The GW Medical Faculty Associates

Name: ______________________________ DOB: ________________________

Address: ____

____

____

Emergency Contact:

Name: ____________________ Relationship to Patient: ________ Phone: ________

Primary Care Physician:

Name: _______________ Address: _______________________ Phone: ________

Preferred Method of Appointment Confirmation – Please check ONE:

- ☐ Phone: ____________________
- ☐ Text: ____________________
- ☐ Email: ____________________

For GW Patient Portal Access (Follow My Health), please provide:

Email Address: ____

We are now required to collect preferred language, race, and ethnicity. If you prefer NOT to report this information, you may choose to decline. Thank you for your cooperation.

Preferred Language	Race	Ethnicity
☐ English	☐ Alaskan Native/Native American	☐ Hispanic/Latino
☐ Spanish	☐ Asian	☐ Not Hispanic/Latino
☐ Other: __________	☐ Black/African American	☐ Decline to Report
☐ Decline to Report	☐ Pacific Islander/Native Hawaiian	
	☐ White	
	☐ Unknown	
	☐ Decline to Report	

RESTON OBGYN CARE
at The GW Medical Faculty Associates

1800 Town Center Drive, Suite 222
Reston, VA 20190
phone: 703.834.6244
fax: 703-834-6288

I,____________________________ understand that at my annual wellness exam if a problem is discussed and/or treated; there may be an additional charge/copay for those services rendered.

Please be mindful that Labs are separate charges and might not be covered by your insurance, if you have a question regarding a bill please contact LabCorp billing (800)845-6167.

Signature:________________________ Date:__________________.

Thank you,

Kathleen Rausch, M.D.

Manisha Patel, D.O.

Name:	______________________
MRN:	______________________
DOB:	______________________

AUTHORIZATION FOR THE USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

In accordance with HIPAA privacy laws, the GW Medical Faculty Associate ("MFA") may not use or disclose your protected health information ("PHI") without your written authorization, except as provided in our Notice of Privacy Practices. In order for MFA physicians, employees, or representatives to share your PHI with family members, friends, and/or people you choose to have knowledge of your care, you must complete this form.
***** You must specifically state your spouse's name to give us authorization to communicate your PHI to them.***

I, ______________________ (print name) hereby authorize MFA physicians, employees, and/or representatives to share the following PHI with the person(s) listed below.

PLEASE CHECK ALL THAT APPLY:

- ☐ Test results (e.g. lab results, x-rays, biopsies, CT Scans, MRIs);
- ☐ Treatment information (e.g. discussions about prognosis, planned or current procedures, care options);
- ☐ Information pertaining to outside appointments made by our office, (e.g. the date and time of appointment, facility where testing or procedure will be done, why the appointment is being made);
- ☐ Billing issues (e.g. balance due, insurance issues)
- ☐ Other: ____

☐ DO NOT RELEASE MY PROTECTED MEDICAL INFORMATION TO ANYONE

My protected health information may be shared with the following individual(s):

(Name)	(Relationship)	(Phone/Email)
(Name)	(Relationship)	(Phone/Email)

With my signature, I affirm I am capable of giving consent under Va. Code § 54.1-2969. I acknowledge and understand that this authorization will be maintained in my medical record and will remain in effect until revoked by me in writing. I understand that it is my responsibility to notify a representative of MFA if any of the above information changes.

______________________________ (Patient Signature) ______________ (Date)

______________________________ (Witness/MFA Representative) ______________ (Date)

****

You may provide a designated telephone number where messages containing PHI may be left:

☐ Lab Results and medical advice may be left by voicemail at the following number: ______________

The GW Medical Faculty Associates

Acknowledgment Patient Was Provided Notice of Privacy Practices

Patient Name: ______________________________

MRN: ______________________________

Date: ______________________________

I acknowledge I was given MFA's Notice of Privacy Practices today.

____
[Patient Signature]

Witnessed by:

____
MFA Staff Member Name:
Title:

If patient declines to sign, MFA staff member signs below to confirm that Notice was offered to patient on the date listed above and patient declined to sign acknowledgment.

____
MFA Staff Member Name:
Title:

The GW Medical Faculty Associates

CANCELLATION/NO SHOW APPOINTMENT POLICY/PATIENT FINANCIAL RESPONSIBILITY

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients.

Cancellation of an Appointment:
In order to be respectful of the medical needs of other patients, please be courteous and call the office promptly if you unable to attend an appointment. This time will be reallocated to someone who is in need of an appointment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have an earlier appointment.

No-Show Policy:
A "no-show" is someone who misses an appointment without calling 24 hours in advance to cancel. "No-Shows" inconvenience those individuals who need access to medical care in a timely manner, as well as the physician. A failure to show up at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". The first time there is a "no-show" there will be no charge to the patient. Any additional "no-shows" will result in a fee of $50.00

Patient Financial Responsibilities:
- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service
- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.
- Patients may incur, and responsible for payment of additional charges, if applicable.
- By my signature below I understand that I am financially responsible for any and all charges not covered by my health insurer for services provided.

I understand each of these policies

______________________________ ______________________
(Patient's Name) (Date of Birth)

____
(Patient's/Patient's Representative Signature)