Arthritis and Rheumatology Clinical Center of Northern Virginia, PLLC
8130 Boone Blvd suite 340 Vienna VA 22182
Mahsa Tehrani MD **703-734-2222** **Mahnaz Momeni MD**

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, please 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**, lab tests, imaging (i.e. reports of X-rays, MRIs, 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 your visit.
5. **Insurance card** (s) and **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

Privacy Officers: Dr. Mahsa Tehrani & Dr. Mahnaz Momeni: 703-734-2222

HIPPA 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 the form 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 purpose 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 release of information

Name of patient: ____

Signature of Patient:____

Name of Personal Representative ___________________________________
Signature of Personal Representative____
Description of Personal Representative's Authority_____________________________________

Date____

Privacy Officers: Dr. Mahsa Tehrani & Dr. Mahnaz Momeni: 703-734-2222

RELEASE OF INFORMATION TO FAMILY/FRIENDS/RELATIVES:

I hereby authorize Arthritis and Rheumatology Clinical Center of Northern Virginia, PLLC, to release any and all information regarding my private healthcare to the following **family/friend/relative**:

1.____________________________________ relationship___________________

2.____________________________________ relationship___________________

Name of patient: _____________________________________

Signature of patient:___________________________________ Date:___________________

____I **DO NOT AUTHORIZE** the release of my private healthcare information to any family member or friend.

How to contact you to provide you with information:

___**May** send you mail, secure e-mail, or leave a message on your voicemail/answering system regarding labs/imaging/tests/appointment reminders or other protected health information (By checking this, you give our physicians or representatives authorization to contact you with the above information)

___DO NOT contact me; I will provide alternative means of communication (patient must request and fill out a confidential patient communication form)

New Patient Registration Form
Arthritis and Rheumatology Clinical Center of Northern Virginia

General Information:

Name ____

Date of Birth __________________ Sex: M F Social security:_____________________

Marital status: **Single** **Married** **Divorced** **Widowed**

Local address ____

City _________________________State ______________ Zip ______________________

Home phone _________________________ Work phone ____________________________

Cell phone _____________________ EMAIL address______________________________

Secondary address ____

City ________________________ State ______________ Zip _______________________

Employment status: **employed** **not employed** **retired** **student**

Employer: ________________________________

Occupation ___________________________________

Financially responsible party name/relationship_________________________________

Phone number of responsible party____

Address of responsible party____

************************************Insurance Information*************************************

Do you have health insurance? ___YES ____NO

Primary insurance company ____

Primary insurance address____

Primary insurance phone number____

Privacy Officers: Dr. Mahsa Tehrani & Dr. Mahnaz Momeni: 703-734-2222

Policy holder's name ____

Policy holder's date of birth____

Policy holder's address____

Member ID # ______________________________ Group ID #___________________________

Date of Birth ___________________ Relationship to insured ______________

Secondary insurance company ____

Policy holder name ____

Policy holder Date of birth____________ Policy holder address_________________________

Member ID # _______________________________ Group ID #_________________________

Relationship to insured ______________

Doctor Information Primary Care Physician ____

Phone _______________________________

Referring Physician ______________________________Phone_______________________
Specialty_________________________________

Race: choose one

___ **American Indian/Alaskan Native**
___ **Asian**
___ **Black or African American**
___ **Caucasian White**
___ **Multiracial**
___ **Native Hawaiian or other Pacific Islander**
___ **Refused/Declined**

Emergency Contact Info:

Name: ____
Relationship:____
Phone:____
Address:____

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Financial Policy

We are dedicated to providing you with the most outstanding and compassionate care. We believe that your understanding of our financial policies is an essential element of our open communication.

Patient Authorization for ALL PATIENTS:

-Unless other arrangements have been made in advance by yourself or your health coverage carrier, full payment for office services are due at the time of service. For your convenience, we accept VISA, MasterCard, American Express and Discover, as well as cash, or check. I understand that I am financially responsible for services in the office and that refunds from services charged on a credit card will be returned to the same credit card.

-I also understand that any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all cost and fees, including legal fees, relating to the collection of my debt. There will be a $30.00 returned check fee.

-I authorize my physician and Arthritis and Rheumatology Clinical Center of Northern Virginia, PLLC to photograph me for medically related documentation purposes. If my insurance changes, I am responsible for providing the most up to date information. I understand that failure to update insurance information may result in services charged directly to me.

-I am aware that if my plan requires a referral (most HMO plans require a referral from your PCP), I am responsible for providing the referral or I am financially responsible for non-covered services.

-I authorize and assign payment directly to the physician involved in my treatment and authorize release of medical information necessary to process the claim. I further understand I am financially responsible for charges not covered by my insurance.

-There can be significant variations amongst health plans and their coverage. In the event your health plan determines a service to be “not covered,” you will be responsible for the complete charge.

-For your convenience, we will bill your insurance company, but please note, any balances not paid within 45 days will become the responsibility of the patient.

-WORKMAN'S COMPENSATION:
For workman's compensation claims, please provide our office with your active claim number, carrier name, adjustor's name, phone number and pre-authorization. I understand that if for any reason my worker's compensation carrier denies payment for services that were rendered to myself, I will be financially responsible.

By signing below, I acknowledge that I have read and understand the financial policy of the practice and I agree to be bound by its terms. I authorize the release of any information necessary to my insurance company or its intermediaries to process this claim and all future claims.

Patient signature ___________________________________**Date** _________________

Patient Authorization for MEDICARE PATIENTS

I authorize the physicians and/or staff of Arthritis and Rheumatology Clinical Center of Northern Virginia, PLLC, to release to the social security administration, Health Care Financing Administration or its intermediaries or carriers, any information needed for this or any Medicare claim. I understand that I am financially responsible for any services deemed non-covered by Medicare.

Patient signature __________________________________ **Date** ____________________

Patient Authorization for PPO and HMO PATIENTS

I authorize the physicians and or staff at Arthritis and Rheumatology Clinical Center of Northern Virginia, PLLC, to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above named insurance company to pay directly to Arthritis and Rheumatology Clinical Center of Northern Virginia, PLLC the amount due for medical or surgical services. I understand that I am financially responsible for any services deemed non-covered by my insurance company.

Patient signature __________________________________**Date** _____________________

Privacy Officers: Dr. Mahsa Tehrani & Dr. Mahnaz Momeni: 703-734-2222

Office Policies

In our efforts to remain a modern medical practice, we strongly urge you to sign up for our free 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 free of charge to all of our patients, with the ultimate goal of enhancing your safety, security and communication with your provider.

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 online patient portal. Please allow up to a 72- hour turn around 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 refilled 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.

LABS & IMAGING RESULTS

For normal results, you will get a secure email through our portal that results are normal, and we will discuss them at your follow up visit. We will contact you for any abnormal results.

Please allow 48-72 hours for any general telephone or patient portal related questions.

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 24 hours notice will incur a $50 cancellation fee. Patients arriving more than 15 minutes late for their appointment may need to be rescheduled.

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.

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Patient Signature