Dr. Aria
2865 Duke Street, Alexandria, VA 22314

Please read the following office policy information and initial after reading each paragraph

- _____ (initials) I understand that it is my responsibility to provide the doctor with my current and accurate insurance card and a valid referral, if required by my insurance, at the time services are rendered. If I cannot provide my current insurance card and/or referral, my appointment may be rescheduled. Claims that are denied for payment because of incorrect insurance information will become the responsibility of the patient.

- _____ (initials) I acknowledge that if I have a **PPO** plan or **Medicare** a referral may not be required for my visit. I acknowledge that if I have an **HMO** plan, I am required by my insurance company to have an appropriate referral from my primary care physician at the time of my appointment. If I am seen without an appropriate referral, I will be responsible for any non-covered services.

- _____ (initials) If for any reason I need a copy of my records, I acknowledge that this must be requested **in writing** and there will be a record release processing fee. I recognize that it may take up to TWO WEEKS for the request to be processed and that most records are not kept beyond six years. Additionally, I understand the office will not complete any workman's compensation or disability forms.

- _____ (initials) It is my responsibility to schedule any recommended testing or procedure and to obtain referrals to other physicians for biopsy, radiology, consultation and/or surgery. I will follow up with Dr. Aria's office to ensure results have been received by their office.

- _____ (initials) I acknowledge that if I do not comply with Dr. Aria's recommendations to have advised procedures (such as radiology, biopsy or other additional testing) performed, I accept full responsibility for any undesirable consequences of my medical condition.

- _____ (initials) I understand that if I need a refill on a prescription, I will contact my pharmacy and ask them to fax a written request to the office. I recognize that it may take two days for processing, and if I request this process to be expedited, there will be a $25.00 fee. If I have not been seen within one year of receiving the original prescription, I will need to be re-evaluated. If I lose my original prescription there is a $10.00 lost prescription fee and I must come into the office to pick it up.

- _____ (initials) **Per my insurance company, co-pays must be collected at the time of service. Payment is preferred to be made in the form of cash or personal checks.** Health benefits cards are also acceptable. I am aware that my insurance plan may be subject to a deductible for procedures, such as freezing/biopsies/ sonograms. Balances of less than $10.00 may only be billed once a year. If this presents any inconvenience, the office is happy to keep your credit card on file and charge once the balance is due.

- _____ (initials) If I fail to show up to my appointment without giving the office 24 hours notice of cancellation, I am aware that there is a $25.00 cancellation fee.

I have read and understand the above information.

SIGNATURE: _____ DATE: _____

Relationship to Patient: _____