
Williamsburg, VA 23185
(P) 757-220-8579
(F) 757-345-0936

AUTHORIZATION TO RELEASE RECORDS

Patients Name: _____

Date of Birth: _____ SS#: _____

I hereby authorize release of my medical records to the person or persons listed below:

Arthritis & Rheumatic Diseases, P.C.
329 McLaws Circle
Williamsburg, VA 23185
(P) 757-220-8579
(F) 757-345-0936

I have given my consent freely, voluntarily, and without coercion. I may revoke the authorization at any time provided I notify the requesting physician in writing to that effect. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

Term: I understand that this Authorization will remain in effect and will allow Arthritis & Rheumatic Diseases the ability to request medical records on my behalf for the following period of time: (Check One)

[ ] From the date of this Authorization until the _____ day of _____, 20____.
[ ] All past, present, and future time periods.

Patient Signature: _____ Date: _____

ARTHRITIS & RHEUMATIC DISEASES, P.C.

Financial Policy

I hereby acknowledge financial responsibility for costs of services rendered for me or for the person whose account I am acting as guarantor. I am responsible for any non-covered services, supplies, co-payments or deductibles. I am responsible for knowing how my plan works, and I request medical services at this office. This acceptance will be in force for all future services by practitioners from this office.

- Arthritis & Rheumatic Diseases will file both your primary insurance and secondary insurance.
- All co-payments, non-covered services and deductibles are due ate the time of service.
- Please notify us immediately of any changes in your insurance coverage.
- If your insurance company requires a referral, it is your responsibility to obtain that referral from your primary care physician prior to receiving treatment.
- Any problems that are anticipated should be discussed with our billing staff in advance.
- Accounts more than 90 days overdue are considered delinquent. Arthritis & Rheumatic Diseases retains the services of a collection attorney, and in the event your account becomes delinquent, you will be responsible for all costs of collections, including reasonable attorney collection fees, collection warrant service fee, and a filing fee.

I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize Arthritis & Rheumatic Diseases to release all information necessary to secure payment, and agree that a photocopy of my signature is as valid as the original.

Patient Signature: _____ Date: _____

Printed Name of Patient: _____

Office Visit No Show Policy

We believe that follow up care is an important part of maintaining your health and have established a missed appointment policy of which you need to be aware. It is essential that our appointment schedules run efficiently to provide maximum opportunity to see patients needing medical care in a timely manner. You will be notified 2 days in advance of your appointment by our automated phone service. Please press 1 to confirm you appointment.

If you are unable to make a scheduled appointment, please call our office at 757-220-8579 a **minimum of 24 hours in advance**. If you are unable to contact us during business hours, you may call our office after hours and leave a message on the voice mail system.

If you no show for your first consultation appointment without proper notice, you will be charged **$75.00**. This must be paid before the consultation will be rescheduled. If you do not show up or give proper cancellation notice for follow up care with any of our practitioners, you will be charged a **$45.00** no show fee which must be paid before the next visit. Multiple no shows will result in discharge from our practice.

I have read the above policy and agree to comply with the appointment policies of Arthritis & Rheumatic Diseases. I understand that if I do not give proper cancellation notice, I will be charged a fee as stated above.

Patient Signature: _____ Date: _____

ARTHRITIS & RHEUMATIC DISEASES, P.C.

Acknowledgement of Notice of Privacy Policies

I understand that as part of my healthcare, Arthritis & Rheumatic Diseases originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality.

I understand that Arthritis & Rheumatic Diseases maintains a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. The most recent version of this Notice is displayed in the waiting room area. I understand that Arthritis & Rheumatic Diseases reserves the right to change this notice and its practices as needed and will make a reasonable attempt to inform me of any changes. I understand that I can request an additional written copy of this Notice at any time. I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this consent, and
- The right to request restriction as to how my health information may be used or disclosed.

I give my permission to talk to and release information to the following individuals regarding my healthcare:
[ ] Spouse **(Check ALL that Apply)**
[ ] Children
[ ] Other (Please List) Relationship:
_____ _____
_____ _____

Patient Signature: _____ Date: _____

Printed Name of Patient: _____

Notice of Deemed Consent for HIV Testing

As a health care provider, we are required by State Law 32.1-45 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If one of our health care professionals, workers, or employees should be directly exposed to your blood or body fluids, in a way that may transmit disease, your blood will be tested for infection with HIV (the AIDS virus). A physician or other health care provider will tell you the results of the test.
2. If you should be exposed to blood or body fluids of one of our professional workers or employees, in a way that may transmit disease, that person's blood will be tested for the HIV virus (AIDS). A physician or other health care provider will tell you the results of the test.

Patient Signature: _____ Date: _____

ARTHRITIS & RHEUMATIC DISEASES, P.C.

Medication Refill Policy

Advance Notification: We ask that you phone the pharmacy that filled the original prescription first, as they have orders for refills. Reasonable time must be provided to permit nursing staff to call in medication refills. ***A minimum of 48 hours is required during regular business hours.*** Please call between 9:00 am & 4:00 pm.

Follow Up: Refills will ONLY be permitted if follow ups and lab work are current.

After Hours & Weekends: Please anticipate your need for medication refills during regular office hours when your medical record is available. After normal office hours and on weekends, routine refill requests will not be accepted. **PAIN MEDICATION REQUESTS WILL BE ACCEPTED ON AN EMERGENCY BASIS ONLY**.

I have read the above policy and agree to comply with the medication refill policies of Arthritis & Rheumatic Diseases.

Patient Signature: _____ Date: _____

Physician/Nurse Practitioner Office Appointment Policy

Arthritis & Rheumatic Diseases, P.C. has agreed to become part of your healthcare team therefore, it is important that you understand how our practice functions. Our staff is comprised of Rheumatologists and Nurse Practitioners working together in a team approach in the diagnosis and decision-making of your care. Both during your initial consultation or follow up visit, your doctor will discuss with you their findings and a treatment plan will be established. Based upon your diagnosis our doctors may ask you to follow up with their nurse practitioner. Regardless of who sees you, your physician will be kept abreast of your medical progress and will be available to confer with their nurse practitioner as necessary. You should know that your level of care will not decrease. Rather, this arrangement will allow us to improve your care by reducing wait times for appointments, improving your access to our providers, while allowing us to better serve all of our patients' rheumatologic needs.

Many of you are already seeing our nurse practitioners and have found them to be capable, thorough and compassionate. For those who have not yet had the opportunity, we are confident that you will form similarly strong relationships. Thank you for your understanding as we continue to find ways to best meet your medical needs. We look forward to working together with you as we all adjust to the changing face of healthcare.

I have read the above policy and agree to comply with the appointment policies of Arthritis & Rheumatic Diseases.

Patient Signature: _____ Date: _____