Advanced Arthritis Solutions

3620 Joseph Siewick Drive
Suite 200
Fairfax, Virginia 22033-1744
Phone: (703) 648-9800
Fax: (703) 648-9808

Patient's Consent for Financial Responsibility for Non-Covered Services and Insurance Deductible Payments

Type of service being provided: _____

- Some of the procedures not covered by your insurance could be Ultrasounds, some injections or medications, consultations regarding alternative methods of treatment, and orthopedic devices.
- I understand that certain services are not covered when performed in an office setting.
- I understand that the procedure I am about to receive is a non-covered service for which my insurance carrier will not pay for and I agree to be financially responsible for any and all charges incurred for these services.
- I understand that the procedure I am about to receive maybe applied to my insurance deductible and I may have a co-pay due for my office evaluation and treatment.
- I understand I will be responsible for any co-payment my insurance provider requires. I will be responsible to pay Dr. Gradzka for any covered service she provides that is to be applied to my insurance deductible.

Patient's Signature: _____

Witness: _____

Date: _____

Advanced Arthritis Solutions

3620 Joseph Siewick Drive
Suite 200
Fairfax, Virginia 22033-1744
Phone: (703) 648-9800
Fax: (703) 648-9808

New Patient Registration Form

General Information (please print)

Name _____ DOB _____ Sex (please circle) M F

Social Sec # _____ Marital Status (please circle) ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Primary Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Secondary Address _____

City _____ State _____ Zip Code _____

Email Address _____ Authorize Email? (please circle) ☐ Yes ☐ No

Pharmacy Name _____ Phone _____ Fax _____

Employment Status (please circle) Employed Not Employed Retired Student

Occupation _____

Emergency Contact _____ Relationship _____ Phone _____

Doctor Information

Referring Physician _____ Phone _____

Primary Care Physician _____ Phone _____

Primary Insurance

Insurance Name _____ Subscribers Name _____

Social Sec # _____ DOB _____ Relationship to insured _____

Secondary Insurance

Insurance Name _____ Subscribers Name _____

Social Sec # _____ DOB _____ Relationship to insured _____

MARGARET GRADZKA, M.D, F.A.C.R

3620 JOSEPH SIEWICK DRIVE, #200
FAIRFAX, VIRGINIA 22033-1744

TELEPHONE: 703-648-9800
FAX: 703-648-9808

Patient Medical History Description

Patient Name:	
Primary Care Physician	**Referring Physician:**
Height:	**Weight:**

Chief complaint(s):

List Medication(s)	***Dosage***	***How Often***

If you need more space, please use the back of this form.

Allergies to medications and reactions ***(e.g., rash, GI problems, wheezing)*****:**

Do you have any food allergies? ***(e.g., lactose, wheat, etc.)***

Please List Past and Current Conditions ***(e.g., high blood pressure, diabetes, malaria, etc.)*****:**

Hospital and Surgical History ***(including fractures)*****:**

Please Describe Your Family's Medical History ***(for example, rheumatoid or osteoarthritis, cancer, diabetes, etc.)*****:**

Mother:	Father:
Brother(s):	Sister(s):
Maternal Grandparents:	Paternal Grandparents:

Please Describe Your Social History:

Marital Status:	Number of Children:		Occupation:	
Do You Smoke?	Alcohol Use:			
Do You Exercise?		Have You Ever Had A Blood Transfusion?	Yes	No
Have You Ever Used Illegal Drugs? ***(for example, heroin, marijuana, cocaine, etc.***			Yes	No

Accident Information

Is visit related to an auto accident? (please circle): Y N If you answered yes, please complete the following information

Accident claim #_____ Accident Date_____Insurance co._____

Adjuster's name_____ Adjuster's phone_____

Attorney name _____ Attorney phone_____

Patient Authorization for MEDICARE PATIENTS

I authorize Dr. Margaret Gradzka and her staff to release to the Social Security Administration, Health Care Financing Administration or its intermediaries or carriers and/or the above named Medigap any information needed for this or any Medicare and or Medigap claim. I permit a copy of the Authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who may cause Medicare payment information to cross over automatically to my supplemental insurer. I understand that I am financially responsible for any services deemed non-covered by Medicare.

Patient signature Date

Patient Authorization for PPO and HMO Patients

I authorize Dr. Margaret Gradzka and her staff to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above-named insurance company to pay directly to Margaret Gradzka, M.D. the amount due for medical or surgical services. I understand that I am financially responsible for any services deemed non-covered by my insurance company.

Patient signature Date

Patient Authorization for ALL PATIENTS

I understand that I am financially responsible for services in the office and that refunds from services charged on a credit card will be returned to the same credit card. Furthermore, I also understand that any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all cost and fees relating to the collection of my debt. I also authorize Dr. Margaret Gradzka and staff to photograph me for medially related documentation purposes.

Patient signature Date

Patient Phone Message Consent

It is our policy to notify you to confirm appointments. This is to acknowledge that you authorize us to:

- Leave a detailed message on voicemail/answering machine (Please circle AND initial). Yes _____ No _____
- Leave a detailed message with individual answering the phone (Please circle AND initial). Yes _____ No _____

Acknowledgement of Receipt of Private Practices

Notice to patients: We are required to provide you with a copy of our Notice of Privacy Practices which states how we may us and/or disclose our health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign the acknowledgement, if you wish. I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Printed Name: Signature: Date

Advanced Arthritis Solutions

3620 Joseph Siewick Drive
Suite 200
Fairfax, Virginia 22033-1744
Phone: (703) 648-9800
Fax: (703) 648-9808

Phone: (703) 648-9800
Fax: (703) 648-9808

FINANCIAL POLICY

To avoid delays of our services, please be aware of the following:

- All balances must be paid prior to seeing the physician. If not paid, we reserve the right to reschedule your appointment.
- Co-payments will be collected on each visit. We accept cash, checks, VISA, MasterCard, and DISCOVER. Returned checks will result in a $35 additional fee. Patients will be financially responsible for any services that are not covered by their insurance plan.
- Missed appointments will result in a $50 charge if not cancelled with 24 hours prior notice.
- A fee will be charged for any letters written, and for the completion of forms.

Thank you for your understanding and cooperation.

Patient Signature:_____ Date: _____

3620 Joseph Siewick Dr.
Suite 200
Fairfax, VA 22033
Ph: 703-648-9800
Fax: 703-648-9808

PRESCRIPTION POLICY

At Advanced Arthritis Solutions, our goal is to provide exceptional medical care while ensuring the safety and well-being of our patients. Please review the following guidelines regarding our prescription policy:

Prescription Requests:

All prescription requests should be made during regular office hours, **preferably at the time of your appointment**. Refill requests made outside of your appointment or visit to the office may take up to 2-3 business days to process.

Refill Requests:

Patients are encouraged to plan for prescription refills. Refill requests should be made at least [3-5 business days] before running out of medication. This allows our provider time to review your medical history and ensure refill authorization.

Prior Authorizations:

Certain medications may require prior authorization from your insurance provider. Our office will assist you in obtaining prior authorizations whenever necessary. Please be aware that this process may take some time, so initiating the request as early as possible is advisable.

Prescription Renewals for all Medication Controlled Substances:

Prescription renewals for chronic and ongoing conditions and controlled substances, such as opioids or stimulants, are subject to strict regulations, and may require a follow-up appointment with your healthcare provider. Patients receiving controlled medications will be required to adhere to our controlled substance policy.

Electronic Prescriptions:

Whenever feasible, prescriptions will be sent electronically to the patient's preferred pharmacy. Patients are responsible for verifying that the correct pharmacy information is on file with our office.

Patient Responsibility:

It is the responsibility of the patient to monitor their medication supply and adhere to prescribed dosages. Please inform our office of any changes in your medication regimen.

If you have any questions or concerns regarding our prescription policy, please don't hesitate to contact our office. Thank you for entrusting us with your healthcare needs.

Patient Signature_____Date:_____

MARGARET GRADZKA, M.D., F.A.C.R
RHEUMATOLOGY

FAIR OAKS MEDICAL PLAZA
3620 JOSEPH SIEWICK DRIVE
SUITE 200
FAIRFAX, VA 22033
(703) 648-9800 FAX (703) 648-9808

PRIVACY POLICY

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment and healthcare operations (TPO). To that end, our practice and its physicians and staff will–

- Adhere to the standards set forth in the Notice of Privacy Practices.
- Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- Use and disclose PHI to remind patients of their appointments unless they instruct us not to.
- Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its physicians and staff will
  - Implement reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy. Our practice and its physicians and staff respect the patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will:
  - Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
  - Not disclose PHI data unless the patient (or his or her authorized representative) has properly consented to or authorized the release or the release is otherwise authorized by law.

- Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its physicians and staff will--

  - Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.

  - Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.

- All physicians and staff of our practice will maintain a list of all disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization. We will provide this list to patients upon request, so long as their requests are in writing.

- All physicians and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.

- All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.

- Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

PRIVACY PROCEDURES TO ACCOMPLISH THIS PRIVACY POLICY

- The Privacy Officer will provide the front office staff with an original form for patients to complete when the patient desires to inspect and copy his/her PHI.

- The front office staff will photocopy and make available to patients the form to Inspect and Copy PHI.

- The front office staff will respond to patients' requests and questions concerning inspecting and copying their PHI. In addition, the front office staff will distribute the form to the patients upon their request.

- Once the patient completes the form, the front office staff should forward the form to the Privacy Officer for review.

- Once the patient has submitted his/her request in writing (using the practice's form is optional), the front office staff must verify that the patient's signature matches his/her signature on file.

- The Privacy Officer must review the patient's request and respond to the patient within 30 days from the date of the request. The Privacy Officer can request an additional 30-day extension as long as the request is made to the patient in writing with the reason for the delay clearly explained.

- The Privacy Officer should agree to all reasonable requests. If access is denied, the Privacy Officer must provide the patient with an explanation for the denial as well as a description of the patient's review appeal.

- When the patient has requested to inspect their PHI and his/her request has been accepted, the Privacy Officer or other authorized practice representative should accompany the patient to a private area to inspect his/her records. After the patient inspects the record, the Privacy Officer will note in the record the date and time of the inspection, and whether the patient made any requests for amendments or changes to the record.