ARTHRITIS
AND
RHEUMATISM
ASSOCIATES, P.C.

Arise Infusion Therapy Services
Arthritis and Rehabilitation Therapy Services
Gout Center of Excellence
Medical Cannabis Institute
Wellness and Weight Loss Center

DIVISIONS OF ARTHRITIS AND RHEUMATISM ASSOCIATES, P.C

Dear Patient:

Enclosed you will find forms relating to our financial policy, patient registration and insurance information and a medical history form which includes a place to list your medications. Please complete the forms in advance and bring them with you to your appointment. Feel free to call our office with any questions.

In addition, remember to:

- Bring your insurance card(s) and a referral form and co-payment, if required by your insurance plan. Also, please bring your doctor's prescription.
  Wear something that does not have metal buttons, zippers or hooks around the waist and hip area. Bra hooks are okay.
- Avoid taking medication that contains calcium (i.e.: calcium supplements, multivitamins, Tums, etc.). You may take all other medications, including osteoporosis drugs like Fosamax, Miacalcin, Actonel, Evista, etc.
- Allow at least a two week interval following any previous x-ray study involving contrast (like barium).
- Arrive with your forms completed!
- There is a weight limit to our DEXA table. If your weight exceeds 350 pounds, it is possible that only a single scan (of the distal forearm) can be performed.

If you have any questions, please do not hesitate to call before your appointment date.

We look forward to seeing you!

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Patient Registration

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_____

PREFFERED LANGUAGE_____

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

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.

For practice use only: MRN: _____ DOS: _____

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 _____

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 CareFirst Medicare Advantage HMO and PPO, and Johns Hopkins Medicare Advantage HMO and PPO. If you have a non-participating 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.

For practice use only: MRN:_____DOS: _____ 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 their care. If an established patient's visit is related to a work injury, the patient must contact the Business Office prior to their appointment and provide complete billing information for the workers' compensation carrier. This includes the active claim number, carrier name, adjustor's name and phone number, and pre-authorization from the insurance company. If the employer is disputing the case, it will not be considered a workers' compensation case until an independent medical examiner, or the court makes a ruling. In such cases, we will bill the patient's health insurance. If the 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, Disability, and Other 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 or for longer than one year, and also at least once in the last 6 months. 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 $35 fee if your physician completes the disability documents outside of a scheduled visit. 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. Other forms, such as but not limited to, handicapped placards, workplace accommodations, jury duty excuse, and transportation / Metro Access forms, will be subject to the $35 fee if requested to be completed outside of a scheduled office visit.

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.

For practice use only: MRN:_____DOS: _____ 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.

Bank Payment Dispute/Chargeback Policy

A $25 chargeback fee will be added to any patient's account that erroneously disputes a credit card payment without first contacting the Business Office for dispute resolution. The chargeback fee is to cover bank processing fees associated with the dispute.

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 $50.

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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DEXA Medical History

Name: (Last, First, MI): _____ **Date of Birth:** _____

Date of Service: _____ **(Office Use Only) Medical Record #:** _____

Please Answer the Following Questions

Race: ○ Caucasian ○ Asian ○ Hispanic ○ Black

Sex: ○ Female ○ Male Ordering Physician: _____

Have you ever had a bone density test before? ……	○Yes	○No
If yes, when? _____ Where? _____		
Have you fractured any bones after the age of 18? ……	○ Yes	○ No
If yes, what? _____ When? _____		
Did your Mother or Father ever have a hip fracture (s) before the age of 85? ……	○ Yes	○ No
Do you currently smoke? ……	○ Yes	○ No
Do you consume three or more alcoholic beverages daily? ……	○ Yes	○ No
Do you have a family history of osteoporosis?.....	○ Yes	○ No

Women Only:

Are you Post Menopausal?..... ○ Yes ○ No Age at Menopause? _____		
Are you currently on Hormone Replacement Therapy? (HRT/ERT)? ……	○ Yes	○ No
Have you ever taken Provera (Depo-Provera)?.....○ Yes ○ No If Yes, How long? _____		
If you are Premenopausal, when was your last menstrual period? _____		
Are you currently on Birth Control Pills?..... ○ Yes ○ No Are you currently Pregnant?....	○ Yes	○ No

Men Only:

Hypogonadism (Low Testosterone) ……	○ Yes	○ No
Lupron Depot ……	○ Yes	○ No

Have you ever been diagnosed with any of the following conditions?

Hyperparathyroidism ……	○ Yes	○ No	Rheumatoid Arthritis ……	○ Yes	○ No
Lupus ……	○ Yes	○ No	Ankylosing Spondylitis ……	○ Yes	○ No
Paget's Disease ……	○ Yes	○ No	Liver Disease (i.e.: Hepatitis) ……	○ Yes	○ No
Kidney Disease ……	○ Yes	○ No	Kidney Stones ……	○ Yes	○ No
Crohn's/Colitis/Celiac Disease……	○ Yes	○ No			

Have you ever had any of the following procedures?

Gastric Bypass/Lap Band? ……	○ Yes	○ No
Orthopedic hardware/medical devices in your hips and/or spine? ……	○ Yes	○ No
Cancer(s) ……	○ Yes	○ No
If Yes, type(s)? _____ When? _____		
If Yes to Breast Cancer, have you ever taken Aromatase Inhibitor Therapy Drugs:		
[Arimidex (Anastrozole), Femara (Letrozole), Aromasin (Exemestane), etc.]? ……	○ Yes	○ No
Have you ever taken Tamoxifen? ……	○ Yes	○ No
Have you had Radiation Therapy? ……○ Yes ○ No Have you had Chemotherapy? ……	○ Yes	○ No

For practice use only: MRN: _____ DOS: _____

Are you taking/have you taken any of the following medications?

Steroids for 3 months or longer (Prednisone, Cortisone) ..... O Yes O No

If Yes, for what condition(s)? _____

Thyroid medication ..... O Yes O No

Antidepressants (SSRI: Drugs like Prozac)..... O Yes O No

Anti-seizure/epilepsy meds ..... O Yes O No

Insulin Dependent Diabetes ..... O Yes O No

Are you taking or have you ever taken any of the following medications?

Actonel (Risedronate)	O Yes O No	How Long? _____	If Stopped, when? _____
Aredia (Pamidronate).....	O Yes O No	How Long? _____	If Stopped, when? _____
Atelvia (Risedronate)	O Yes O No	How Long? _____	If Stopped, when? _____
Boniva (Ibandronate)	O Yes O No	How Long? _____	If Stopped, when? _____
Duavee (bazedoxifene & conjugated estrogen)...	O Yes O No	How Long? _____	If Stopped, when? _____
Evenity (romosozumab-aqqg)	O Yes O No	How Long? _____	If Stopped, when? _____
Evista (Raloxifene)	O Yes O No	How Long? _____	If Stopped, when? _____
Forteo (Teriparatide)	O Yes O No	How Long? _____	If Stopped, when? _____
Fosamax (Alendronate)	O Yes O No	How Long? _____	If Stopped, when? _____
Miacalcin/Fortical (Calcitonin)	O Yes O No	How Long? _____	If Stopped, when? _____
Prolia (Denosumab)	O Yes O No	How Long? _____	If Stopped, when? _____
Reclast(Zoledronic Acid)	O Yes O No	How Long? _____	If Stopped, when? _____
Tymlos (Abaloparatide)	O Yes O No	How Long? _____	If Stopped, when? _____
Zometa (Zoledronic Acid)	O Yes O No	How Long? _____	If Stopped, when? _____

Do you take any of the following supplements?

Calcium.....	O Yes O No	If Yes, Dose: _____
Vitamin D	O Yes O No	If Yes, Dose: _____
Mulivitamin	O Yes O No	If Yes, Dose: _____

OFFICE USE ONLY

Tallest Height: _____ Height (in):_____ Weight (lbs): _____

Dietary Calcium:

_____

_____

_____

_____

_____

Patient Exercise: O Yes O No

_____

_____

_____

_____

_____

General Comments:

_____

_____

_____

Counseling and educational material given to patient? ..... O Yes O No

Diagnoses: _____

Signature of DEXA Technologist: _____ Date: _____

Physician Signature: _____

Revised 12/2020

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DEXA & Pregnancy

*TO ALL FEMALE PATIENTS BETWEEN 12 AND 55 YEARS OF AGE:

Your physician has requested that you have a Dual Energy X-ray Absorptiometry (DXA) test performed. If you are a female between 12 and 55 years of age we need you to address the following:

The National Council on Radiation Protection and Measurements recommends that X-ray exams of the abdomen, pelvis, hip and/or proximal femur be performed only during the 14 days following the onset of menstruation to prevent exposure to a developing pregnancy.

Is there a chance that you may be pregnant? ☐ Yes ☐ No

If no, does one of the following apply to you?

☐ Hysterectomy *If you checked this, please sign below.

☐ Menopause *If you checked this, please sign below.

If you are using birth control, what method? _____

First day of your last menstrual period? _____

By signing this form, you are advising us of your pregnancy status and giving your consent to undergo the radiologic procedure requested by your physician.

_____ _____
Patient's Name (Please Print) Date of Exam

_____
Patient's Signature

_____
Technologist's Signature

Revised 12/2020

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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.

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: _____

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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
_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Patient Signature	_____ Date

Revised 5/2021

For practice use only: MRN: _____ DOS: _____