ARTHRITIS &
REHABILITATION
THERAPY
SERVICES

*A Division of Arthritis and Rheumatism Associates, P.C.*

A COMPREHENSIVE REHABILITATION CENTER

Dear New Patient,

Welcome to Arthritis and Rehabilitation Therapy Services. We are glad that you and your physician have entrusted your physical therapy care to us, and we look forward to helping you achieve your goals.

Enclosed, you will find forms related to your medical history, insurance information and demographics. Please complete the forms in advance and bring them with you to your Initial Evaluation appointment.

Cancellation or "no show" of a new patient appointment is subject to a $50.00 fee and that of a follow-up appointment is subject to a $25.00 fee if notice is not provided at least 24 business hours prior to the appointment. If you are unable to make your first appointment, you may be asked to reschedule the full sequence of visits, as your first visit requires more time than subsequent visits. If you are more than fifteen (15) minutes late to ANY appointment, please be advised that your visit may be canceled or limited, to adequately accommodate other patients and the therapist's schedule. To achieve the best results with therapy, we kindly ask that you make a concerted effort to keep your appointments and to be on time.

For your first appointment, please remember to:

- Bring your updated insurance card(s).
- Bring the applicable physical therapy referral and/or prescription from your physician. If you do not have a referral or prescription, you may be asked to reschedule your visit.
- Be prepared to pay any applicable co-pays. Please check with your insurance company prior to your first visit.
- Inform the receptionist and therapist if you have any metal implants (i.e. pacemaker, joint replacement, etc.)
- Wear comfortable clothing and shoes. Please make sure that the body part to be treated is accessible.
- Bring a translator if you do not speak English.
- Children are NOT ALLOWED in the treatment area.
- Videotaping or recording is prohibited.
- Cell phone use is not permitted in the clinic.

We look forward to seeing you at your Initial Evaluation.

Sincerely,
Matthew Reed, MPT & Joshua Costa, DPT
Executive Directors of Rehabilitation

ARTHRITIS AND RHEUMATISM ASSOCIATES, P.C.

*Osteoporosis Assessment Center • Arthritis and Rehabilitation Therapy Services*
*The Center for Rheumatology and Bone Research • Arise Infusion Therapy Services*
*Divisions of Arthritis and Rheumatism Associates, P.C.*


2730 University Blvd. West, Ste 714, Wheaton, MD 20902
14995 Shady Grove Road, Ste 320, Rockville, MD 20850
5454 Wisconsin Avenue, Ste 600, Chevy Chase, MD 20815
2021 K Street, NW, Ste 310, Washington, D.C. 20006


# Patient Registration

**Call Center: 301-942-7600**

PATIENT NAME LAST FIRST M | DATE OF BIRTH | BIRTH SEX ☐ M ☐ F

HOME ADDRESS | APT NO. | CITY | STATE | ZIP

EMAIL ADDRESS:

HOME PHONE | CELL PHONE | PATIENT STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER :

PREFERRED PRONOUNS
☐ HE, HIM, HIS ☐ SHE, HER, HERS ☐ THEY, THEM, THEIRS ☐ ZE, HIR ☐ DECLINED ☐ OTHER

GENDER IDENTITY
☐ M ☐ F ☐ MALE-TO-FEMALE ☐ FEMALE-TO-MALE ☐ GENDERQUEER ☐ DECLINED ☐ OTHER

SEXUAL ORIENTATION
☐ HETEROSEXUAL/STRAIGHT ☐ BISEXUAL ☐ HOMOSEXUAL/LESBIAN/GAY ☐ DECLINED ☐ OTHER

RACE________________________________ ETHNICITY: ☐ HISPANIC/LATINO ☐ NON-HISPANIC/LATINO

PREFFERED LANGUAGE___________________________________

FINANCIALLY RESPONSIBLE PARTY ☐ PATIENT ☐ SPOUSE ☐ PARENT ☐ OTHER: | RESPONSIBLE PARTY'S NAME | CELL PHONE

RESPONSIBLE PARTY'S ADDRESS | HOME PHONE

DO YOU HAVE AN "ADVANCE MEDICAL DIRECTIVE"? | MAY WE KEEP A COPYON FILE?

**IN CASE OF EMERGENCY, PLEASE NOTIFY:**
Name______________________________________________
First Middle Last
Address____________________________________________

Relationship__________________
Home Phone __________________
Work Phone __________________

PRIMARY INSURANCE COMPANY | POLICY/ID NO. | GRP. NO/SERV. CODE

PRIMARY INSURANCE COMPANY ADDRESS
__________________________________________________Phone ______________
Street Suite # City State Zip
Name of Policyholder______________________________ ☐ Male ☐ Female Relationship________________

POLICYHOLDER'S DATE OF BIRTH | POLICYHOLDER'S ADDRESS

SECONDARY INSURANCE COMPANY | POLICY/ID NO. | GRP. NO/SERV. CODE

SECONDARY INSURANCE COMPANY ADDRESS
__________________________________________________Phone ______________
Street Suite # City State Zip
Name of Policyholder______________________________ ☐ Male ☐ Female Relationship________________

POLICYHOLDER'S DATE OF BIRTH | POLICYHOLDER'S ADDRESS

IS THIS CONDITION RELATED TO: ☐ EMPLOYMENT ☐ AUTO ☐ OTHER ACCIDENT

ARA does not treat conditions related to Employment, Auto or Other Accident. Please contact the office at 301-942-7600.

**PLEASE READ AND SIGN**

**Medicare Patients Only**

"I request that payment of authorized Medicare benefits be made on my behalf to Arthritis & Rheumatism Associates, P.C. for any services furnished to me by that physician or supplier. 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 these benefits or the benefits payable for related services."

Signature of policyholder or beneficiary___________________________________Date ______________________

**Other Insurance**

I hereby authorize Arthritis & Rheumatism Associates, P.C. to apply for benefits on my behalf for covered services rendered by Arthritis & Rheumatism Associates, P.C. and request that payments from ______________________________insurance company for covered services be made directly to Arthritis & Rheumatism Associates, P.C. at their payment address.

Furthermore, I agree to designate Arthritis & Rheumatism Associates, P.C. to receive payment directly from the above-named insurance company in the event I file a claim for benefits myself and to forward within 15 business days any payments I may receive from the above-named insurance company for any services rendered by Arthritis & Rheumatism Associates, P.C.

Signature of policy holder or beneficiary___________________________________Date _______________

I certify that the information I have reported with regard to my insurance coverage and benefits is correct and further authorize the release of any necessary information, including protected health information, for this or any related claim to any billing agent acting on behalf of Arthritis & Rheumatism Associates, P.C. I permit a copy of this authorization to be used in place of the original and I understand that this authorization may be revoked by me at any time by submitting a written revocation.

Signature of policy holder or beneficiary_____________________________________Date _______________

**Medigap Patients Only**

"I request that payment of authorized Medigap benefits be made on my behalf to Arthritis & Rheumatism Associates, P.C. for any services furnished to me by that provider of services or supplier. I authorize any holder of Medicare information about me be released to __________________________________________ any information deeded to determine these benefits payable for related services." (NAME OF MEDIGAP INSURER)

Signature of policyholder or beneficiary____________________________________Date _______________

ARTHRITIS
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# FINANCIAL POLICY STATEMENT

Welcome to Arthritis and Rheumatism Associates, P.C. (ARA). We are pleased to have you as a patient and we are committed to providing you with the best medical care possible. In order to assist you in receiving the maximum benefits allowable by your insurance, we ask that you read and sign this statement. We must emphasize that as medical care providers, our relationship is with you and not your insurance carrier. As a courtesy to you, we may file your claim; however you are responsible for charges incurred from the date services are provided unless our contractual agreement with your carrier states otherwise. Because of the ongoing growth and change in available health care plans, it is imperative that you understand your benefits and responsibilities prior to being seen at ARA.

## COST-SHARE RESPONSIBILITY

Many insurance carriers require patients to share the cost of their medical services through copay, coinsurance, or deductible.

Health insurance cost-share definitions are as follows:

**Copay** – a fixed dollar amount that a patient is required to pay per visit.

**Coinsurance** – a fixed percentage of the final dollar amount that patients are required to pay for a medical service.

**Deductible** – a fixed dollar amount that patients are required to pay first before their insurance carrier begins to pay for their medical service.

Patient cost-sharing is an integral part of the health insurance benefit plan for both federal and commercial insurance carriers. As a patient, you are expected to understand your healthcare benefits and cost-share amounts associated with your plan. ARA will make every attempt to collect all patient responsibility payments as determined by your insurance. Your insurance should provide you with an explanation of benefit (EOB) after a medical service claim is processed. All copayments are due at the time of service. Coinsurance, deductible, and any outstanding balance will be billed to you.

A plan is considered out-of-network if there is no contractual agreement with the health plan and ARA. If the health plan's out-of-network coverage is less than the ARA's acceptable rate, ARA reserves the right to balance bill a patient.

## MEDICARE PART B

ARA participates with Medicare and accepts assignment. We will file your claim and ask you to pay any deductible you may owe plus your 20% coinsurance at the time of checkout. If you have a secondary insurance, we will file the claim for you, and you will be billed for any remaining balance. In order to receive a non-covered supply or service, you will be required to sign a Medicare waiver (Advance Beneficiary Notice or ABN) and pay in full. ARA does not participate with any Medicare Advantage Plans, with the exception of Johns Hopkins Medicare Advantage HMO and PPO. If you have a Medicare Advantage HMO plan, you will not have any out of network benefits. If you are covered by a Medicare Advantage PPO plan that gives you out of network benefits, you may have to pay any deductible and coinsurance payments due as determined by each individual Medicare Advantage Plan. If you are seeking services from Arthritis Rehabilitation Therapy Services (ARTS), Medicare will not pay for outpatient physical therapy while concurrently receiving home care services. In order for Medicare to cover your physical therapy at ARTS, you must discontinue ALL home care services (physical, occupational or speech therapy, nursing, home health aide, social work). If you do not, Medicare will automatically choose to pay for the home care services only, and you will be financially responsible for your outpatient physical therapy at ARTS.

Patient Name: ____________________________

**CareFirst Blue Cross Blue Shield**

ARA is a participating provider with CareFirst of the National Capital Area and CareFirst of Maryland. Our contract with CareFirst includes all products: HMO (BlueChoice), Point of Service, Federal Employee, PPO, Blue Card, National Account and Indemnity Plans. The HMO plan requires that you obtain a referral to see a specialist which must be presented at check-in. Otherwise you will need to sign a waiver agreeing to pay for all services rendered.

**PPO, POS and HMO Plans**

Currently, ARA participates with Aetna HMO and PPO, CIGNA, Multiplan, PHCS and Priority Partners. All PPO and HMO patients are required to pay their copayment at check-in. Those patients whose plan requires a referral to see a specialist must present it at check-in or sign a waiver agreeing to pay for all services rendered. Those using a POS benefit will be required to sign a referral waiver and to pay any deductible or coinsurance their plan requires. *ARA will be in violation of our contracts if we fail to collect amounts you are contractually obligated to pay.*

**Workers' Compensation**

ARA does not accept new patients with work-related injuries who will be using workers' compensation to cover the cost of their care. In the event that an established patient's visit is due to a work-related injury, the patient must provide this office with complete billing information for the workers' compensation carrier prior to treatment. We will need: active claim number, carrier name, adjustor's name, phone number and pre-authorization by the insurance company for your care. If the case is being contested by an employer, then it will not qualify as a workers' compensation case until an independent medical examiner or the court rules. In this circumstance we will bill the patient's health insurance carrier. If a patient does not have health insurance, payment will be required at the time of service.

**Liability Cases/Auto Accidents**

ARA will not bill the personal injury protection (PIP) portion of your auto insurance coverage. Physicians will treat patients injured in personal injury or auto accident cases, but the patient's own health insurance carrier will be billed for all services rendered. In the event that a patient does not have health insurance (or their health insurance denies the claim), payment will become the responsibility of the patient.

**FMLA and Disability Forms**

ARA physicians do not fill out FMLA forms nor do they provide disability assessments or supporting documents for patients unless they have been seen for at least 6 visits and / or have been a patient of the practice for at least one year. Even beyond this time frame, your physician may determine that it is more appropriate for your primary care provider or other specialist to manage your disability application and forms. ARA physicians do not have the experience or training to prepare disability documents from a legal perspective. If your physician provides disability documents, the information used will be primarily based on objective information obtained from physical examination, diagnostic studies, and laboratory findings which may not support a disability claim. You will also be charged a $25 fee if your physician completes the disability documents. You may be better served if you discuss with your attorney whether disability documents should be obtained from another specialist who performs disability evaluations on a regular basis.

**All Other Insurance (Including Secondary/Tertiary)**

As a courtesy to you, ARA will file your primary insurance claim once, provided that we have complete insurance information at the time of service. We do not file secondary or tertiary insurance claims unless we are contractually obligated to do so. Depending on the carrier, you may be asked to pay your balance in full or pay any deductible or copayment due. Any balances not paid by the patient's insurance company/companies within 45 days will be charged directly to the patient.

Patient Name: ____________________________

**Self-Pay**

ARA offers a self-pay rate to patients who have no health insurance or have non-participating health insurance. The self-pay amount owed is expected to be paid in full at the time of service as ARA will not be submitting a claim to an insurance carrier. Self-pay patients are responsible for ancillary service charges such as laboratory, radiology, or any other services performed by ARA providers on the date of service.

**Non-Sufficient Funds (NSF) Policy**

A $50 NSF fee will be added to any patient's account that is returned by our bank for non-sufficient funds.

**No Show and Cancellation Policy**

We request that cancellations or scheduling changes be made during clinic hours no later than the last business day prior to your appointment. If you are a new patient to our practice, the missed appointment fee is $100. If you are an established patient of the practice, the missed appointment fee is $25. In order to reschedule your missed appointment, you will be required to pay the missed appointment fee.

If you have an appointment with Arthritis Rehabilitation Therapy Services (ARTS) the new patient missed appointment fee is $50 and the follow up missed appointment fee is $25.

**Assistance**

Our Business Office staff is available to assist you with any special concerns or questions. Please feel free to call (301) 942-3126 for personal attention.

**Responsibility**

Failure to disclose a change in insurance coverage or failure to disclose another (primary, secondary, or tertiary) insurance coverage will not absolve the patient of responsibility for all charges, and may also be grounds for dismissal from the practice.

Patients are responsible for any outstanding balances. In the event a patient's account is turned over (for collections) or (to a third party), the patient will be responsible for any and all collection costs, interest, Attorney's fees and Court costs.

I have read, understand and agree to abide by the policies of ARA as stated in this document.

________________________________ ________________

**Signature** **Date**

________________________________

**Print Name**

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14995 Shady Grove Road, Ste 320, Rockville, MD 20850
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2021 K Street, NW, Ste 310, Washington, D.C. 20006

# MEDICAL RECORDS RELEASE FORM

Patient Name: ______________________________ Date of Birth: ______ / ______ / ____________
Address: ______________________________ City: ______________________________
State: ____________________ Zip Code: ____________________ Phone #: ______________________________

☐ I authorize Arthritis & Rheumatism Associates, P.C. (ARAPC) to **use/disclose the following information to**:

☐ Myself ☐ See additional designee(s) attached

______________________________
Name of Provider / Facility / Person(s)

______________________________
Address

______________________________
City / State / Zip Code

(_____) - _____ - ______ (_____) - _____ - _______
Phone Number Fax Number

☐ I authorize Arthritis & Rheumatism Associates, P.C. (ARAPC) to **receive the following information from**:

______________________________
Name of Provider / Facility / Person(s)

______________________________
Address

______________________________
City / State / Zip Code

(_____) - _____ - ______ (_____) - _____ - _______
Phone Number Fax Number

**RECORDS TO BE RELEASED:**

☐ **ARAPC Records ONLY** ☐ **Include Records from Outside Providers**

| | | | | | |
|---|---|---|---|---|---|
| Progress Notes: | ☐ Most Recent | ☐ From | ______________ | to ______________ | ☐ All |
| Labs: | ☐ Most Recent | ☐ From | ______________ | to ______________ | ☐ All |
| Radiology: | ☐ Most Recent | ☐ From | ______________ | to ______________ | ☐ All |
| DEXA: | ☐ Most Recent | ☐ From | ______________ | to ______________ | ☐ All |
| EMG: | ☐ Most Recent | ☐ From | ______________ | to ______________ | ☐ All |
| Physical Therapy: | ☐ Most Recent | ☐ From | ______________ | to ______________ | ☐ All |
| Other: | | | | | |

**PURPOSE(S) FOR THIS REQUEST:**

☐ Referred to Outside Provider ☐ Changing Physicians ☐ Physician's Request ☐ Personal Use
☐ Insurance Purposes ☐ Legal Purposes ☐ Moving ☐ Employer's Request
☐ Other: ______________________________

____ Initials I understand that the person(s) (or practice) I am authorizing to use/disclose my protected health information may charge a third party for doing so.

____ Initials I understand that I may refuse to sign this authorization and that if I do, it will not affect my ability to obtain treatment, payment, or eligibility for benefits and that I may inspect or copy any information used or disclosed under this authorization. If I refuse to sign this form, the practice cannot use or disclose my protected health information for purposes outside TPO. (Treatment, Payment, and healthcare Operations)

____ Initials I understand that if the party receiving this information is not a healthcare provider or health plan subject to the federal privacy regulations that the information described above may be re-disclosed and no longer protected by the privacy regulations.

____ Initials I understand that I may revoke this authorization in writing at any time except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Official at 2730 University Boulevard West, Suite 310, Wheaton, MD 20902.

By signing this authorization it becomes effective immediately and will expire once the request has been completed. Every new request thereafter will require a new authorization form to be completed, per our practice policy.

______________________________ ______________________________
Signature of Patient or Personal Representative Date

______________________________ ______________________________
Print Patient Name or Personal Representative Name Relationship to Patient

ARTHRITIS
AND
RHEUMATISM
ASSOCIATES, P.C.

# MDHAQ

DATE:________________________ Primary Care Physician: ________________________

NAME:________________________ Date of Birth: ________________________

Email Address: ________________________ Preferred Contact Method: ________________________

**This questionnaire includes information not available from blood tests, X-rays, or any source other than you. Please try to answer each question. There are no right or wrong answers. Please answer exactly as you think or feel. Thank you.**

Please check (✓) the **ONE** best answer for your abilities at this time:

| **OVER THE PAST WEEK,** were you able to: | Without **ANY** difficulty | With **SOME** difficulty | With **MUCH** difficulty | **UNABLE** to do |
|---|---|---|---|---|
| Dress yourself, including tying shoelaces and doing buttons? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Get in and out of bed? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Lift a full cup or glass to your mouth? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Walk outdoors on flat ground? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Wash and dry your entire body? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Bend down to pick up clothing from the floor? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Turn regular faucets on and off? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Get in and out of a car, bus, train, or airplane? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Walk two miles? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Participate in sports and games as you would like? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Get a good night's sleep? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Deal with feelings of anxiety or being nervous? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Deal with feelings of depression or feeling blue? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |

**2. Pain Scale**

How much pain have you had because of your condition **OVER THE PAST WEEK?** Please indicate below how severe your pain has been:

**NO PAIN** ○ 0 ○ 0.5 ○ 1 ○ 1.5 ○ 2 ○ 2.5 ○ 3 ○ 3.5 ○ 4 ○ 4.5 ○ 5 ○ 5.5 ○ 6 ○ 6.5 ○ 7 ○ 7.5 ○ 8 ○ 8.5 ○ 9 ○ 9.5 ○ 10 **PAIN AS BAD AS IT COULD BE**

**3. Patient Status**

Considering all the ways in which illness and health condition may affect you at this time, please indicate below how you are doing:

**VERY WELL** ○ 0 ○ 0.5 ○ 1 ○ 1.5 ○ 2 ○ 2.5 ○ 3 ○ 3.5 ○ 4 ○ 4.5 ○ 5 ○ 5.5 ○ 6 ○ 6.5 ○ 7 ○ 7.5 ○ 8 ○ 8.5 ○ 9 ○ 9.5 ○ 10 **VERY POORLY**

**4. Skilled Nursing Facility**

Are you currently staying in a skilled nursing facility? Yes ☐ No ☐

**5. Home Health Care Services**

Are you currently receiving Home Health Care Services? Yes ☐ No ☐

**6. Clinical Trials**

Are you interested in learning about **participation** in our clinical trials program? Yes ☐ No ☐

ARTHRITIS & REHABILITATION THERAPY SERVICES

*A Division of Arthritis and Rheumatism Associates, P.C.*

A COMPREHENSIVE REHABILITATION CENTER

# ARTS MEDICAL HISTORY

**Patient Name:** ________________________________________

**Patient DOB:** ________________________________________

| | | COMMENTS | P.T. Use |
|---|---|---|---|
| 1. Do you have a pacemaker or an electronic implant | Yes☐No☐ | | U, E |
| 2. Have you been diagnosed with a carotid sinus or cervical ganglia | Yes☐No☐ | | U |
| 3. Have you been diagnosed with a cardiac or pulmonary disorder | Yes☐No☐ | | T, E |
| 4. Do you have a history of decreased circulation or vascular insufficiency | Yes☐No☐ | | U, T |
| 5. Do you have a history of a Deep Vein Thrombosis (DVT) | Yes☐No☐ | | U |
| 6. Do you have a history of a Thrombophlebitis | Yes☐No☐ | | U |
| 7. Do you currently have active bleeding | Yes☐No☐ | | U, E |
| 8. Have you been diagnosed with an Aortic Aneurysm | Yes☐No☐ | | T |
| 9. Have you ever been diagnosed with Phlebitis | Yes☐No☐ | | E |
| 10. Do you have a history or diagnosis of Meningitis | Yes☐No☐ | | T |
| 11. Have you ever been diagnosed with a Sei ure Disorder | Yes☐No☐ | | E |
| 12. Do you have a history of Cancer or Tumors | Yes☐No☐ | | U, T, E |
| 13. Do you have a history of decreased sensation in any part of your body | Yes☐No☐ | | U |
| 14. Have you ever been diagnosed with osteomyelitis | Yes☐No☐ | | E |
| 15. Have you recently suffered a sprain, strain, fracture, subluxation, dislocation or inflammation | Yes☐No☐ | | T |
| 16. Have you been diagnosed with Rheumatoid Arthritis | Yes☐No☐ | | T |
| 17. Have you ever had a spinal surgery | Yes☐No☐ | | T |
| 18. Have you ever been diagnosed with Spondylolistheses | Yes☐No☐ | | T |
| 19. Do you currently have Temporomandibular/Jaw pain | Yes☐No☐ | | T |
| 20. Have you ever been diagnosed with vertebral instability | Yes☐No☐ | | T |
| 21. Have you ever been diagnosed with a bone or joint disease | Yes☐No☐ | | T |
| 22. Do you have a history of a Hiatal Hernia | Yes☐No☐ | | T |
| 23. Do you have a history of Osteoporosis | Yes☐No☐ | | T |
| 24. Are you currently pregnant or do you plan on becoming pregnant while in physical therapy | Yes☐No☐ | | U, T, E |
| 25. Do you have any superficial implants | Yes☐No☐ | | U, E |
| 26. Do you currently have an infection | Yes☐No☐ | | U |
| 27. Other relevant medical history Add comments | Yes☐No☐ | | |

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# AUTHORIZATION TO RELEASE INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996 (HIPAA), in order for your physician or his/her staff to discuss your medical and/or financial information with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode, or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I DO authorize the Practice to release any or all information to the following individuals:

| Name | Relationship |
|---|---|
| ______________________ | ______________________ |
| ______________________ | ______________________ |
| ______________________ | ______________________ |

Patient Signature ______________________ Date ______________________

Revised 5/2021

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# ARA PATIENT CODE OF CONDUCT

**Cell Phones/Electronic Devices**: Cell phones and electronic devices are permitted in the office but must be turned to silent or vibrate. Phone conversations, video chat, and live-stream are prohibited while in the office. Headphones must be worn while using a cell phone or electronic device for listening to music, watching videos, etc.

**Photographs/Recording:** Photos, Audio and Video recording, using any electronic device, is strictly prohibited.

**Masks**: Masks are required to be worn over the nose and mouth by all patients and visitors while in the office. Mask may be medical grade or cloth. Mask removal is permitted only for taking oral medications, eating, and drinking. Masks must be promptly replaced after eating and drinking.

**Children under 18 years:** All children under 18 years old must be accompanied by an adult. Children may not be left alone without adult supervision in any area of the office and are not allowed in treatment areas, including but not limited to, the infusion, physical therapy, radiology departments. Patients under 18 years old must be accompanied by an adult.

**Privacy**: We ask that you respect the privacy of other patients. All patients must remain in designated patient areas (waiting room, exams rooms, and other testing/treatment areas). Patients may not enter any area designated for staff only.

**Safety:** The staff takes every precaution to ensure a safe and pleasant visit. Safety is our highest priority. If you have any safety concerns, please bring it to the attention to a staff member or a manager immediately.

**Respect:** We ask that you respect the staff and other patients in the office. Any threatening or derogatory language, racial slurs, cursing, etc., will not be tolerated. Anyone who engages in this behavior will be asked to leave immediately and may be discharged from the practice.

**No Show / Same Day Cancellation Fee**: A Fee will be assessed for all no shows or same day cancellations. We request that cancellations or scheduling changes be made during clinic hours no later than the last business day prior to your appointment.

I, ______________________________ , certify that I have read and understand the code of conduct and will comply with all ARA /ARISE protocols. I acknowledge that failure to do so may result in being discharged from ARA and all its services.

Signature: _____________________________________ Date: __________________________