NOVA Arthritis

821 S King St., Suite L, Leesburg, VA 20175 • 8100 Boone Blvd., Suite 300, Vienna, VA 22182 • (703) 988-4142 • www.nova-arthritis.com

Patient Registration Date _____

First Name _____ Last Name _____ Middle Initial ___

Birth Date _____/_____/_____ Age_____ Sex ___M ____F Email Address _____

Primary Address_____ Occupation _____

City _____ State _____ Zip Code _____ Marital Status: ___S ___M___D___W

Home Phone _____ Mobile Phone _____ Work Phone_____

Pharmacy _____ Address _____ Ph_____

Referral Information

Reason for Visit: _____ Referring Provider: _____

Primary Care Physician_____ Phone_____

Responsible Party:

If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

First Name _____ Last Name _____ Middle Initial ___

Birth Date _____/_____/_____ Relationship to Patient _____ Contact Phone _____

Primary Address (if different from patient):

Emergency Contact:

First Name _____ Last Name _____ Middle Initial ___

Contact Phone _____Relationship to Patient _____

Insurance Information:

Primary Insurance _____

Card Holder's Name _____ Card Holder's Birth Date ____/_____/_____

Identification Number _____ Group Number _____ Effective Date _____

Address _____ City _____ State _____ Zip Code _____ Phone _____

Secondary Insurance _____

Card Holder's Name _____ Card Holder's Birth Date ____/_____/_____

Identification Number _____ Group Number _____ Effective Date _____

Address _____ City _____ State _____ Zip Code _____ Phone _____

Patient Contact Preferences:

Home Phone: It's ok to leave a message_____

Cell Phone: It's ok to leave a message _____

Work Phone: It's ok to leave a message _____

Written Communications:

Okay to send written to home address _____

Okay to send written to Email _____

Do you give the office of NOVA Arthritis permission to discuss your medical information with family members? YES_____ NO_____

If Yes, Which Family Member? _____Signature_____

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Patient Financial Responsibility Form

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the patient, to check with your insurance company regarding your coverage. It is your responsibility to know your individual coverage. Failure to comply could result in you, the patient, being responsible for all costs incurred. Please remember, your insurance policy is between you and your insurance company, not between your doctor and your insurance company.

We collect copays and against deductibles at the time of service. To assist you in finding out what coverage you have, feel free to ask for assistance in finding phone number or addresses of your insurance company. Many insurance companies today need referral forms from a primary care physician or group. If your insurance meets this requirement, it will be your responsibility to furnish this referral at the time of service. Failure to provide correct insurance information or a referral may require you to reschedule your appointment and/or accept full responsibility for payment. Some insurances state you cannot go out of network. Many companies have instituted a mandatory second opinion program, and these are changing day by day. We cannot keep up with the changes and are often unaware of them until it is too late.

I have read the financial policy statement above and understand that if I do not provide correct and updated insurances or referrals (if a referral is required for your plan) for any date of service provided to me, I may be responsible for any and all charges incurred thereof. I understand that failure to provide current insurance information will result in being considered self-pay. I understand that failure to pay any balance in a timely manner may result in termination of relationship. I understand that failure to pay any outstanding balance in full will result in my account being forwarded to a collection company with fees added as allowed. I also understand that that I am required to give 24 hours' notice when canceling appointments and if I cancel my appointment without a minimum of 24 hours' notice prior to my appointment time I am subject to a $50 fee for my missed appointment that is patient responsibility and will not be filed with insurance.

Printed Name _____ **Signature** _____ **Date**_____

HIPPA and Privacy Policies

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This notice summarizes our duties and your rights concerning your protected health information. We are required to abide by the terms of our notice that is currently in effect under the Health Insurance Portability and Accountability Act. I have reviewed the HIPPA and Privacy Policies.

Printed Name _____ **Signature** _____ **Date**_____

Relationship to Patient: _____

Assignment of Benefits and Records Release

I hereby authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance, and other health plans to NOVA Arthritis and Rheumatology Specialists, LLC of any medical benefits payable to me for the services provided at NOVA Arthritis and Rheumatology Specialists, LLC. I also authorize the release of all medical information necessary to process insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claims processing or as long as dictated by payor. I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance deemed patient responsibility by the insurance company. I understand it is my responsibility to pay the balance in full if the insurance information provided proves false or otherwise ineffective. I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to appointment. I will be responsible for the unpaid balance due any bills if this is not done. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection.

X_____

Patient Signature or Signature of Parent or Guardian Date:

Medicare Patients ONLY – Lifetime Signature on File and Lifetime Consent

I request that payment of authorized Medicare benefits be made on my behalf to NOVA Arthritis and Rheumatology Specialists, LLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services. I request that payment of authorized Medigap or Secondary insurance benefits be made on my behalf to NOVA Arthritis and Rheumatology Specialists, LLC. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

X_____

Patient Signature Date:

NOVAArthritis and Rheumatology Specialists
Sepehr Mesdaghinia, MD

Medication List

Name:_____ Date of Birth (MM/DD/YY):_____

MEDICATION	DOSAGE	FREQUENCY

NOVA Arthritis and Rheumatology Specialists
Sepehr Mesdaghinia, MD

FAMILY AND SOCIAL HISTORY

NAME _____ DATE OF BIRTH (mm/dd/yy) _____

MEDICAL AND FAMILY HISTORY

(Please check those that apply. For "Other", please fill in the information.)

	SELF	MOTHER	FATHER	OTHER
RHEUMATOID ARTHRITIS				
GOUT				
LUPUS				
PSORIASIS				
OTHER AUTOIMMUNE DISEASE				
CANCER				
CARDIOVASCULAR DISEASE				

SOCIAL HISTORY

SMOKING	☐ YES	☐ NO	IF YOU SAID "YES", HOW MANY PACKS PER DAY?	
DRINKING	☐ YES	☐ NO	IF YOU SAID "YES", HOW MANY DRINKS PER WEEK?	

SIGNATURE _____ DATE (mm/dd/yy) _____