ARTHRITIS
AND
RHEUMATISM
ASSOCIATES, P.C.

Arise Infusion Therapy Services
Arthritis and Rehabilitation Therapy Services
Gout Center of Excellence
Medical Cannabis Institute
Wellness and Weight Loss Center

DIVISIONS OF ARTHRITIS AND RHEUMATISM ASSOCIATES, P.C

Patient Notice

Welcome to Arise Infusion Therapy Services! We are looking forward to meeting you at your scheduled appointment(s). Enclosed, you will find forms regarding your medical history. Please complete the forms prior to your appointment and bring them to the initial visit with your physician.

Please arrive ***15 minutes*** prior to your appointment time, this will allow us to complete your check-in promptly andenable you to start at your scheduled time. You will receive a phone call confirming your appointment one to four days prior to your scheduled appointment. All insurance copayments and deductibles are due at time of service.

Please be sure to bring the following items with you:

- **Insurance card(s)**
- **Current driver's license or non-driver's ID**
- **Referral form (if required by carrier)**
- **Method of payment (cash, check, AMEX, MC, VISA or Discover)**

Please note the following information:

We have a No Show / Same Day Cancellation policy. Cancellations or schedule changes need to be made during clinic hours no later than the last business day prior to your appointment. Same-day cancellation or failing to come to your appointment without notification, will result in an assessed **fee of $25** for infusion appointments and you will not be allowed to reschedule your appointment without paying the fee. If you arrive more than 30 minutes after your scheduled time without notification, your appointment will be rescheduled.

During your infusion treatment, any guests that come with you are welcome to wait in the waiting room. **Guests are only permitted in the infusion suite to assist with mobility, personal hygiene, or communication.** If you need your aide/guest for restroom assistance, the nurse will call them back to the infusion room to escort you. **The nurses cannot leave the infusion suite or assist with personal hygiene needs.**

Some of the medications administered require an observation period. These observation periods are for your health and safety. If the medication that you are receiving requires an observation period, you must remain in the infusion suite for the entirety of the observation period. Failure to do so may result in a discharge from our practice.

Please review our Patient Code of Conduct for company policies. All patients must abide by the Patient Code of Conduct while receiving infusion services.

Please call **301-942-7600** to make all doctor's appointments. All infusion patients must see their physicians every 6-12 months. Please call ARISE at **240-514-5000** for any questions or to make infusion appointments.

By signing below, I acknowledge and agree to abide by these and all other Arise Infusion policies.

_____	_____	_____
Patient Name (Print)	**Signature**	**Date**

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Patient Registration

PATIENT NAME LAST	FIRST	M	DATE OF BIRTH	BIRTH SEX ☐ M ☐ F

HOME ADDRESS	APT NO.	CITY	STATE	ZIP

EMAIL ADDRESS:

HOME PHONE	CELL PHONE	PATIENT STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER :

PREFERRED PRONOUNS

☐ HE, HIM, HIS ☐ SHE, HER, HERS ☐ THEY, THEM, THEIRS ☐ ZE, HIR ☐ DECLINED ☐ OTHER

GENDER IDENTITY

☐ M ☐ F ☐ MALE-TO-FEMALE ☐ FEMALE-TO-MALE ☐ GENDERQUEER ☐ DECLINED ☐ OTHER

SEXUAL ORIENTATION

☐ HETEROSEXUAL/STRAIGHT ☐ BISEXUAL ☐ HOMOSEXUAL/LESBIAN/GAY ☐ DECLINED ☐ OTHER

RACE_____

PREFFERED LANGUAGE_____

ETHNICITY: ☐ HISPANIC/LATINO ☐ NON-HISPANIC LATINO ☐ DECLINED

FINANCIALLY RESPONSIBLE PARTY ☐ PATIENT ☐ SPOUSE ☐ PARENT ☐ OTHER:	RESPONSIBLE PARTY'S NAME	CELL PHONE

RESPONSIBLE PARTY'S ADDRESS	HOME PHONE

DO YOU HAVE AN "ADVANCE MEDICAL DIRECTIVE"?	MAY WE KEEP A COPYON FILE?

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name_____
First Middle Last

Address_____

Relationship_____

Home Phone _____

Work Phone _____

PRIMARY INSURANCE COMPANY	POLICY/ID NO.	GRP. NO/SERV. CODE

PRIMARY INSURANCE COMPANY ADDRESS

_____Phone _____
Street Suite # City State Zip

Name of Policyholder_____ ☐ Male ☐ Female Relationship_____

POLICYHOLDER'S DATE OF BIRTH	POLICYHOLDER'S ADDRESS

SECONDARY INSURANCE COMPANY	POLICY/ID NO.	GRP. NO/SERV. CODE

SECONDARY INSURANCE COMPANY ADDRESS

_____Phone _____
Street Suite # City State Zip

Name of Policyholder_____ ☐ Male ☐ Female Relationship_____

POLICYHOLDER'S DATE OF BIRTH	POLICYHOLDER'S ADDRESS

IS THIS CONDITION RELATED TO: ☐ EMPLOYMENT ☐ AUTO ☐ OTHER ACCIDENT

ARA does not treat conditions related to Employment, Auto or Other Accident. Please contact the office at 301-942-7600.

For practice use only: MRN: _____ DOS: _____

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 payments from _____insurance company for covered services be made directly to Arthritis & Rheumatism Associates, P.C. at their payment address.

Furthermore, I agree to designate Arthritis & Rheumatism Associates, P.C. to receive payment directly from the above-named insurance company in the event I file a claim for benefits myself and to forward within 15 business days any payments I may receive from the above-named insurance company for any services rendered by Arthritis & Rheumatism Associates, P.C.

Signature of policy holder or beneficiary_____Date _____

I certify that the information I have reported with regard to my insurance coverage and benefits is correct and further authorize the release of any necessary information, including protected health information, for this or any related claim to any billing agent acting on behalf of Arthritis & Rheumatism Associates, P.C. I permit a copy of this authorization to be used in place of the original and I understand that this authorization may be revoked by me at any time by submitting a written revocation.

Signature of policy holder 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 deeded to determine these benefits payable for related services." (NAME OF MEDIGAP INSURER)

Signature of policyholder or beneficiary_____Date _____

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Patient History Form

Appointment Date:____/____/_____ Age: _____ Birth Sex: ☐F ☐M Birthplace: _____
mm dd yyyy

Name:_____ Birthdate:____/____/_____
Last First Middle Maiden mm dd yyyy

Referred by (Check one):____Self____Family____Friend____Physician____Other Healthcare Professional

Name of Person Making Referral:_____Medication Recommended: _____

Name of Primary Care Physician: _____

Present Problem
Diagnosis:_____Date of Onset: _____

Present Symptoms: _____

Severity (1-10):_____Location: _____

Drug Allergies: No_____Yes_____List: _____

Type of Reaction: _____

Present Medications (Please list any medications you are taking. Include any over the counter medications.)

Name of Drug	**Dose**	**Number of Pills & How Often**	**How Long Have You Taken Meds?**	**Helped A Lot**	**Helped Some**	**Did Not Help at All**
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

Past Medical Conditions (Check all that you have now or have had before.)

☐ Arthritis (Type) _____
☐ Osteoporosis
☐Gout
☐ Lupus or SLE
☐ Myositis
☐Ankylosing Spondylitis
☐ Psoriasis
☐ Scleroderma
☐ Crohn's/Colitis
☐ Stomach Ulcers
☐ Multiple Sclerosis
☐ Epilepsy
☐ High Blood Pressure
☐ Heart Disease
☐ Heart Attack
☐ Stroke
☐ Diabetes
☐ High Cholesterol
☐ Alcoholism
☐ Hepatitis/Liver Disease
☐ HIV/AIDS
☐ Sexually Transmitted Disease
☐ Lung Problems_____
☐ Kidney Problems_____
☐ Thyroid Problems _____
☐ Cancer (Type) _____
☐ Bleeding Tendency
☐ Anemia
☐ Depression/Anxiety
☐ Tuberculosis
☐ Asthma

☐ Other Significant Illnesses (Please List All)

Surgeries
(Please List All)

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 of ages_____
Daughters _____ Sons_____ Adopted_____

Any blood relatives that have had any of the following.

Condition	Relative Relationship	Condition	Relative Relationship
Arthritis (all types)		Cancer (Type)	
Gout		Tuberculosis	
Lupus		Stroke	
Osteoporosis		Crohn's/Colitis	
Psoriasis		Heart Disease	
Asthma		High Blood Pressure	
Diabetes		Bleeding Tendency	
Thyroid Disease		Multiple Sclerosis	
		Epilepsy	

Social History

Primary language spoken: _____ Hand Dominance: ☐ Right ☐ Left
Occupation: _____ Retired: ☐No ☐Yes Date: _____
Employer: _____

House Pets: ☐No ☐Yes Type: _____
Do you smoke? ☐No ☐Yes☐ Past – How long ago: _____ Packs per day: _____Number of years:_____
Do you drink alcohol? ☐No ☐Yes -Number per week: _____Have you been told to reduce your drinking?_____
Do you drink caffeinated beverages? ☐No ☐Yes Type of beverages: _____ Glasses/Day:_____
Do you use drugs for reasons that are not medical? ☐ No ☐ Yes
Do you use supplements or vitamins? ☐No ☐Yes List: _____
Recent Travel: Out of State ☐No ☐Yes-_____ Internationally ☐No ☐ Yes-_____

Marital Status

☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse/Significant Other: ☐ Alive-Age_____ ☐ Deceased-Age_____ Major Illnesses: _____

Diagnostic Tests and Vaccines

Date of last eye exam: _____/_____/_____ MRI Scan: ☐ No ☐ Yes

Date of last chest x-ray: _____/_____/_____ CT Scan: ☐ No ☐ Yes

Date of last TB test: _____/_____/_____ Biopsy: ☐ No ☐ Yes

Date of last bone densitometry: _____/_____/_____ Location of last bone densitometry: _____

Vaccines: Shingles ☐ No ☐ Yes Date:_____ Pneumonia ☐ No ☐ Yes Date:_____

Influenza ☐ No ☐ Yes Date: _____ BCG ☐ No ☐ Yes Date:_____

Review of Systems(review the following list, and check any problems which have significantly affected you)

Constitutional

☐ Fatigue ☐ Recent Weight Gain

☐ Fever Lbs: _____

☐ Malaise ☐ Recent Weight Loss

☐ Night Sweats Lbs: _____

HEENT

☐ Eye Dryness ☐ Redness of Eyes, Ears, Nose,

☐ Eye Pain Mouth, Throat

☐ Loss of Hearing ☐ Loss of Smell

☐ Visual Changes ☐ Difficulty Swallowing

☐ Sores in Mouth ☐ Nose Bleeds

☐ Hoarseness ☐ Dry Mouth

Respiratory

☐ Cough ☐ Shortness of Breath

☐ Wheezing (Asthma) ☐ Coughing up Blood

Cardiovascular

☐ Chest Pain ☐ Difficulty Breathing at night

☐ Swollen Legs/Feet ☐ Irregular Heart Beat

Vascular

☐ Cool Extremity ☐ Thrombosis Phlebitis

☐ Ulcer ☐ Raynaud's

Gastrointestinal

☐ Abdominal Pain ☐ Jaundice

☐ Diarrhea ☐ Heartburn

☐ Vomiting ☐ Increasing Constipation

☐ Nausea ☐ Blood in Stool

☐ Changes in Stool - _____

Genitourinary

☐ Difficulty Urinating ☐ Blood in Urine

☐ Urinary Incontinence ☐ Increased Urinary Frequency

Endocrine

☐ Excessive Thirst ☐ Abnormal Sleep

☐ Goiter ☐ Tremors

☐ Hair Changes

Reproductive

Female

☐ Vaginal Discharge ☐ Breast Discharge

☐ Vaginal Dryness ☐ Sexual Dysfunctions

☐ Irregular Menses

Male

☐ Penile Discharge ☐ Sexual Dysfunctions

Neurological System

☐ Gait Disturbance ☐ Extremity Numbness

☐ Headaches ☐ Dizziness

☐ Memory Loss ☐ Vertigo

☐ Seizures

Psychiatric

☐ Depression ☐ Anxiety

☐ Insomnia

Intergumentary Skin

☐ Sun Sensitivity ☐ Hair Loss

(Sun Allergy) ☐ Rash

☐ Hives ☐ Skin Thickening

Musculoskeletal

☐ Back Pain ☐ Joint P ain

☐ Neck Pain ☐ Joint Swelling

☐ Muscle Tenderness ☐ Muscle Weakness

☐ Morning Joint Stiffness

Lasting How Long: _____Minutes _____Hours

Hematologic/Lymphatic

☐ Easy Bruising ☐ Easy Bleeding

☐ Swollen Glands ☐ Anemia

Allergic/Immunologic

☐ Asthma ☐ Seasonal Allergies

☐ Food Allergies ☐ Environmental Allergies

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.

COST-SHARE RESPONSIBILITY

Many insurance carriers require patients to share the cost of their medical services through copay, coinsurance, or deductible.

Health insurance cost-share definitions are as follows:

Copay – a fixed dollar amount that a patient is required to pay per visit.

Coinsurance – a fixed percentage of the final dollar amount that patients are required to pay for a medical service.

Deductible – a fixed dollar amount that patients are required to pay first before their insurance carrier begins to pay for their medical service.

Patient cost-sharing is an integral part of the health insurance benefit plan for both federal and commercial insurance carriers. As a patient, you are expected to understand your healthcare benefits and cost-share amounts associated with your plan. ARA will make every attempt to collect all patient responsibility payments as determined by your insurance. Your insurance should provide you with an explanation of benefit (EOB) after a medical service claim is processed. All copayments are due at the time of service. Coinsurance, deductible, and any outstanding balance will be billed to you.

A plan is considered out-of-network if there is no contractual agreement with the health plan and ARA. If the health plan's out-of-network coverage is less than the ARA's acceptable rate, ARA reserves the right to balance bill a patient.

MEDICARE PART B

ARA participates with Medicare and accepts assignment. We will file your claim and ask you to pay any deductible you may owe plus your 20% coinsurance at the time of checkout. If you have a secondary insurance, we will file the claim for you, and you will be billed for any remaining balance. In order to receive a non-covered supply or service, you will be required to sign a Medicare waiver (Advance Beneficiary Notice or ABN) and pay in full. ARA does not participate with any Medicare Advantage Plans, with the exception of CareFirst Medicare Advantage HMO and PPO, and Johns Hopkins Medicare Advantage HMO and PPO. If you have a non-participating Medicare Advantage HMO plan, you will not have any out of network benefits. If you are covered by a Medicare Advantage PPO plan that gives you out of network benefits, you may have to pay any deductible and coinsurance payments due as determined by each individual Medicare Advantage Plan. If you are seeking services from Arthritis Rehabilitation Therapy Services (ARTS), Medicare will not pay for outpatient physical therapy while concurrently receiving home care services. In order for Medicare to cover your physical therapy at ARTS, you must discontinue ALL home care services (physical, occupational or speech therapy, nursing, home health aide, social work). If you do not, Medicare will automatically choose to pay for the home care services only, and you will be financially responsible for your outpatient physical therapy at ARTS.

For practice use only: MRN:_____DOS: _____ Patient Name: _____

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 (BlueChoice), Point of Service, Federal Employee, PPO, Blue Card, National Account and Indemnity Plans. The HMO plan requires that you obtain a referral to see a specialist which must be presented at check-in. Otherwise you will need to sign a waiver agreeing to pay for all services rendered.

PPO, POS and HMO Plans

Currently, ARA participates with Aetna HMO and PPO, CIGNA, Multiplan, PHCS and Priority Partners. All PPO and HMO patients are required to pay their copayment 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 coinsurance their plan requires. *ARA will be in violation of our contracts if we fail to collect amounts you are contractually obligated to pay.*

Workers' Compensation

ARA does not accept new patients with work-related injuries who will be using workers' compensation to cover their care. If an established patient's visit is related to a work injury, the patient must contact the Business Office prior to their appointment and provide complete billing information for the workers' compensation carrier. This includes the active claim number, carrier name, adjustor's name and phone number, and pre-authorization from the insurance company. If the employer is disputing the case, it will not be considered a workers' compensation case until an independent medical examiner, or the court makes a ruling. In such cases, we will bill the patient's health insurance. If the patient does not have health insurance, payment will be required at the time of service.

Liability Cases/Auto Accidents

ARA will not bill the personal injury protection (PIP) portion of your auto insurance coverage. Physicians will treat patients injured in personal injury or auto accident cases, but the patient's own 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.

FMLA, Disability, and Other Forms

ARA physicians do not fill out FMLA forms nor do they provide disability assessments or supporting documents for patients unless they have been seen for at least 6 visits or for longer than one year, and also at least once in the last 6 months. Even beyond this time frame, your physician may determine that it is more appropriate for your primary care provider or other specialist to manage your disability application and forms. ARA physicians do not have the experience or training to prepare disability documents from a legal perspective. If your physician provides disability documents, the information used will be primarily based on objective information obtained from physical examination, diagnostic studies, and laboratory findings which may not support a disability claim. You will also be charged a $35 fee if your physician completes the disability documents outside of a scheduled visit. You may be better served if you discuss with your attorney whether disability documents should be obtained from another specialist who performs disability evaluations on a regular basis. Other forms, such as but not limited to, handicapped placards, workplace accommodations, jury duty excuse, and transportation / Metro Access forms, will be subject to the $35 fee if requested to be completed outside of a scheduled office visit.

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 we are contractually obligated to do so. Depending on the carrier, you may be asked to pay your balance in full or pay any deductible or copayment due. Any balances not paid by the patient's insurance company/companies within 45 days will be charged directly to the patient.

Self-Pay

ARA offers a self-pay rate to patients who have no health insurance or have non-participating health insurance. The self-pay amount owed is expected to be paid in full at the time of service as ARA will not be submitting a claim to an insurance carrier. Self-pay patients are responsible for ancillary service charges such as laboratory, radiology, or any other services performed by ARA providers on the date of service.

Non-Sufficient Funds (NSF) Policy

A $50 NSF fee will be added to any patient's account that is returned by our bank for non-sufficient funds.

Bank Payment Dispute/Chargeback Policy

A $25 chargeback fee will be added to any patient's account that erroneously disputes a credit card payment without first contacting the Business Office for dispute resolution. The chargeback fee is to cover bank processing fees associated with the dispute.

No Show and Cancellation Policy

We request that cancellations or scheduling changes be made during clinic hours no later than the last business day prior to your appointment. If you are a new patient to our practice, the missed appointment fee is $100. If you are an established patient of the practice, the missed appointment fee is $25. In order to reschedule your missed appointment, you will be required to pay the missed appointment fee.

If you have an appointment with Arthritis Rehabilitation Therapy Services (ARTS) the new patient missed appointment fee is $50 and the follow up missed appointment fee is $50.

Assistance

Our Business Office staff is available to assist you with any special concerns or questions. Please feel free to call (301) 942-3126 for personal attention.

Responsibility

Failure to disclose a change in insurance coverage or failure to disclose another (primary, secondary, or tertiary) insurance coverage will not absolve the patient of responsibility for all charges, and may also be grounds for dismissal from the practice.

Patients are responsible for any outstanding balances. In the event a patient's account is turned over (for collections) or to a third party, the patient 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 **Date**

Print Name

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AUTHORIZATION TO RELEASE INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996 (HIPAA), in order for your physician or his/her staff to discuss your medical and/or financial information with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode, or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I DO authorize the Practice to release any or all information to the following individuals:

Name	Relationship
Name	Relationship
Name	Relationship
Patient Signature	Date

Revised 5/2021

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ARA PATIENT CODE OF CONDUCT

Cell Phones/Electronic Devices: Cell phones and electronic devices are permitted in the office but must be turned to silent or vibrate. Phone conversations, video chat, and live-stream are prohibited while in the office. Headphones must be worn while using a cell phone or electronic device for listening to music, watching videos, etc.

Photographs/Recording: Photos, Audio and Video recording, using any electronic device, is strictly prohibited.

Children under 18 years: All children under 18 years old must be accompanied by an adult. Children may not be left alone without adult supervision in any area of the office and are not allowed in treatment areas, including but not limited to, the infusion, physical therapy, radiology departments. Patients under 18 years old must be accompanied by an adult.

Privacy: We ask that you respect the privacy of other patients. All patients must remain in designated patient areas (waiting room, exams rooms, and other testing/treatment areas). Patients may not enter any area designated for staff only.

Safety: The staff takes every precaution to ensure a safe and pleasant visit. Safety is our highest priority. If you have any safety concerns, please bring it to the attention to a staff member or a manager immediately.

Respect: We ask that you respect the staff and other patients in the office. Any threatening or derogatory language, racial slurs, cursing, etc., will not be tolerated. Anyone who engages in this behavior will be asked to leave immediately and may be discharged from the practice.

No Show / Same Day Cancellation Fee: A Fee will be assessed for all no shows or same day cancellations. We request that cancellations or scheduling changes be made during clinic hours no later than the last business day prior to your appointment.

I, _____ , certify that I have read and understand the code of conduct and will comply with all ARA /ARISE protocols. I acknowledge that failure to do so may result in being discharged from ARA and all its services.

Signature: _____ Date: _____

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How We Handle Laboratory Test Results

In the event you may have had lab work performed today and your lab work is normal, you will not hear from our office. However, your physician will discuss the results with you at the time of next office visit. We will call you for any abnormal laboratory tests that require immediate attention; otherwise they will be discussed at your next visit unless your physician has specifically asked you to call for results.

Remember, we will call you if any of your lab work requires immediate attention; otherwise, your results will be discussed at your next visit. You can access your reports through the patient portal.

How We Handle Prescription Refills

- If you have a prescription that needs to be refilled, please bring it to the attention of the medical assistant or your physician at the time of your visit.

- ARA uses e-prescribing to deliver all prescription orders to your pharmacy. E-prescribing is a seamless process that is accomplished through a few clicks in our electronic medical records system. It is strongly encouraged by the Centers for Medicare and Medicaid and many commercial insurance companies because it makes it much easier to track prescriptions and improves patient safety. Unfortunately, technicians at some area pharmacies continue to rely on outdated fax technology to request authorization for refills. ARA does not accept fax requests for refill Authorizations.

- We kindly request that you remind your pharmacy to use the e-prescribing system if they inform you that they have not received a response to their faxed refill request from ARA.

How We Handle Prior Authorizations

We want to let you know that insurance companies often require prior authorizations for certain medications, and this process can take longer at the start of the year. Insurers may also require switching from brand-name biologic medications to their preferred biosimilars. Our providers will only appeal for a brand-name medication if the preferred alternative has been tried and was not effective. Thank you for your understanding.

Thank You,
The Physicians and Staff at ARA

Revised 3/2026

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Infusion Copay Assistance Programs Agreement

I, _____, acknowledge the following:
Print Name

Arise Infusion provides the service of enrolling our patients into available copay programs that are provided by drug manufacturers. If approved, we submit the explanation of benefits (EOB) to the programs on the patients' behalf.

However, maintaining an active status in these programs is ultimately the responsibility of the patient. Patients must verify their dates of eligibility in the copay assistance program and notify Arise Infusion when they need to re-enroll. Patients are responsible for monitoring their awarded dollar amount to know if/when they run out of funds and are also responsible for notifying Arise Infusion when they have exhausted their funds.

If a co-pay program does not pay for a claim for any reason, Arise Infusion will assist the patient in the appeal process. However, if the services are not covered, it is the responsibility of the patient to pay for all non-covered services.

Please check on of the following:

- ☐ **Yes,** I want to enroll (continue to the payment section below)
- ☐ **No,** I do not want to be enrolled. By declining, I understand I am responsible for all costs that my insurance does not cover.

_____ _____
Patient Signature Date

Payment Method

The copay program will assist you towards your cost share for the infusion medication. The program reimburses your cost share either directly to you by check or to us via credit card or electronic funds transfer (EFT). We strongly suggest that you choose the credit card/EFT option. If you choose to receive the reimbursement by credit card/EFT, our office will wait until the card is loaded or an EFT is sent prior to collecting your owed portion. If you choose to receive reimbursement by check, you will be responsible for your portion of payment on the medication and administration **prior** to each infusion. You will then be responsible for receiving your personal reimbursement by check from the pharmaceutical support company. Without payment we will not be able to infuse you.

Please indicate below how you would like to be reimbursed:

- ☐ By Credit Card/EFT - Use to pay Arise Infusion
- ☐ By Check - Pay the infusion medication cost to Arise Infusion at the time of service

_____ _____
Patient Signature Date

Patient Name: _____
Date of Birth: _____

Arthritis and Rheumatism Associates provides medically integrated dispensing services at select clinic locations for your convenience. If you qualify for these services and are prescribed a specialty medication, a team member will contact you to review your options.

You always have the right to choose where your prescription is filled. This includes selecting your preference on where to obtain your medication. In addition, your medication may be billed under your pharmacy benefits, depending on your specific plan coverage and the nature of the medication.

By signing this form, you acknowledge that you have been informed of your choices and if you choose to fill your prescription through the ARA Dispensary you are consenting to the statements below.

Acknowledgment and Declaration

I, the undersigned patient, declare the following:

1. I acknowledge that I have been informed of the option to obtain my prescription drugs from a pharmacy.

2. I affirm that I have determined, based on my own judgment, that a pharmacy is not conveniently available to me.

3. I understand that this determination was made solely by me, without influence or suggestion from the licensee or their staff.

4. I consent to receive prescription drugs dispensed directly by the licensee.

Patient Signature and Date

Signature: _____
Date: _____

ARTHRITIS
AND
RHEUMATISM
ASSOCIATES, P.C.

Arise Infusion Therapy Services
Arthritis and Rehabilitation Therapy Services
Gout Center of Excellence
Medical Cannabis Institute
Osteoporosis Assessment Center
Wellness and Weight Loss Center

DIVISIONS OF ARTHRITIS AND RHEUMATISM ASSOCIATES, P.C

Patient Financial Responsibility Waiver for Infusion Therapy Services

This waiver outlines your financial responsibilities related to infusion therapy received at ARISE Infusion Therapy Services. It is essential that you understand and agree to your obligations regarding insurance coverage disclosure and payment responsibility.

You are required to:

- Disclose all insurance coverage, including primary, secondary, and tertiary plans—regardless of whether ARISE participates in the plan.
- Immediately notify ARISE of any changes, lapses, or termination of insurance.
- Ensure your insurers are informed of any multiple policies to coordinate benefits properly.

Failure to Disclose

If you do not provide accurate and timely insurance information or fail to report changes in coverage:

- You will be financially responsible for all services rendered.
- Treatment may be delayed or suspended until insurance issues are resolved.
- Any denied claims due to lack of coordination or coverage disclosure will become your responsibility.

Acknowledgment

Please check each box to confirm your understanding and agreement:

☐ I am responsible for disclosing all insurance coverage, including primary, secondary, and tertiary plans—regardless of ARISE's participation.

☐ I may be billed directly for any services not covered or denied due to failure to disclose or update insurance. This may result in full financial responsibility and possible dismissal from the practice.

☐ I am responsible for all deductibles, co-pays, coinsurance, and any remaining balances.

I, the undersigned, acknowledge that I have read and understand the above statement and have been given the opportunity to ask questions. I confirm that I am the patient, or the patient's duly authorized representative.

_____
Print Patient or Representative Name

_____ _____
Patient or Representative Signature Date

If signed by someone other than the patient, please specify relationship to the patient: _____