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 New Patient:

Welcome to our office! We are looking forward to meeting you at your scheduled appointment. Enclosed, you will find forms related to your medical history, please complete the forms in advance and bring them with you to your initial visit. In addition, please arrive 30 minutes prior to your appointment time, this will allow us to complete your check-in promptly and enable you to see the doctor at your scheduled time.

Please also be sure to bring the following items with you:

- List or prescription bottles of all current medications
- Insurance and prescription card(s)
- Current driver's license or non-driver's ID
- Referral form (if required by carrier)
- Method of payment (cash, check, AMEX, MC, VISA or Discover)

Please note the following information:

- We request that cancellations or scheduling changes be made during clinic hours no later than the last business day prior to your appointment. Our same day cancellation and no show fee is $200.
- You will receive a reminder notification via email, text, or phone call two to four days prior to your scheduled appointment.

If you have any questions prior to your visit, please feel free to contact us. We look forward to a meaningful patient-physician-staff relationship.

Sincerely,
Arthritis and Rheumatism Associates, P.C.

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

Patient Name: _____ DOB: _____

Thank you for choosing Arthritis & Rheumatism Associates to assist you with your care. Please check the primary source of how you heard about our practice to make the decision to visit:

☐ My Primary Care Physician referred me. (Name): _____

☐ Specialty Physician referred me. (Name): _____

☐ A friend or family told me about practice (Word of Mouth)

☐ I was a former patient of practice

☐ Internet (Select One):

☐ Google Search ☐ Yelp ☐ Vitals ☐ Healthgrades

☐ Ratings.MD ☐ Nextdoor ☐ Facebook ☐ Twitter

☐ Instagram ☐ YouTube ☐ Online Yellow Pages

☐ Advertisements (Select One):

☐ School PTA Directory ☐ Bethesda Magazine ☐ Washingtonian

☐ Your Health Magazine ☐ Northern VA Magazine

☐ TV (Select One):

☐ USA 9 ☐ ABC 7 ☐ Channel 8 News

☐ Radio

☐ Event (Which): _____

☐ Other: _____

Revised 12-2021

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

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 froma 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 alsobe charged a $35 fee for 1 or 2 page forms or $100 for forms greater than 2 pages 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, transportation / Metro Access forms, and medical necessity letters will be subject to the $35 or $100 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.

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 $200. If you are an established patient of the practice, the missed appointment fee is $50. 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 $200 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 _____

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

Patient History Form

Date of first appointment:_____/_____/_____ Age: _____ Birth Sex: ☐F ☐M Birthplace: _____
mm dd yyyy

Name: _____ Birthdate: _____/_____/_____
LAST FIRST MIDDLE MAIDEN mm dd yyyy

Referred by: (check one) ____Self ____Family ____Friend ____Physician ____Other Health Professional

Name of Person Making Referral: _____

Name of Primary Care Physician:_____

PRESENT PROBLEM **DIAGNOSIS:** _____

Problem onset_____

Present symptoms _____

Severity 1-10 _____

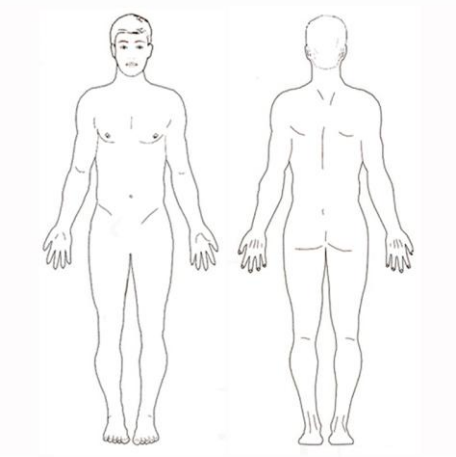
Location _____

Pain quality_____

Aggravated by _____

Relieved by _____

Please shade all the locations of your pain **over the past week** on the **body figures**



Drug allergies: ☐ No ☐ Yes To what? _____

_____

Type of reaction: _____

For practice use only: MRN: _____ DOS: _____

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements)

Name of Drug	Dose	Number of pills and how often?	How long have you taken this medication?	Please check: Helped? A Lot	Some	Not at all
1.				☐	☐	☐
2.				☐	☐	☐
3.				☐	☐	☐
4.				☐	☐	☐
5.				☐	☐	☐
6.				☐	☐	☐
7.				☐	☐	☐
8.				☐	☐	☐
9.				☐	☐	☐
10.				☐	☐	☐

PAST MEDICAL HISTORY

Do you now or ever had: (check if "yes")

☐ Cancer type_____
☐ Goiter
☐ Depression/Anxiety
☐ Nervous Breakdown
☐ High Blood Pressure
☐ Stroke
☐ Asthma
☐ Leukemia
☐ Rheumatic Fever
☐ Bleeding Tendency
☐ Alcoholism
☐ Epilepsy
☐ Heart attack
☐ Angina
☐ Heart Failure
☐ Diabetes
☐ Stomach Ulcers
☐ Liver Problems
☐ Kidney Problems
☐ Osteoarthritis
☐ Gout
☐ Childhood Arthritis
☐ Psoriatic Arthritis
☐ Osteoporosis
☐ Thyroid Problems
☐ Lung Problems _____type
☐ Anemia
☐ Cholesterol
☐ HIV/AIDS
☐ Glaucoma
☐ Hepatitis
☐ Ankylosing Spondylitis
☐ Scleroderma
☐ Lupus or "SLE"
☐ Rheumatoid Arthritis
☐ Arthritis (unknown type)
☐ Colitis
☐ Psoriasis
☐ Tuberculosis
☐ Other significant illnesses (please list)
_____
_____

SURGERIES:

☐ Total knee replacement
☐ Total hip replacement
☐ Back Surgery
☐ Hysterectomy
☐ Prostate
☐ Other _____

Family History:

	IF LIVING		IF DECEASED	
	Age	**Health**	**Age at death**	**Cause**
Father				
Mother				

Number of siblings_____ Number living_____ Number deceased_____ Sisters _____Brothers _____
Number of children_____ Number living_____Number deceased_____ List ages of each _____
Daughters _____ Sons _____ Adopted _____

At any time has a blood relative had any of the following? (give relationship)

	Relative Relationship		Relative Relationship
Arthritis (unknown type)		Cancer	
Osteoarthritis		Leukemia	
Gout		Stroke	
Childhood arthritis		Colitis	
Lupus or "SLE"		Heart Disease	
Rheumatoid Arthritis		High Blood Pressure	
Ankylosing Spondylitis		Bleeding Tendency	
Osteoporosis		Alcoholism	
Psoriatic Arthritis		Asthma	
Scleroderma		Epilepsy	
Rheumatic Fever		Diabetes	
		Goiter	
Other arthritis conditions:			

SOCIAL HISTORY

Primary language spoken: _____ Hand Dominance: ____Right ____Left

Education: (circle highest level attended)

Grade School: 7 8 9 10 11 12 College: 1 2 3 4 Graduate School: _____

Occupation: _____Number of hours worked/average per week:_____

Employer: _____ Retired _____ Date _____

Military Service: _____yes _____No Current status: _____

MARITAL STATUS: ☐ Never Married ☐ Married ☐ Divorced ☐Separated ☐ Widowed

Spouse/Significant Other: ☐ Alive/Age ____☐ Deceased/Age _____ ☐ Major Illnesses _____

Do you smoke? ☐ Yes ☐ No ☐ Past – How long ago? _____ Packs a day _____ Number of years _____

Do you drink alcohol? ☐ Yes ☐ No Number per week _____ Has anyone ever told you to cut down on your drinking? _____

Do you drink caffeinated beverages? ☐ Yes ☐ No Type of Beverage _____ Cups/Glasses per day? _____

Do you use drugs for reasons that are not medical? ☐ Yes ☐ No

If yes, please list: _____

_____

Activity Level: ☐Sedentary ☐Moderate ☐Vigorous

Type of Exercise: ☐ Aerobic ☐ Golf ☐ Jogging ☐ Skiing ☐ Swimming ☐ Walking ☐ Yoga

House Pets: ☐ Yes ☐ No Type: _____

Recent Travel: Out of State _____ International _____

DIAGNOSTIC TESTS

MRI Scan _____ CT Scan _____ Biopsy_____

Date of last mammogram ____/_____/_____ Date of last eye exam ____/_____/_____ Date of last chest x-ray____/_____/_____

Date of last Tuberculosis test ____/_____/_____ Date of last bone densitometry ____/_____/

REVIEW OF SYSTEMS

As you review the following list, please check any of those problems which have significantly affected you.

Constitutional

☐ Fatigue ☐ Fever ☐ Malaise ☐ Night sweats
☐ Recent weight gain (amount) ☐ Recent weight loss (amount)

HEENT

☐ Eye dryness ☐ Eye pain ☐ Difficulty swallowing ☐ Nose bleeds
☐ Redness of eyes ☐ VisualcChanges ☐ Dry mouth ☐ Hoarseness
Ears-Nose-Mouth-Throat ☐ Sores in mouth ☐ Loss of smell ☐ Loss of hearing

RESPIRATORY

☐ Shortness of breath ☐ Cough ☐ Coughing up blood ☐ Wheezing (asthma)

CARDIOVASCULAR

☐ Difficulty breathing at night ☐ Chest pain ☐ Swollen legs or feet ☐ Irregular heart beat

VASCULAR

☐ Cool extremity ☐ Ulcer ☐ Raynaud's ☐ Thrombosis phlebitis

GASTROINTESTINAL

☐ Abdominal pain ☐ Jaundice ☐ Diarrhea
☐ Heartburn ☐ Vomiting ☐ Increasing constipation
☐ Nausea ☐ Blood in stools ☐ Changes in stools

GENITOURINARY

☐ Difficulty urinating ☐ Blood in urine ☐ Increased urinary frequency ☐ Urinary incontinence

REPRODUCTIVE

Female

☐ Vaginal discharge ☐ Breast discharge ☐ Vaginal dryness ☐ Sexual dysfunctions
☐ Irregular menses

Male

☐ Penile discharge ☐ Sexual dysfunctions

ENDOCRINE

☐ Excessive thirst (Polydipsia) ☐ Abnormal sleep ☐ Goiter ☐ Tremors
☐ Hair changes

NEUROLOGICAL SYSTEM

☐ Gait disturbance ☐ Headaches ☐ Dizziness ☐ Memory loss
☐ Extremity numbness ☐ Seizures ☐ Vertigo

PSYCHIATRIC

☐ Depression ☐ Anxiety ☐ Insomnia

INTERGUMENTARY SKIN

☐ Sun sensitive (sun allergy) ☐ Hair loss ☐ Rash ☐ Hives
☐ Skin thickening

MUSCULOSKELETAL

☐ Back pain ☐ Joint pain ☐ Morning stiffness ☐ Joint swelling
☐ Muscle weakness ☐ Neck pain ☐ Muscle tenderness
Lasting how long:_____Minutes _____Hours

HEMATOLOGIC/LYMPHATIC

☐ Easy bruising ☐ Easy Bleeding ☐ Swollen Glands ☐ Anemia

ALLERGIC/IMMUNOLOGIC

☐ Asthma ☐ Seasonal allergies ☐ Food allergies ☐ Environmental allergies

For practice use only: MRN: _____ DOS: _____

PAST MEDICATIONS

Name of Drug ***Non-Steroidal/Anti-Inflammatory Drugs (NSAIDs)***	Length of time	Please check: Helped? A Lot	Some	Not at all	Reactions
Ansaid (flurbiprofen)		☐	☐	☐	
Arthrotec (diclofenac + misoprostil)		☐	☐	☐	
Aspirin (including coated aspirin)		☐	☐	☐	
Celebrex (celecoxib)		☐	☐	☐	
Clinoril (sulindac)		☐	☐	☐	
Daypro (oxaprozin)		☐	☐	☐	
Disalcid (salsalate)		☐	☐	☐	
Dolobid (diflunisal)		☐	☐	☐	
Feldene (piroxicam)		☐	☐	☐	

Non-Steroidal/Anti-Inflammatory Drugs (NSAIDs)	Length of time	Please check: Helped? A Lot	Some	Not at all	Reactions
Indocin (indomethacin)		☐	☐	☐	
Lodine (etodolac)		☐	☐	☐	
Meclomen (meclofenamate)		☐	☐	☐	
Motrin/Rufen (ibuprofen)		☐	☐	☐	
Nalfon (fenoprofen)		☐	☐	☐	
Naprosyn (naproxen)		☐	☐	☐	
Oruvail (ketoprofen)		☐	☐	☐	
Tolectin (tolmetin)		☐	☐	☐	
Trilisate (choline magnesium trisalicylate)		☐	☐	☐	
Vioxx (rofecoxib)		☐	☐	☐	
Voltaren (diclofenac)		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Pain Relievers Acetaminophen (Tylenol)	Length of time	Please check: Helped? A Lot ☐	Some ☐	Not at all ☐	Reactions
Oxycodone, Percocet, Oxycontin		☐	☐	☐	
Propoxyphene (Darvon/Darvocet)		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Disease Modifying Antirheumatic Drugs (DMARDS)	Length of time	Please check: Helped? A Lot	Some	Not at all	Reactions
Gold Salts/pills (Myochrysine or Solganol)		☐	☐	☐	
Hydroxychloroquine (Plaquinil)		☐	☐	☐	
Penicillamine (Cuprimine or Depen)		☐	☐	☐	
Methotrexate (Rheumatrex)		☐	☐	☐	
Azathioprine (Imuran)		☐	☐	☐	

Sulfasalazine (Azulfidine)		☐	☐	☐	
Cyclophosphamide (Cytoxan)		☐	☐	☐	
Cyclosporine A (Sandimmune, Neoral or Gengraf)		☐	☐	☐	
Etanercept (Enbrel)		☐	☐	☐	
Infliximab (Remicade)		☐	☐	☐	
Adalimumab (Humira)		☐	☐	☐	
Rituximab (Rituxan)		☐	☐	☐	
Abatacept (Orencia)		☐	☐	☐	
Leflunimde (Arava)		☐	☐	☐	
Other:		☐	☐	☐	

Osteoporosis Medications	*Length of time*	*Please check: Helped? A Lot*	*Some*	*Not at all*	*Reactions*
Estrogen (Premarin, etc.)		☐	☐	☐	
Alendronate (Fosamax)		☐	☐	☐	
Etidronate (Didronel)		☐	☐	☐	
Raloxifene (Evista)		☐	☐	☐	
Flouride		☐	☐	☐	
Calcitronin injection or nasal (Miacalcin, Calcimar)		☐	☐	☐	
Residronate (Actonel)		☐	☐	☐	
Boniva		☐	☐	☐	
Other:		☐	☐	☐	
Gout Medications	Length of time	Please check: Helped? A Lot	Some	Not at all	Reactions
Probenecid (Benemid)		☐	☐	☐	
Colchicine		☐	☐	☐	
Allopurinol (Zyloprim/Lopurin)		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Other Medications	Length of time	Please check: Helped? A Lot	Some	Not at all	Reactions
Tamoxifen (Nolvadex)		☐	☐	☐	
Tiludronate (Skelid)		☐	☐	☐	
Cortisone/Prednisone		☐	☐	☐	
Hyalgan/Synvisc injections		☐	☐	☐	
Herbal or Nutritional Supplements		☐	☐	☐	
Please list supplements: _____					

Have you participated in any clinical trials for new medications? ☐ Yes ☐ No If yes, list: _____

ARTHRITIS
AND
RHEUMATISM
ASSOCIATES, P.C.

2730 University Blvd. West, Ste 310, Wheaton, MD 20902
14995 Shady Grove Road, Ste 250, Rockville, MD 20850
5454 Wisconsin Avenue, Ste 600, Chevy Chase, MD 20815
18111 Prince Philip Drive, Ste 323, Olney, MD 20832
161 Thomas Johnson Drive, Ste 250, Frederick MD 21702
2021 K Street, NW, Ste 300, Washington, D.C. 20006
8270 Willow Oaks Corporate Drive, Ste 150, Fairfax, VA 22031

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.

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

How We Handle Laboratory Test Results

In the event you may have had lab work performed today and your lab work is normal, you will not hear from our office. However, your physician will discuss the results with you at the time of next office visit. We will call you for any abnormal laboratory tests that require immediate attention; otherwise they will be discussed at your next visit unless your physician has specifically asked you to call for results.

Remember, we will call you if any of your lab work requires immediate attention; otherwise, your results will be discussed at your next visit. You can access your reports through the patient portal.

How We Handle Prescription Refills

- If you have a prescription that needs to be refilled, please bring it to the attention of the medical assistant or your physician at the time of your visit.

- ARA uses e-prescribing to deliver all prescription orders to your pharmacy. E-prescribing is a seamless process that is accomplished through a few clicks in our electronic medical records system. It is strongly encouraged by the Centers for Medicare and Medicaid and many commercial insurance companies because it makes it much easier to track prescriptions and improves patient safety. Unfortunately, technicians at some area pharmacies continue to rely on outdated fax technology to request authorization for refills. ARA does not accept fax requests for refill Authorizations.

- We kindly request that you remind your pharmacy to use the e-prescribing system if they inform you that they have not received a response to their faxed refill request from ARA.

How We Handle Prior Authorizations

We want to let you know that insurance companies often require prior authorizations for certain medications, and this process can take longer at the start of the year. Insurers may also require switching from brand-name biologic medications to their preferred biosimilars. Our providers will only appeal for a brand-name medication if the preferred alternative has been tried and was not effective. Thank you for your understanding.

Thank You,
The Physicians and Staff at ARA

Revised 3/2026

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

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: _____

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

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: _____

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

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 ○ 1.5 ○ 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 ○ 1.5 ○ 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 ☐

Patient Name: _____
Date of Birth: _____

Arthritis and Rheumatism Associates provides medically integrated dispensing services at select clinic locations for your convenience. If you qualify for these services and are prescribed a specialty medication, a team member will contact you to review your options.

You always have the right to choose where your prescription is filled. This includes selecting your preference on where to obtain your medication. In addition, your medication may be billed under your pharmacy benefits, depending on your specific plan coverage and the nature of the medication.

By signing this form, you acknowledge that you have been informed of your choices and if you choose to fill your prescription through the ARA Dispensary you are consenting to the statements below.

Acknowledgment and Declaration

I, the undersigned patient, declare the following:

1. I acknowledge that I have been informed of the option to obtain my prescription drugs from a pharmacy.

2. I affirm that I have determined, based on my own judgment, that a pharmacy is not conveniently available to me.

3. I understand that this determination was made solely by me, without influence or suggestion from the licensee or their staff.

4. I consent to receive prescription drugs dispensed directly by the licensee.

Patient Signature and Date

Signature: _____
Date: _____