

**PATIENT
REGISTRATION**

ARTHRITIS & RHEUMATISM ASSOCIATES, P.C.

2021 K STREET, N.W., SUITE 300
WASHINGTON, DC 20006
CENTRAL CALL CENTER 301-942-7600

DAVID G. BORENSTEIN, M.D.
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Please Print Clearly

PATIENT NAME LAST FIRST MIDDLE		HOME PHONE		CELL PHONE	
HOME ADDRESS			APT NO.	CITY	STATE ZIP
PATIENT STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER :			<input type="checkbox"/> EMPLOYED <input type="checkbox"/> FT STUDENT <input type="checkbox"/> PT STUDENT		
EMPLOYER			ADDRESS		WORK PHONE
PATIENT'S OCCUPATION (INDICATE IF STUDENT)			SOCIAL SECURITY NO.		DATE OF BIRTH SEX <input type="checkbox"/> M <input type="checkbox"/> F
FINANCIALLY RESPONSIBLE PARTY <input type="checkbox"/> PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER:		RESPONSIBLE PARTY'S NAME		WORK PHONE	
RESPONSIBLE PARTY'S ADDRESS				HOME PHONE	
DO YOU HAVE AN "ADVANCE MEDICAL DIRECTIVE"?		MAY WE KEEP A COPY ON FILE?			
REFERRED BY		ADDRESS		PHONE	
IN CASE OF EMERGENCY, PLEASE NOTIFY:				Relationship _____	
Name _____		First _____ Middle _____ Last _____		Home Phone () _____	
Address _____				Work Phone () _____	

INSURANCE INFORMATION

Do you have health insurance? yes no (If yes, please complete the following information)

PRIMARY INSURANCE COMPANY		POLICY/ID NO.	GRP. NO/SERV. CODE
PRIMARY INSURANCE COMPANY ADDRESS			
Street		Suite #	City State Zip
Name of Policyholder		<input type="checkbox"/> Male <input type="checkbox"/> Female Relationship _____	
POLICYHOLDER'S DATE OF BIRTH	POLICYHOLDER'S ADDRESS		
POLICYHOLDER'S EMPLOYER OR SCHOOL NAME		POLICYHOLDER'S WORK PHONE	
SECONDARY INSURANCE COMPANY		POLICY/ID NO.	GRP. NO/SERV. CODE
SECONDARY INSURANCE COMPANY ADDRESS			
Street		Suite #	City State Zip
Name of Policyholder		<input type="checkbox"/> Male <input type="checkbox"/> Female Relationship _____	
POLICYHOLDER'S DATE OF BIRTH	POLICYHOLDER'S ADDRESS		
POLICYHOLDER'S EMPLOYER OR SCHOOL NAME		POLICYHOLDER'S WORK PHONE	
IS THIS CONDITION RELATED TO: <input type="checkbox"/> EMPLOYMENT <input type="checkbox"/> AUTO <input type="checkbox"/> OTHER ACCIDENT		IF AUTO, IN WHICH STATE DID ACCIDENT OCCUR?	
DATE OF ACCIDENT	CLAIM/FILE NO.	INSURANCE CARRIER	
INSURANCE CARRIER ADDRESS		EMPLOYER NOTIFIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	UNABLE TO WORK FROM: TO:

PLEASE TURN OVER FOR ADDITIONAL INFORMATION

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 the payments from Blue Cross and Blue Shield of the National Capital Area and/or _____ be made directly to the above named provider.
(OTHER INS CO. NAME)

Signature of policyholder or beneficiary _____ Date _____

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above named carrier at any time in writing.

Signature of policyholder 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 needed to determine these benefits payable for related services." (NAME OF MEDIGAP INSURER)

Signature of policyholder or beneficiary _____ Date _____

8.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Drug allergies: No Yes To what? _____

Type of reaction: _____

PAST MEDICAL HISTORY

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

- | | | | |
|----------------------------------------------|------------------------------------------|---------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> Cancer _____ type | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Angina | <input type="checkbox"/> Lung Problems _____ type | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Nervous Breakdown | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Other significant illnesses (please list) |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> HIV/AIDS | _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Glaucoma | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Hepatitis | _____ |

SURGERIES:

- Total knee replacement
- Total hip replacement
- Back Surgery
- Hysterectomy
- Prostate

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 _____

Do you know of any blood relative who has or had: (check and give relationship)

- | | | | |
|-----------------------------------|----------------------------------------------|------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Asthma | <input type="checkbox"/> Goiter |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Psoriasis | |

At any time have you or a blood relative had any of the following? (check if "yes")

Yourselves	Relative Name/Relationship	Yourselves	Relative Name/Relationship
	Arthritis (unknown type)		Lupus or "SLE"
	Osteoarthritis		Rheumatoid Arthritis
	Gout		Ankylosing Spondylitis
	Childhood arthritis		Osteoporosis
	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 _____ Other _____
Exercise Frequency: _____ Times/week _____

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 ____/____/____

SYSTEMS REVIEW

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

Constitutional

Fatigue Fever Malaise Night sweats Weakness
 Recent weight gain amount _____ Recent weight loss amount _____

HEENT

Double or blurred vision Eye dryness Feels like something in eye Itching eyes Pain
 Redness Loss of vision

Ears-Nose-Mouth-Throat

Loss of hearing Ringing in ears Loss of smell Nosebleeds Runny nose
 Sores in mouth Difficulty swallowing Hoarseness Sore tongue Frequent sore throat
 Dryness of mouth

RESPIRATORY

Shortness of breath Chest pain Cough Coughing of blood Wheezing (asthma)

CARDIOVASCULAR

Pain in chest Difficulty in breathing at night Swollen legs or feet Irregular heart beat High blood pressure

VASCULAR

Cool extremity Ulcer Raynaud's Varicose Veins Thrombosis phlebitis

GASTROINTESTINAL

Abdominal pain Black stools Blood in stools Increasing constipation Persistent diarrhea
 Difficulty swallowing Jaundice Vomiting of blood or coffee ground material Loss of bowel control
 Stomach pain relieved by food or milk Heartburn

GENITOURINARY

- Cloudy, "smoky" urine Difficulty urinating Blood in urine Getting up at night to pass urine Kidney failure

REPRODUCTIVE

- Discharge from penis/vagina Prostate trouble Vaginal Dryness Sexual Difficulties

ENDOCRINE

- Excessive thirst Abnormal sleep Goiter Increase in hat size Tremors

NEUROLOGICAL SYSTEM

- Gait disturbance Headaches Dizziness Fainting Memory loss Vertigo
 Sensitivity or pain of hands and/or feet Loss of consciousness

PSYCHIATRIC

- Depression Agitation

INTERGUMENTARY SKIN

- Sun sensitive (sun allergy) Hair loss Rash Hives Nodules/bumps Tightness

MUSCULOSKELETAL

- Back pain Joint pain Morning stiffness Joint swelling Muscle tenderness Muscle Weakness Neck pain
Lasting how long?
_____ Minutes _____ Hours

HEMATOLOGIC/LYMPHATIC

- Eye bruising Bleeding gums Swollen glands Anemia

ALLERGIC/IMMUNOLOGIC

- Asthma Hives Food allergies Environmental allergies

PRESENT PROBLEM

DIAGNOSIS: _____

Problem onset _____

Present symptoms _____

Severity 1-10 _____

Location _____

Pain quality _____

Aggravated by _____

Relieved by _____

PAST MEDICATIONS

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

PAST MEDICATIONS (Con't.)

Non-Steroidal/Anti-Inflammatory Drugs (NSAIDs)	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not at all	
Indocin (indomethacin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lodine (etodolac)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Meclomen (meclofenamate)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Motrin/Rufen (ibuprofen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nalfon (fenoprofen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Naprosyn (naproxen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Oruvail (ketoprofen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tolectin (tolmetin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Trilisate (choline magnesium trisalicylate)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vioxx (rofecoxib)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Voltaren (diclofenac)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pain Relievers	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not at all	
Acetaminophen (Tylenol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Oxycodone, Percocet, Oxycontin		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Propoxyphene (Darvon/Darvocet)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Disease Modifying Antirheumatic Drugs (DMARDS)	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not at all	
Gold Salts/pills (Myochrysin or Solganol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydroxychloroquine (Plaquinil)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillamine (Cuprimine or Depen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methotrexate (Rheumatrex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Azathioprine (Imuran)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfasalazine (Azulfidine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclophosphamide (Cytoxan)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclosporine A (Sandimmune, Neoral or Gengraf)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etanercept (Enbrel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infliximab (Remicade)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Adalimumab (Humira)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rituximab (Rituxan)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Abatacept (Orencia)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Leflunimide (Arava)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Past Medications (Con't.)

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

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

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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.

MEDICARE PART B

ARA participates with Medicare and accepts assignment. We will file your claim and ***require*** that you pay any ***deductible and your 20% co-insurance at the time of checkout.*** In order to receive a non-covered supply or service, you will be required to sign a Medicare waiver ***and pay in full.*** If you have a secondary insurance, we will file for you, and you will be billed for any remaining balance. ARA does not participate with any Medicare Advantage Plans. 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 allows you to go out of network, you may have deductible and co-insurance payments that are determined by each individual Medicare Advantage Plan.

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 (Blue Choice), Point of Service, Federal Employee, PPO, Blue Card, National Account and Indemnity Plans.

PPO, POS and HMO Plans

Currently, ARA participates with Aetna PPO, OneNet (formerly Alliance), MAMSI Life and Health, MDIPA, Optimum Choice, First Health, United Health Care, and Priority Partners. All PPO and HMO patients are ***required to pay their co-payment 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 co-insurance their plan requires. ARA will be in violation of our contracts if we fail to collect these contracted obligations.

LIABILITY CASES/AUTO ACCIDENTS

ARA will not bill PIP. Physicians will treat patients with liability/auto accident cases, but their 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.

WORKER'S COMPENSATION

If an injury is work-related, the patient must provide this office with complete billing information prior to treatment. We will need: active claim number, carrier name, adjustor's name, phone number and pre-authorization. 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 health insurance carrier. If a patient does not have health insurance, payment will be required at the time of service.

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 contractually obligated to do so. Depending on the carrier, you may be asked to pay your balance in full or any deductible or co-payment due. Any balances not paid within 45 days will be changed to patient responsibility.

SELF-PAY

Patients without health insurance will be expected to *pay in full for all services rendered at the time of service*. To reduce cost at time of service, some lab work may be billed to the patient by the lab at a later date, although this option will result in higher overall cost to the patient. Any special payment arrangements must be set up with the Business Office *prior* to the visit. We accept cash, checks, money orders, and MC or VISA.

NON SUFFICIENT FUNDS (NSF) POLICY

A \$50.00 NSF fee will be added to any patient's account that is returned by our bank for non sufficient funds.

ARA CANCELLATION POLICY

We request that cancellations or scheduling changes be made at least 24 hours in advance of your appointment. We reserve an appointment time exclusively for you. Without proper notification we cannot utilize the time slot you vacate to care for someone else. ARA has a missed appointment fee of \$50.00.

ASSISTANCE

Our Business Office staff is available to assist you with any special concerns or questions. Please feel free to call (301) 942-3126 or stop by our location in Room 708 of the Westfield North building for personal attention.

RESPONSIBILITY

"I understand that I am responsible for *any outstanding balance*. In the event my account is turned over (for collections) or (to a third party), I 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 _____ (SEAL) Date: ____/____/____

Thank you for choosing Arthritis and Rheumatism Associates, P.C., a progressive health care team dedicated to excellence in patient care and service.