NORTHERN VIRGINIA CENTER FOR ARTHRITIS

PLEASE PRINT

PATIENT REGISTRATION

Patient's Name:_____DOB:_____Sex:_____

Address:_____

_____

PLEASE CHECK THE BOX AFTER THE PHONE NUMBER THAT YOU WANT AS YOUR PREFERRED NUMBER

Home#( )_____[__]__Cell#( )_____[__]__Work#( )_____[__]_

Race:_____Ethnicity:_____Preferred Language:_____

Name of Primary Care Physician:_____Phone#_____

Name of Referring Physician:_____Phone#_____

Employer:_____

Employer's Address:_____

Marital Status:_____Spouse's Name:_____

Spouse's DOB:_____Spouse's Phone#_____

Emergency Contact's Name:_____Phone#_____

HEALTH INSURANCE COVERAGE: (To be completed by all patient-please note: WE DO NOT ACCEPT MEDICAID)

Primary Health Insurance Company Name:_____

Address:_____

ID#_____Group#_____

Subscriber's Name:_____DOB:_____Relationship to Patient:_____

Secondary Health Insurance Company Name:_____

Address:_____

ID#_____Group#_____

Subscriber's Name:_____DOB:_____Relationship to Patient:_____

REVERIFIED INFORMATION

Patient's Signature:_____Date:_____

NORTHERN VIRGINIA CENTER FOR ARTHRITIS

PLEASE PRINT

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

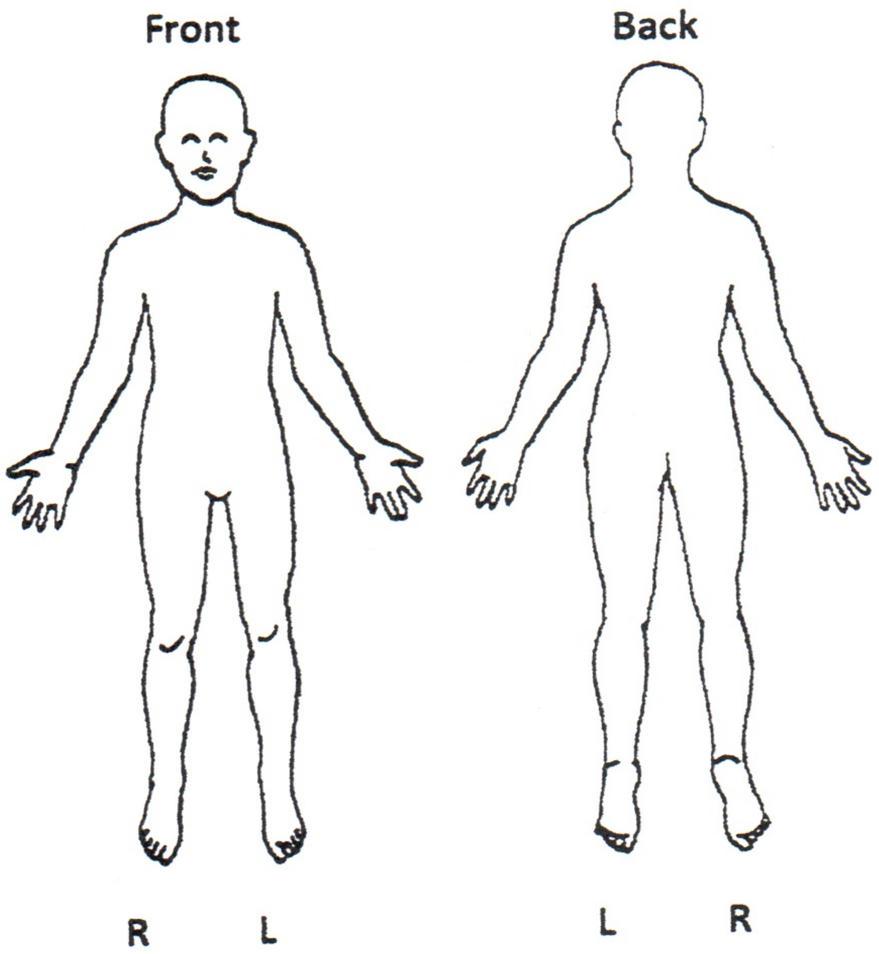
PLEASE PRINT

PATIENT QUESTIONNAIRE

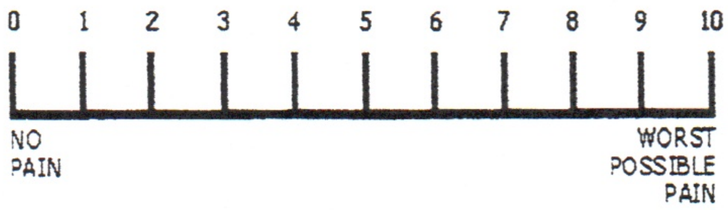
Patient's Name:_____ **Date:**_____

Chief Complaint-(reason for visit):_____

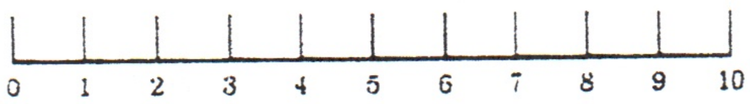
On the diagram below, mark the areas where you feel pain:



Pain level today-(circle number)



Stiffness level today-(circle number)



Your pain occurs: [ ] intermittent [ ] continuous [ ] occasional [ ] rare

Describe your pain: [ ] throbbing [ ] dull [ ] aching [ ] shooting [ ] stabbing [ ] burning

Is your pain: [ ] mild [ ] moderate [ ] severe [ ] unbearable

The pain has been occurring for:_____ [ ] days [ ] weeks [ ] months [ ] years

I have morning stiffness that lasts for:_____ [ ] minutes [ ] hours

I have tried the following medications for this problem in the past:_____

_____

Past Surgical History – (please list all surgeries with year they were preformed):_____

_____

_____

NORTHERN VIRGINIA CENTER FOR ARTHRITIS

PLEASE PRINT

PATIENT QUESTIONNAIRE

Past Medical History: - (Please check all that apply)

[ ] Headaches [ ] High blood pressure [ ] High cholesterol [ ] Heart disease [ ] Diabetes [ ] Cancer [ ] Arthritis

[ ] Stroke [ ] Thyroid disease [ ] Peripheral vascular disease [ ] Neurological disease [ ] Stomach ulcers

[ ] Hepatitis [ ] Asthma [ ] Depression [ ] Anxiety [ ] Lupus [ ] Anemia [ ] Glaucoma [ ] Lyme's disease

[ ] Gout [ ] Psoriasis [ ] Kidney disease [ ] HIV

Family History: -(Please check all that apply for each family member)

	Mother	Father	Sister	Brother	Other Family
Arthritis	[ ]	[ ]	[ ]	[ ]	[ ]
Anxiety/Depression	[ ]	[ ]	[ ]	[ ]	[ ]
Cancer	[ ]	[ ]	[ ]	[ ]	[ ]
Gout	[ ]	[ ]	[ ]	[ ]	[ ]
Heart Disease	[ ]	[ ]	[ ]	[ ]	[ ]
Lupus	[ ]	[ ]	[ ]	[ ]	[ ]
Neurological Disorders	[ ]	[ ]	[ ]	[ ]	[ ]
Osteoporosis/Osteopenia	[ ]	[ ]	[ ]	[ ]	[ ]
Psoriasis	[ ]	[ ]	[ ]	[ ]	[ ]
Thyroid Disease	[ ]	[ ]	[ ]	[ ]	[ ]
Vasculitis	[ ]	[ ]	[ ]	[ ]	[ ]

Social History:

Tobacco Use: [ ] Yes [ ] No _____per day

Alcohol Use: [ ] Yes [ ] No [ ] Socially [ ] Daily [ ] Weekly

Do you have problems with Drug or Alcohol use or dependency? [ ] Yes [ ] No

The above information is accurate to the best of my knowledge.

Patient's Signature:_____Date:_____

Northern Virginia Center for Arthritis, P.C.

OFFICE POLICIES

1. We require 24-hour notice if you need to cancel or reschedule your appointment. We reserve the right to charge $50.00 for new patient appointments and $25.00 for established patients. Please make sure your cell phone number and email address are up to date in order to receive confirmation text messages or emails. We kindly ask that you confirm your appointments.
2. All co-pays and balances must be paid in full before being seen for an appointment in the office.
3. Insurance coverage is the patient's responsibility. This includes coverage for telemedicine appointments. Any discrepancies or questions should be directed to the insurance company. Our office DOES NOT participate with any MEDICAID insurance plans, any product from the Exchange, or any Dual Medicare/Medicaid plans.
4. For patients with HMO insurance policies, you must present your referral upon checking in. Our contract with the insurance company states that we are not permitted to see a patient without a valid referral. We ask that the patient hand carry the referral to the appointment. Our office is NOT responsible for obtaining the referral.
5. All narcotic prescriptions are now required to be sent electronically. Please be advised that narcotic prescriptions will NOT be filled after hours by the on-call provider. The providers do check the PMP (Prescription Monitoring Program).
6. If you require copies of your medical records, you will need to provide a signed medical release. Charges for records are: a $10.00 initial charge plus $0.10/per page. Payments must be made before records will be released. Records released to doctors' offices will be sent without a charge, but a signed release is still required.
7. There will be a charge for any forms that need to be filled out by the provider. This includes, but is not limited to, medical leave forms, long term care insurance forms, and any other relevant medical forms. The charge depends on the complexity of the form. Please note, we DO NOT fill out disability forms. We will send medical records with a signed release.
8. Prior authorizations for medications and outside procedures can take several business days depending on the insurance plan. The office does not have control of how long the process takes. We are happy to offer samples, if available, while the approval is pending. We do not do prior authorizations for pain medications.
9. The office does offer a patient portal, Breeze. The portal is a great way to communicate with your provider and have access to some of your medical records. Please be advised that there may be a delay in a reply during evenings, weekends, holidays and if the provider is off. The portal is NOT to be used for emergencies, but for routine questions, results and refills. If you would like to have access to the portal, please make sure we have your email address and have the office send you an invitation.

Print Patient's Name:_____

Signature:_____Date:_____

Updated 01/2022

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 if I fail to provide Northern Virginia Center for Arthritis, P.C. with any new insurance information that I may have, within a timely manner, it 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.

Patient's Name (please print)_____

Patient's Signature_____ Date_____

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

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

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

_____

_____

_____

_____

Privacy Officer's contact information
(703) 689-2050

Updated 01/2022