



**PATIENT REGISTRATION**

**CURRENT MEDICATIONS**

Name of Medication:	Strength:	Directions:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**PHARMACY INFORMATION**

Name of Local Pharmacy: \_\_\_\_\_ Phone# \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name of Specialty Pharmacy: \_\_\_\_\_ Phone# \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

**NORTHERN VIRGINIA CENTER FOR ARTHRITIS, P.C.**

**PATIENT AUTHORIZATION AND ASSIGNMENT**

I, \_\_\_\_\_, hereby authorize Northern Virginia Center for Arthritis, P.C. to apply for benefits on my behalf for services rendered. I request that payment be made directly to Northern Virginia Center for Arthritis, P.C. I certify that the information provided regarding insurance coverage is true and accurate. I further authorize the release of any medical or other information for this or any related claims to my insurance companies. I permit a copy of this authorization and assignment to be used in place of the original. This will remain in effect until revoked by me in writing. I understand that I am responsible for all charges whether or not paid by said insurance. I agree to assume responsibility for all charges incurred should collection of this balance become necessary including court costs and attorney's fees. I also understand that failure to provide Northern Virginia Center for Arthritis with new insurance information that I may have within a timely manner will result in my personal financial responsibility.

\_\_\_\_\_

Patient or Guardian's Signature

\_\_\_\_\_

Date

**NORTHERN VIRGINIA CENTER FOR ARTHRITIS, P.C.**

**PRIVACY POLICIES**

Please sign below that you were offered a copy of our privacy policy notice.

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Patient's Name-(please print)

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Patient's Signature

Date

Please check the box if you give Northern Virginia Center for Arthritis permission to share your protected health information with other health care professionals.

Please check the box if you give Northern Virginia Center for Arthritis permission to leave messages on your answering machine regarding appointments, test results or other protected health information.

Please check the box if you give Northern Virginia Center for Arthritis permission to mail test results or other protected health information to you upon request.

My protected health information may be shared with the following peron(s):

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Privacy Officer's contact information

(703) 689-2050

**NORTHERN VIRGINIA CENTER FOR ARTHRITIS, P.C.**

**OFFICE POLICES**

- 1. We require 24 hour notification if you need to cancel your appointment. We reserve the right to charge a \$50.00 charge for new patient and a \$25.00 charge for established patients. Please make sure you update your phone numbers with the receptionist to receive your reminder call.**
- 2. All co-pays and balances must be paid and up to date before being seen by the physician. Insurance coverage is the patient's responsibility and any discrepancies or questions should be directed to the insurance company.**
- 3. For all patients with HMO insurance policies, you must present your referral to the receptionist upon signing in. If you do not have your referral, you will be asked to reschedule your appointment. We have a contract with the insurance companies and are not allowed to see the patient without the referral. We ask that you hand carry your referral. It is the responsibility of the patient to obtain their referral-NOT OUR OFFICE.**
- 4. All prescriptions for narcotics must be picked up and signed for. We can no longer mail these prescriptions. If someone other than yourself is picking up the prescription, they must have a SIGNED letter from you and a photo ID.**
- 5. Labs, x-ray reports and non-narcotic prescriptions may be picked up. Please give us advanced notice so that we can have them ready for you.**
- 6. If you require copies of your medical records a \$10.00 initial charge and .10 cents/page will apply.**
- 7. There will be a charge for any forms that need to be filled out by the physician, this includes but not limited to medical leave forms, long term care insurance or any insurance forms. The charge will depend upon the complexity of the forms. Please note: we do not fill out functionality or disability forms. We will send medical records.**
- 8. We do not fax or call to mail order pharmacies. If you use mail order pharmacies, you can come and pick up the prescription or get it at the time of your appointment. If you use a local pharmacy and need a refill, please have your local pharmacy fax the request to our office. Please allow 24-48 hours for the request to be returned to the pharmacy.**
- 9. Any inappropriate behavior in the office may lead to you being dismissed from our practice.**

**Thank you for your understanding.**

**Patient's Name Printed: \_\_\_\_\_**

**Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_**