Name:	DOB:	· .
Address:		
Emergency Contact:		
Name:	Relationship to Patient:	Phone:
Primary Care Physic	ian:	
Name:	Address:	Phone:
Preferred Method of	Appointment Confirmation - Please che	eck ONE:
□ Phone:	·	
□ Text:		
□ Email:		
For GW Patient Port	al Access (Follow My Health), please pro	<u>vide</u> :
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.

100 gr	Preferred Language	Towns on Williams of the Control of	Race	Ethnicity
	English		Alaskan Native/Native	Hispanic/Latino
	Spanish		American 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

l, <u> </u>		ur	ndersta	nd that	at my	annual	wellness exam
if a problem is disc for those services							
Please be mindful your insurance, if billing (800)845-61	you have a						
Signature:	 		Date:_		<u> </u>	· · · · · · · · · · · · · · · · · · ·	
Thank you,					·		
Kathleen Rausch, N	M.D.						
Manisha Patel, D.C).			ur.			

Name:	
MRN:	
DOB:	



AUTHORIZATION FOR THE USE & DISCLOSURE OF PROTECTED

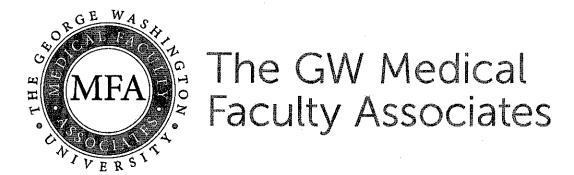
DOB:	V E R S I L	HEALTH INFORMATION
your protected health information (") of Privacy Practices. In order for MF members, friends, and/or people you ** You must specifically state your specifically state your specifically state your specifically state.	PHI") without your written authorize FA physicians, employees, or represeductions to have knowledge of your pouse's name to give us authorizations.	
representatives to share the following	g PHI with the person(s) listed below	V.
☐ Treatment information (e.g. of Information pertaining to our appointment, facility where to Billing issues (e.g. balance du ☐ Other:	x-rays, biopsies, CT Scans, MRIs); discussions about prognosis, planne tside appointments made by our off testing or procedure will be done, w	hy the appointment is being made);
My protected health information may	y be shared with the following indiv	idual(s):
(Name)	(Relationship)	(Phone/Email)
(Name)	(Relationship)	(Phone/Email)
With my signature, I affirm I am ca understand that this authorization wil	pable of giving consent under Va. Il be maintained in my medical recor	Code § 54.1-2969. I acknowledge and d and will remain in effect until revoked presentative of MFA if any of the above
(Patient Signature)		(Date)
(Witness/MFA Representative)		(Date)
*******	***********	***********
You may provide a designated telepl	hone number where messages cont	aining PHI may be left:

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



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 Noto patient on the date listed above and patient declined to sign acknowled	
,	J
MFA Staff Member Name: Title:	



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)	·