Greater Washington
Arthritis, Rheumatology and Osteoporosis Center

14904 Richmond Highway, Suite 203
Woodbridge, VA 22191
Tel: (703) 492-6660 • Fax: (703) 492-6661

Payman Monshie, M.D., F.A.C.R.
Diplomat, American Board of Rheumatology

Jung Whan (James) Yoon, D.O., M.P.H., F.A.C.R.
Rheumatologist, American Board of Internal Medicine

Amanda Renèe Laurent, PA-C
Board Certified Physician Assistant

Demographic

Patient Name: _____
Last **First** **M.I.**

SSN: _____ **D.O.B:** _____ **Age:** _____

Gender: **Male**_____ **Female**_____ **Marital Status (Please Circle):** **S** **M** **D** **W**

Address: _____ **City:** _____ **State:** _____

Zip code: _____ **Home:** _____ **Cell:** _____

Work: _____ **E-Mail:** _____

Employer Name: _____

Employer Address: _____

Primary Insurance: _____ **ID#** _____

Group # _____ **Subscriber Name:** _____

D.O.B: _____ **Subscriber SSN:** _____ **Relationship to Insured:** _____

Secondary Insurance: _____ **ID#**_____

Group # _____ **Subscriber Name:** _____

D.O.B:_____ **Subscriber SSN:** _____ **Relationship to** Insured: _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Primary Provider/Physician: _____ **Phone:** _____

Referring Provider/Physician: _____ **Phone:** _____

I, the undersigned, have insurance coverage with _____and assign all the medical benefits, directly to Greater Washington Arthritis; I understand that, I am financially responsible for all charges for any services rendered, whether or not paid by my insurance; hereby I authorizes the practice to release all information necessary to secure the payment of benefits and authorize the use of this signature on all of my insurance submissions. I understand that any charges incurred are ultimately my responsibility. If this account becomes delinquent, any fees Incurred in the attempt to collect the balance will be added onto my debt. I also understand that there will be a $45.00 fee for any returned checks or insufficient funds. I have read and agree to the above terms and conditions.

Signature of Patient/Guardian: _____**Date:** _____

Patient/Guardian Name: (Please Print) _____

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Office Policy

1) If you are more than 15 minutes late for your appointment, you will need to reschedule your appointment.

2) Prescription requests will be processed 1-2 business days after the request was submitted. If the request was made on a Friday, it will be processed the following week.

3) For narcotic medication refills, you will need to come in **EVERY MONTH** for your refill. Unless, other arrangements are made through the **Provider.**

4) You will need to schedule your follow up appointment before you leave the office; our schedule fills up quickly and we are not able to accommodate last minute scheduling. **With the exception of emergencies, medication refills are not considered emergencies.**

5) Voicemail messages are retrieved 2-3 times a day. If you leave a voicemail message, it will be returned within ONE business day.

6) Your co-pay and balance is due at time of your visit, unless arrangements are made **BEFORE** your appointment.

7) Please remember to ask your provider to refill all of your prescriptions during your visit. If you call to request a refill for a medication that you forgot to ask for, it will take 1-2 business days to process the request.

8) **Narcotic medications will NOT be replaced if lost or stolen.**

9) If any of your information (i.e. address, phone number, primary doctor, insurance, etc.) has changed, you will need to notify the staff.

10) **If your insurance requires a referral, it is your responsibility to get one from your primary care physician before your appointment.**

11) Please do not be disrespectful or disruptive in office. In the case of the use of foul language to the office staff and other patients, for the first offense, there will be a verbal warning noted in your chart; for the second offense, there will be a written warning that's also noted in your chart and for the third offense you will be discharged from this office. **(If you are discharged from the office you will be given a 30-day supply of your medication ONLY).**

12) Your billing statement will be mailed to you **ONLY 3 times;** after the third attempt, you will be sent to collections.

13) There will be a **$50.00 'NO SHOW FEE'** if you don't show up or cancel your appointment in a less than 24 hours.

14) There will be a fee for filling out paperwork and writing Restriction/Limitations letters which as follows: For FMLA packets: $50.00; Disability packets: $ 100.00 to $150.00; Restriction/Limitations letters: $50.00 and Medical Records to patient: $25.00 or 10 cents per page.

15) **The Self-Pay consultation fee is $300.00 and Self-Pay follow up visit fee is $100.00.**

- By signing below you agree to follow the policies of our office. We reserve the right to change these policies at any time and will provide each patient with a new office policies form.

Patient/Guardian Signature: _____ **Date Signed:** _____

Patient/Guardian Name: (Please Print) _____

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully, the privacy of your health is important to us.

Our Legal Duty

We are required by Federal and state law to maintain the privacy of our health information. We are also required to give you this notice about our privacy practices, legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the notice while in effect. This notice will remain in effect until we replace it.

We reserve the right to change our privacy practice. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed on the top of this notice.

Uses and Disclosures of Health Information

Treatment: We may use and disclose your information to a healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provided to you.

Healthcare Operations: We may use and disclose your healthcare information in connection with our healthcare operations. Health care operations include quality, assessment, and improvement activities: reviewing the competence or qualifications of healthcare professionals; evaluating practitioner and provider performance; and conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorizations to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.
We must disclose your health information if we get subpoena from the court. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons involved in care: We may use or disclose health information to notify or assist in the notification of "(including locating) a family member, your personal representative or another person responsible for your care, or your location, general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is relevant to the person's involvement in your healthcare.

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Medical Information Release Form

(HIPAA Release Form)

Name:_____ **Date of Birth:** _____

Release of Information

[ ] I authorize the release of information including but not limited to the diagnosis, treatment, medications list, records of examination, labs and radiology reports, and claims information.

This information may be released to:

[ ] Spouse:_____

[ ] Child:_____

[ ] Other:_____

[ ] **Information is not to be released to anyone but myself.**

This Release of Information will remain in effect until terminated by me in writing

For Messages, please call: [ ] My home [ ] My work [ ] My cell _____

If unable to reach to me:

[ ] You may leave a detailed message.

[ ] Please leave a message asking me to return your call.

[ ] Other _____

The best time to reach me is Between (time) _____ and _____ .

Patient/Guardian Signature: _____ **Date:** _____

Patient/Guardian Name: (Please Print) _____

Contract for Narcotic Medications

(Please initial each statement)

_____ 1) I understand that the use of opiate medications has the risk of misuse, abuse, and addiction.

_____ 2) I will NOT use any illegal controlled substances such as heroin, marijuana, cocaine, etc.

_____ 3) I agree that the opiate medications is strictly for my own use. I will not share, sell, or trade my opiate medications with others.

_____ 4) I agree to keep my opiate medication in a safe and secure location and out of reach of children.

_____ 5) I certify that I will receive opiate pain medication and all other pain medication ONI.Y from the physician at Greater Washington Arthritis, Rheumatology and Osteoporosis Center that is treating me for pain management.

_____ 6) I agree to have all my pain medications filled at a single pharmacy and notify the physician/staff of any changes.

Pharmacy Name: _____ **Phone:** _____

_____ 7) I agree to submit to a urine/blood test for both prescription and non-prescription. To protect you as the patient, f you refuse or choose not to submit a drug test when asked, you will NOT receive your narcotic prescription.

_____ 8) I agree to bring in any remaining prescribed opiate tablets to my physician for a "pill count" if requested by the physician.

_____ 9) I agree I will NOT take more than prescribed of my opiate medications and I will NOT request early refills.

_____ 10) I understand that opiate pain medication may cause a variety of side effects, including nausea, vomiting, drowsiness, constipation, mental slowing, flushing, sweating, itching, and weight changes.

_____ 11) I understand that these are potentially dangerous medications and if taken improperly may lead to excess sedation, respiratory depression, and death.

_____ 12) I authorize my physician to monitor my pain medications on the state website, Prescription Monitoring Program.

_____ 13) I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Patient/Guardian Signature:_____ **Date:** _____

Patient/Guardian Name: (Please Print):_____

Prescription & Supplemental Drug List

Patient Name:_____

Known Drug Allergies:_____

	Medication	Dosage	Frequency	Prescriber
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				