ARTHRITIS & RHEUMATIC DISEASES, P.C.
PATIENT INFORMATION

(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 _____ SEX M__ F__

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME # _____ CELL #_____ WORK # _____

EMAIL _____ EMPLOYER _____

SPOUSE'S NAME_____ EMPLOYER _____

PRIMARY CARE PHYSICIAN_____ REFERRING PHYSICIAN _____

PHARMACY _____PHONE #_____

MAIL ORDER PHARMANCY_____ PHONE #_____

PRIMARY INSURANCE:

NAME _____ GROUP NAME _____

POLICY # _____ GROUP #_____

POLICY HOLDER_____DATE OF BIRTH_____RELATIONSHIP_____

SECONDARY INSURANCE:

NAME _____GROUP NAME_____

POLICY #_____ GROUP#_____

POLICY HOLDER_____DATE OF BIRTH_____

CONTACT IN CASE OF EMERGENCY:

NAME _____CELL # _____

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.

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: _____ DOB: _____

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 your 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 **$100.00**. 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 **$50.00** 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.

No-Show, Late, & Cancellation Policy

Thank you for trusting your medical care to Arthritis & Rheumatic Diseases, P.C. When you schedule an appointment with Arthritis & Rheumatic Diseases, P.C., we set aside enough time to provide you with the highest quality care. We believe that follow-up care is an important part of maintaining your health and have established a missed appointment policy of when 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. **You must press 1 to confirm your appointment, or you will receive a phone call the day prior to your appointment, from one of our receptionists confirming your appointment via phone.**

- Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a No Show and charged a $50 fee.

- If a patient arrives late to their appointment (greater than 10-15 minutes after expected arrival time), the possibility arises that a patient may not be able to be seen by the provider on that day, patients would then be rescheduled for a future follow up visit, if available.

- Any new patients who fail to show for their initial visit will not be rescheduled without paying a $100 no-show fee prior to being rescheduled.

- In the event a patient has incurred three (3) documented "no-shows" and /or "same day cancellations," that patient may be subject to dismissal from Arthritis & Rheumatic Diseases. The patient's chart is reviewed, and dismissals are determined by management and physicians.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you are unable to make a scheduled appointment, please call our office as 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 voicemail system.

I have read and understand the No-Show, Late, & Cancellation Policy of Arthritis & Rheumatic Diseases and agree to it terms.

_____	_____	_____
Printed Name (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 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 waiting times for appointments, improving your access to our providers, while allowing us to better serve all 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: _____

Arthritis & Rheumatic Diseases, P.C.
PRIVACY POLICY ACKNOWLEDGEMENT/RELEASE

I, _____, have received a copy of Arthritis & Rheumatic Diseases Notice of Privacy Policies and understand that my protected health information may be released to other healthcare providers, insurance companies, etc. As outlined in the Privacy Policy, I also agree that a photocopy of my signature it as valid as the original.

_____ _____

Signature of Patient *Date*

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (*check all that apply*)

( ) Home Telephone _____
- ( ) O.K. to leave message
- ( ) Leave message with callback number only

( ) Work Number _____

( ) Cell Number _____
- ( ) O.K. to leave message
- ( ) Leave message with callback number only

( ) Written Communication
- ( ) O.K. to mail to my home address
- ( ) O.K. to mail to my work/office address

( ) O.K. to fax to this number

_____

I give my permission to talk to and release information to the following individuals regarding my healthcare (*check all that apply*)

- ( ) Spouse
- ( ) Children
- ( ) Other (Please List)

Relationship

_____ _____

_____ _____

_____ _____

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.

Elena Flagg, MD Laila Rahbar, MD Misty White, NP Audra Albert, NP
329 McLaws Circle
Williamsburg, VA 23185
Phone: (757) 220-8579 Fax: (757) 345-0936

Assignment of Benefits

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to Arthritis & Rheumatic Diseases, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the abovenamed health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.
In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named healthcare provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place alien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

This lifetime assignment will remain in effect until revoked by me in writing. It is valid for all administrative and judicial reviews under PPACA (healthcare reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it were the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT:

Name: _____ *DOB:* _____

Signature: _____ *Date:* _____