The Arthritis Clinic of Northern Virginia, P.C.

1635 N. George Mason Dr. Suite 220, Arlington, VA 22205

Phone (703) 525-3069 **Fax** (703) 525-3850 **Email**: arthclinic@gmail.com

PHILLIP W. KEMPF, MD, FACR

DR. SAIRA BILAL, MD FACR

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:

Mailing address:	City:	State:	ZIP code:

Home Phone:	Cell Phone:	Work Phone:

EMAIL:

Date of Birth:	Age:	Gender:		Marital Status:				
		☐ M	☐ F	☐ single	☐ married	☐ divorced	☐ widowed	☐ other

Social Security no.:	Employer Name and Address:

Employment Status:

☐ Full Time	☐ Part Time	☐ Not Employed	☐ Retired	☐ Student

If patient is a minor, please give parent/guardian names and specify relation to patient:

INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Primary Insurance:	Name of Policy Holder/Subscriber:	
Subscriber ID:	Group Number:	Subscriber's date of birth:

Primary Insurance Address:

Relationship to Subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other, please specify:

SECONDARY INSURANCE

Name of Secondary Insurance (if applicable):	Name of Policy Holder/Subscriber:	
Subscriber ID:	Group Number:	Subscriber's Date of Birth:

Secondary Insurance Address:

Relationship to Subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other, please specify:

RESPONSIBLE PARTY (GUARANTOR)

The guarantor is the person responsible for the patient's bill. **If the patient is responsible for his/her own bill, please skip the next section.** If the patient is a minor (under the age of 18), the parent or guardian bringing the patient to the visit is usually the guarantor for the patient.

Guarantor's last name:	Guarantor's first name:	Guarantor's middle name:

Guarantor's mailing address, if different from patient:	City:	State:	ZIP:

Guarantor's phone number:	Relationship to patient:	Guarantor's date of birth:	Guarantor's Social Security No.:

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PHARMACY INFORMATION

LOCAL PHARMACY	
Name of Local Pharmacy	Address/Location
Pharmacy Phone Number:	Pharmacy Fax Number:
SPECIALTY/MAIL-ORDER PHARMACY	
Name of Specialty Pharmacy:	Address
Pharmacy Phone Number:	Pharmacy Fax Number:

IN CASE OF EMERGENCY CONTACT

Name of emergency contact person:		Relationship to patient:	
Home Phone:	Cell Phone:	Work Phone:	
EMAIL:			
Home Address:	City:	State:	Zip:

OTHER MEDICAL PROVIDERS

PRIMARY CARE PHYSICIAN	
Name of Primary Care Doctor:	Address/Location:
Phone:	Fax:
REFERRING PROVIDER (IF APPLICABLE)	
Name of Referring Provider:	Address/Location:
Phone:	Fax:

PLEASE LIST ALL CURRENT MEDICATIONS

PLEASE LIST ALL ALLERGIES

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FINANCIAL POLICY, ASSIGNMENT INFORMATION, AND RELEASE OF INFORMATION

I authorize release of any information acquired in the course of treatment necessary to complete and file medical claims to my insurance company or Medicare on my behalf. I hereby acknowledge financial responsibility for costs of services rendered for me or for the person whose account I am acting as guarantor. I authorize (assign) any insurance or Medicare benefits to be paid directly to Arthritis Clinic of Northern VA, PC or its assignees. 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 and assignment will be in force for all future services by practitioners from this office.

____ ________________________

Signature of Patient or Patient's guardian/representative Date

____

Printed name of person signing above

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand that as part of my health care, Arthritis Clinic of Northern VA, PC originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and 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 Clinic of Northern VA, PC 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 available in the waiting room area. I understand that Arthritis Clinic of Northern VA, PC 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 restrictions as to how my health information may be used or disclosed.

I have had an opportunity to receive and review the *Notice of Privacy Practices* of Arthritis Clinic of Northern VA, PC

____ ________________________

Signature of Patient or Patient's guardian/representative Date

____

Printed name of person signing above

E-PRESCRIBING INFORMATION & CONSENT

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe Program. These include:

- **Formulary and benefit transactions** - Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Arthritis Clinic of Northern Virginia, PC can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes. *Understanding all of the above, I hereby provide informed consent to that Arthritis Clinic of Northern Virginia, PC to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.* ***I understand that it is my responsibility to provide full and accurate Pharmacy information; failure to do so will likely result in delayed or unfilled prescriptions.***

____ ________________________

Signature of Patient or Patient's guardian/representative Date

____

Printed name of person signing above