ARLINGTON MEDICAL ASSOCIATES, PLLC
2800 S Shirlington Rd Ste 410
Arlington, VA 22206-3618
Phone (703) 533-2222 Fax (703)533-0314

PLEASE PRINT LEDGIBLY AND COMPLETE ALL AREAS

DEMOGRAPHIC INFORMATION

LAST NAME: _____ **FIRST NAME:** _____ **MIDDLE INITIAL:** _____

DATE OF BIRTH: ____/____/____ **GENDER:** ◯ **FEMALE** ◯ **MALE**
MONTH DAY YEAR

MOTHER'S MAIDEN NAME: _____

ADDRESS: _____

_____ ◯ **VA** ◯ **DC** ◯ **MD** ◯ **OTHER** _____
CITY STATE ZIPCODE

( ) _____ **( )** _____ **( )** _____
HOME PHONE WORK PHONE CELL PHONE

MARITAL STATUS: ◯ **Single** ◯ **Married** ◯ **Divorced** ◯ **Domestic Partnership** ◯ **Widowed**

EMAIL ADDRESS: _____

CONTACT PREFERENCE: ◯ **Home Phone** ◯ **Work Phone** ◯ **Cell Phone**

RACE: (Check one) ◯ **Black/African American** ◯ **White** ◯ **Hispanic/Latin** ◯ **Asian**

◯ **American Indian** ◯ **Alaska Native** ◯ **Native Hawaiian/Pacific Islander** ◯ **Declined**

PRIMARY LANGUAGE: (Check one) ◯ **English** ◯ **Spanish** ◯ **Tagalog** ◯ **French** ◯ **Vietnamese**

◯ **Russian** ◯ **Farsi** ◯ **Korean** ◯ **Hindi** ◯ **Other** _____

SECONDARY LANGUAGE: (Check one) ◯ **English** ◯ **Spanish** ◯ **Tagalog** ◯ **French** ◯ **Vietnamese**

◯ **Russian** ◯ **Farsi** ◯ **Korean** ◯ **Hindi** ◯ **Other** _____

EMERGENCY CONTACT

LAST NAME: _____ **FIRST NAME:** _____ **MIDDLE INITIAL:** _____

Relationship to patient: ◯ **Spouse** ◯ **Father** ◯ **Mother** ◯ **Sister** ◯ **Brother** ◯ **Friend** ◯ **Other (List)** _____

◯ **Same Address as Patient (You do not need complete information below.)**

ADDRESS: _____

_____ ◯ **VA** ◯ **DC** ◯ **MD** ◯ **OTHER** _____
CITY STATE ZIPCODE

( ) _____ **( )** _____ **( )** _____
HOME PHONE WORK PHONE CELL PHONE

INSURANCE INFORMATION (*Please present ALL insurance cards and photo ID to the receptionist)*

PRIMARY INSURANCE INFORMATION ◯ **Patient is Policy Holder (You do not need complete information below.)**

Policy Holder:

LAST NAME: _____ **FIRST NAME:** _____ **MIDDLE INITIAL:** _____

Date of Birth: _____ **Relationship to Patient:** ◯ **Spouse** ◯ **Parent** ◯ **Other** _____

SECONDARY INSURANCE INFORMATION ◯ **Patient is Policy Holder (You do not need complete information below.)**

Policy Holder:

LAST NAME: _____ **FIRST NAME:** _____ **MIDDLE INITIAL:** _____

Date of Birth: _____ **Relationship to Patient:** ◯ **Spouse** ◯ **Parent** ◯ **Other** _____

ARLINGTON MEDICAL ASSOCIATES, PLLC
POLICES AND PROCEDURES

TARDINESS: Please call our office if you are running late. Patients arriving more than 15 minutes late **MAY** be asked to reschedule their appointment at the discretion of the provider.

MISSED APPOINTMENTS/CANCELLATIONS: Patients who are unable to keep an appointment are requested to contact our office at least 24 hours prior to the scheduled appointment time since there are usually other patients that could benefit from this slot. Patients who do not contact the office within a 24 hours period may be charged a $40.00 fee (at the discretion of the physician.)

ANNUAL WELLNESS VISITS: Insurance companies and Medicare are required to cover one **Annual Wellness Visit** every 365 days. At the discretion of your provider, you may be billed for an actual office visit (follow-up/sick visit) in addition to the wellness visit should there be multiple issues covered during the visit. This may result in a co-payment and/or a deductible that the patient will be responsible to pay.

REFERRALS: Please allow at least 48-72 hours to process non-emergency referral requests. Emergency referrals will be handled as quickly as possible and may be expedited by the staff. All referrals are electronic and processed through your insurance company's website. Insurance companies prohibit retroactive referrals, so it is the patient's responsibility to obtain a referral **before** your appointment with a specialist. Referrals may be picked up in person or mailed to your home if time allows. If you call from a specialist's office and need a referral processed in order to keep your appointment, there will be a **$10.00** fee.

INSURANCE: AMA providers participate in most major insurance companies. It is your responsibility to provide your correct insurance information at each visit. Insurance companies required that we keep a copy of your insurance card on file. The Federal Trade Commission (FTC) requires that we keep a **photo ID** on file. This may be a State Driver's License, State Identification Card, Military Identification Card, School Identification Card, or similar photo identification.

PAYMENT: Co-payments and any outstanding balances are to be paid prior to seeing a provider of service. Any prior balance that have been adjusted and/or sent to our collection agency **must be paid in full** before an appointment will be made. AMA accepts cash, personal check, Visa, Master Card or Discover.

PRECRIPTIONS: Prescriptions refills require close monitoring by your provider to ensure the safe continuation of the appropriate dose, frequency, and term of the specific medication. Your provider will prescribe the appropriate number of prescription refills until you next scheduled appointment. Please allow **48-72 hours** to process your prescription requests. Electronic requests may be requested through your pharmacist. If you have not been seen at the office form more that 6 months, you may need an appointment with your provider before your prescription will be refilled. Medications requiring **Pre-Authorization** from your insurance company may require additional time to process. Please plan ahead for refills during the holidays and when traveling. A **photo ID or patient authorization** is required when picking up any prescription, sample medications, documents and/or referrals.

Prescription drugs classified as controlled substances are **NOT** processed after normal office hours or on the weekends. Our providers participate in the Virginia Prescription Monitoring Program.

COMPLETION OF FORMS: We are happy to complete any form you have. However, due to the additional time required to complete these forms, there **MAY** be an additional charge as follows:

Simple Health Declaration	$10.00
Complicated Health Declaration	$35.00
Health and Wellness form(s) (not related to a visit)	$25.00
DMV form(s) (not related to a visit)	$25.00
Medical Testimony (reasonable accommodation, disability, etc.)	$50.00
Faxing stat referrals to specialist office	$10.00

Signature:_____ **Date:**_____

Consent for Treatment

1. **GENERAL CONSENT FOR TREATMENT:** I hereby authorize employees and agents of Arlington Medical Associates, PLLC, including physicians, physician assistants nursing and other staff members to render medical evaluations and care to the patient indicated below.

I acknowledge that according to Commonwealth of Virginia law, I shall be deemed to have consented to the testing for infection with Human Immunodeficiency virus (HIV), Hepatitis B, Hepatitis C viruses should any healthcare provide, or any persons employed by or under the direction and control of a healthcare provider, by directly exposed to my body fluids in connection with rendering care to me the patient, in a manner which may, according to the current guidelines of the Center for Disease Control (CDC), transmit HIV, Hepatitis B, or Hepatitis C viruses. Test results may be release to the person exposed.

2. **E-PRESCRIBING CONSENT:** The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescibe program. These include:

   - **Formulary and benefit transactions:** Gives the prescriber information about which drugs are covered by the drug benefit plan.
   - **Medication History Transactions:** Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
   - **Monitoring:** Our providers participate in the Commonwealth of Virginia Prescription Monitoring Program.

3. **PATIENT INFORMATION:** I authorize the practice to **ONLY** provide the following individuals with information regarding my treatment and billing information other than my insurance company or other treating physicians. This release will remain active in your electronic health record and will **NOT** be cancelled without written authorization from the patient.

Name	**Relationship**
Name	**Relationship**
Name	**Relationship**

4. **PAYMENT:** I agree to pay for all services rendered Arlington Medical Associates, PLLC including physicians, physicians assistants and/or nurses, except where, by director contract between Arlington Medical Associates, PLLC and my insurance company, the patient/responsible party is only responsible to pay for non-covered services, deductibles, and/or copayments, in which case I, the undersigned patient/responsible party, agrees to pay in full for such not covered services, deductibles, and/or co-payments. I agree that all co-payments and outstanding balances are to be paid in full prior to receiving treatment by a member of Arlington Medial Associates, PLLC. This agreement is entered into in the City of Alexandria, Commonwealth of Virginia.

I hereby authorized Arlington Medical Associates, PLLC to file claims to my insurance carrier on my behalf and the release of any medical information medical information necessary to process any of the claim(s).

PRINT: Name of Patient/Responsible Party	**Signature: Patient/Responsible Party**

Date

ACKNOWLEDGEMENT OF RECEIPT OF
ARLINGTON MEDICAL ASSOCIATES, PLLC (AMA) GROUP POLICIES AND PROCEDURES
Of

By signing here, I attest to the following Arlington Medical Associates, PLLC Group Policies and Procedures which I have received and reviewed.

PATIENT FINANCIAL REPONSIBILITY FOR SERVICES

I have read and understand the Patient Financial Responsibility for Services and have provided true and correct insurance and demographic information. Per the policy, I will promptly notify AMA of any changes to my health insurance carrier and provide AMA with a copy of my current and correct insurance card.

PRESCRIPTION REFILL POLICY

I have read, understand and will comply with the Prescription Refill policy as set forth by Arlington Medical Associates, PLLC.

REFERRAL POLICY

I have read and understand that AMA must adhere to guidelines as outlined by the contracts in play with my insurance company. I acknowledge that I have a responsibility to understand my insurance plan's requirements and to follow them.

I attest that all submitted information is true and accurate to the best of my knowledge and that I have read, understand and agree to compliance with the aforementioned AMA Policies and Procedures,

_____ _____

PRINT: Name of Patient/Responsible Party **Signature: Patient/Responsible Party**

_____

Date

Arlington Medical Associates, PLLC

2800 S SHIRLINGTON RD STE 410
ARLINGTON, VA 22206-3618

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED BY ARLINGTON MEDICAL ASSOCIATES, PLLC AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. PLEASE READ CAFEFULLY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by Arlington Medical Associates, PLLC in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may disclose your health information. We may use and disclose your medical information only for each of the following purposes: treatment, payment and health care operations.

Treatment: Providing, coordinating or managing health care and related services by one or more health care providers.
Payment: Obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review.
Health Care Operations: The business aspects of running our practice, i.e., conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you via telephone, e-mail and/or postcard or letter to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and/or disclosures will be made only with **your written authorization**. You may revoke such authorization **in writing** and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you exercise by presenting a written, signed, and dated request to our Privacy Officer(s).

- The right to request restrictions on certain uses and disclosures of protected health information including those related to disclosures to family members, other relative and close personal friends, or any other person identified by you. We are, however, no required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree, in writing, to remove it.
- The right to **reasonable** requests to receive confidential communications of protected health information from us by alternative means.
- The right to inspect and received a copy of your protected health information. There is a fee associated with the coping of any protected health information for personal use.
- The right to amend you protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practice with respect to protected health information.

The following are specific uses and methods of Arlington Medical Associates, PLLC to ensure the privacy of protected health information:

- Arlington Medical Associates maintains one electronic medical and financial chart for each patient.
- Arlington Medical Associates makes every effort to minimize access to patients' protected health information to staff who is not directly involved in the patient's care.
- The practice manager is the Compliance Office for Arlington Medical Associates, PLLC. All requests for information by a patient should be directed to his attention.
- All staff of Arlington Medical Associates sign a confidentially statement within five days of their employment.
- All papers containing individually identifiable personal and health information to be discarded will be shredded.
- Patient education/instruction will be conducted behind closed doors or in a secluded are to insure patient privacy and confidentiality.

- Minimum protected health information will be sent to business associates when ordering supplies for the treatment of patients.
- All business associates of Arlington Medical Associates have signed confidentiality agreements to ensure the privacy of protected health information. If a business associates violates this agreement the contract with this associate will be terminated.
- A copy of this Notice of Privacy Practices and its revisions and updates will be posted in the lobby of the Arlington Medical Associates' office.
- Every effort will be made to avoid disclosing protected health information either verbally or visually.
- Use and disclosure of protected health information to obtain payment for services rendered: When challenging an insurance company's decision of a payment only protected health information directly relating to that service will be release to the insurance company.
- Use and disclosure of protected health information including written, verbal or faxed information to coordinate care with other health care providers outside of Arlington Medical Associates, PLLC to include, but not limited to, Emergencies Rooms, Hospitals, Laboratories, Radiological Facilities, Physical Therapy, Visiting Nurses, Home Health Agencies, Pharmacies, other physicians or dentists treating the patient.
- Use and disclosure of protected health information to obtain referrals or pre-authorizations as required by insurance companies.
- The collection agency used by Arlington Medical Associates will only be provided with demographic information for the purpose of collecting unpaid balances.
- Billing issues will only be addressed by the billing staff within the confines of the business office.
- Billing staff will discuss billing issues with the parent of a minor child. Every effort will be taken to ensure that telephone conversations are with individuals authorized to discuss billing issues (i.e., certain questions may be asked of the caller to identify them as an authorized individual).
- Billing staff will not discuss billing issues with the patient's spouse unless a written authorization is on file.
- Billing issues will only be discussed with the authorized individual of parent or non-minor children.

This notice is effective September 1, 2016 and we are required to abide by the terms of the Notice of Privacy Practice currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from the Compliance Officer at Arlington Medical Associates, PLLC.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of Arlington Medical Associates, PLLC. We will not retaliate against you for filing a complaint.

Please contact us for more information at:
Arlington Medical Associates, PLLC
Attn.: HIPAA Compliance Officer
2800 S Shirlington Rd Ste 410
Arlington, VA 22206-3618
(703) 533-2222

For more information regarding HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave SW
Washington, DC 20201-0004
(202) 619-0257
(877) 696-6775

Arlington Medical Associates, PLLC
2800 S Shirlington Rd Ste 410 Arlington, VA 22206-3618
(703) 533-2222 (703) 533-3421 (Fax)
www.amava.us

WELLNESS CARE/HEALTH MAINTENANCE EXAM/ANNUAL EXAM/PHYSICALS

The purpose of this notice is to provide transparency and address questions that have arisen regarding billing.

Most insurance plans cover a once yearly wellness visit. This service has a unique billing code and includes a limited number of topics; nutrition, vaccines, cancer screenings, heart disease risk factor evaluation, and screening examination of the body.

Culturally, patients do not think of a wellness visit in this manner; they imagine this visit as a head to toe "physical" where they can discuss a litany of concerns. These problems, as well as creating plans for chronic conditions, are **NOT** considered wellness and need to be billed as non-wellness codes. Common examples of non-wellness items include treatment plans for ongoing health problems (e.g., diabetes, high cholesterol, high blood pressure), follow-up on new symptoms, and treatment plans for new abnormal exam findings.

Dr. Pamela Kasenetz and Kristin Vidwans, PA-C, offer an annual gynecologic care visit. For the sake of being thorough, this visit may be separate from the wellness visit. If this is the case, your insurance will **NOT** be billed for two annual wellness exams.

If you have a copay, co-insurance, or unmet deductible for non-wellness services, you will incur an out of pocket expense for the non-wellness services performed today. The amount will vary depending on the terms of your insurance plan, the amount of time spent at the visit, and/or the complexity of issues discussed. The cost of non-wellness services will be what you would normally pay for your non-wellness physician visits. For most patients, this is your standard copay unless you have an unmet deductible. If you have questions regarding your deductible, please contact your insurance company.

If you wish to use your annual wellness benefit **ONLY** at today's appointment, please let the physician know and be mindful that all non-wellness issues will be deferred to a future appointment.

We do not think this national billing system established by the American Medical Association is ideal, but we have no control over it. Thank you for understanding.

Sincerely,

Pamela H. Kasenetz, MD
Adrian L. Uy, MD
Neil M. Vidwans, MD
Kristin E. Vidwans, PA-C

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