Inova™

1PAND

Patient Information:
Name (last, first, middle initial): _____ Email Address: _____

Address: _____ Apt # _____ City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____ Legal Sex: ☐ Male ☐ Female ☐ X Social Security #: _____ Preferred Language: _____

Phone Number (mobile): _____ Phone Number (alternate): _____ ☐ home ☐ work

To minimize disruption to your daily life but also keep you informed, Inova uses SMS text message to communicate non-clinical messages like appointment reminders and surveys. If you would prefer that we contact you via another method, please let us know.

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired Employer: _____
☐ Student ☐ Other _____

Emergency Contact: _____ Relationship to Patient: _____

Address: _____

Phone Number (home): _____ Phone Number (alternate): _____ ☐ cell ☐ work

Demographics: Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native
☐ More than one race ☐ Hispanic ☐ Native Hawaiian or other Pacific Islander
☐ Decline to say ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to say

Insurance Information – We will request to scan your ID and insurance card.
Primary Insurance: _____ Patient is Subscriber/Policy Holder: ☐ Yes ☐ No
Member ID # _____ Provider/Insurance Services Phone Number _____
Secondary Insurance: _____ Patient is Subscriber/Policy Holder: ☐ Yes ☐ No
Member ID # _____ Provider/Insurance Services Phone Number _____

Insured Information (if other than patient):
Subscriber/Policy Holder: _____ Relationship to Patient: _____
Address: _____
Social Security Number: _____ Date of Birth: _____ Subscriber Employer: _____

Please indicate your referring provider in addition to other providers who will need your treatment information.

Primary Care Provider Name: _____
Address: _____ Phone Number: _____ Fax Number: _____
Specialty Care Provider Name: _____ Specialty: _____
Address: _____ Phone Number: _____ Fax Number: _____
Specialty Care Provider Name: _____ Specialty: _____
Address: _____ Phone Number: _____ Fax Number: _____

Patient/Parent/Guardian (signature): _____ Date: _____ Time: _____
Patient/Parent/Guardian (print name): _____ Relationship: _____

Interpreter Information (To be completed by Inova staff, if applicable):
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____
Date of Birth: _____ Medical Record # _____

Inova Physician Services
Patient Registration Form

Outpatient Location: _____

CAT # 30806/R082323 • PKGS OF 100

Inova™

1PMTREV

Department/Location: _____

1. For Medicare Recipients:
I certify that the information provided to me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to Inova (or its affiliates) for any services furnished to me during the applicable periods of medical care.

2. Assignment and Coordination of Insurance Benefits:
I agree to provide information regarding all health insurance benefits to which I/the patient may be entitled. I hereby assign payment(s), if any, from insurance carrier(s) health benefit plan to Inova (or its affiliates) for services rendered to the patient. I hereby authorize payments directly to Inova, including any benefits otherwise payable to me under the terms of my policy, but not to exceed the balance due to Inova (or its affiliates) for services rendered to me during the applicable periods of medical care.

3. Unauthorized, Non-covered, or Out of Plan Services:
I understand and acknowledge:

- If my insurance carrier or administrator of benefits does not consider any services rendered covered services, or has not authorized these services, they will not pay and I agree to pay for these services.
- **One or more of my physicians may not accept insurance or may be out of network with my health insurance.**
- In the case of out of plan/network physician or services, there may be reduced benefits and I may be required to pay a higher co-pay, deductible or co-insurance amount.

4. Responsibility for Payment:
In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible including but not limited to health benefit deductibles, copayments, co-insurance and non-covered services. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorneys' fees and other collection costs.

5. Automobile Accident Patients - Notice regarding the assignment of medical expense benefits will be provided to you in a separate document.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered, and accept the above conditions and terms; and I agree to pay all charges for which I may be legally and/or contractually responsible, including but not limited to health insurance deductibles, co-payments, and non-covered services. **I understand that Inova, its affiliates, agents (including but not limited to debt collectors) or designees may contact me about outstanding balances through various methods including the use of manual representative outbound calls and voice messages and/or automated dialing services and pre-recorded artificial voice messages, at any telephone number I provide to Inova.** I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Inova. *I understand and agree this document will remain in effect for my present outpatient visit and any future outpatient or physician office visits to Inova, unless specifically cancelled in writing by me.* I understand that I will be asked to review and sign this form once per calendar year as long as I remain a patient of Inova.

_____ _____ _____ _____

Patient/Guardian/etc. (signature) **Patient/Guardian/etc.** (print name) Date Time

_____

Relationship to Patient (if not signed by patient)

Interpreter Information (To be completed by Inova staff, if applicable):
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova

Authorization for Claims, Payment, and Reviews - Ambulatory

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH

☐ IMG: _____ ☐ Other: _____

White: Medical Records • *Yellow:* Patient Copy

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Inova™

1HIPAA

I certify that I have received Inova's **Notice of Privacy Practices** and that I have a right to receive an additional copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Inova's health care operations. The Notice also describes my rights and Inova's duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Inova's web site at www.inova.org. I may request that a copy be mailed to me by calling **571-472-8187.**

Inova reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**. I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing Inova's web site listed above to view the most current version.

Patient or Personal Representative (signature) _____ Date _____ Time _____

Patient or Personal Representative (print name) _____

Description of Personal Representative's Authority _____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Inova

Acknowledgement of Receipt of Notice of Privacy Practices

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH

☐ Outpatient Location: _____

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Inova™

1CNT

Inova Staff Instructions:

- Use this form ONLY when a patient refuses to use Inova's interpreters (spoken or sign language) and insists on using their own interpreter.
- A trained interpreter must be used when reviewing and obtaining signature on this waiver.
- The completed form must be scanned into the electronic health record or placed in the shadow chart (Medical Records will scan into the record).
- Staff may call an Inova interpreter to remain in the room if they feel that the patient's preferred interpreter is unable or unwilling to interpret correctly.
- This form must be completed for each episode of care or change of interpreter.

For Patient Review and Signature:

Inova staff has offered me free interpreter services by qualified interpreters.

☐ I am declining Inova's interpreters at this time.

☐ I am choosing to use my own interpreter at this time. The name of my interpreter is _____. This person is 18 years old or older.

Inova staff has explained to me, in my own language, the risks of using untrained interpreters, including friends or family members, as my medical interpreters. These risks include:

(1) Untrained interpreters may convey inaccurate information, add or leave out part of the message, misunderstand what my caregiver says, or not know and/or understand the correct medical terminology.
(2) My medical treatment may involve issues that are difficult for a family member or friend to discuss with me.
(3) Family members or friends may learn and share with others information about my health that I do not want anyone else to know.
(4) My treatment may be delayed if my chosen interpreter, family member or friend is not present when needed to interpret.

I understand that:

- If the medical team in charge of my care requests an Inova trained interpreter, one will be provided.
- I can change my mind at any time and use the services of an interpreter provided by Inova at no cost to me.
- This form does not give permission for an interpreter to act as my authorized representative.

I understand the risks of not using an interpreter provided by Inova and will not hold responsible Inova and/or its physicians or staff for any issues that may result from mistaken, inaccurate or incomplete interpretation of information.

Patient/Patient Authorized Representative (signature): _____ Date: _____ Time: _____

Patient/Patient Authorized Representative (print name): _____ Relationship to Patient (if applicable): _____

Patient's Designated Interpreter (signature): _____ Date: _____ Time: _____

Patient Designated Interpreter (print name): _____ Relationship to Patient: _____

Staff Member (signature): _____ Date: _____ Time: _____

Staff Member (print name): _____

Inova Interpreter Used (To be completed by Inova staff, if applicable):

☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova

Waiver of Interpreter Services

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH

☐ IMG: _____

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MEDICARE QUESTIONNAIRE

Patient Instructions:

1. Complete Parts I and II.
2. Your answer to Part III will direct you to one last section (Part IV, V or VI).

Instructions for Hospital Use:

1. The MSP Questionnaire must be completed for every inpatient, outpatient, and ER visit.
2. Use the MSP worksheet to determine the occurrence, condition and/or accident type fields and dates that must be entered on the UB 92 screen.
3. If a code appears in more than one answer, you need only enter it once in the appropriate field on the UB 92 screen.

Medicare Questionnaire

Please complete this questionnaire for each Medicare patient. Where indicated, please enter the correct corresponding condition code and/or occurrence code with date on the UB 92 screen.

SET MEDICARE QUESTIONNAIRE FLAG IF QUESTIONNAIRE NOT COMPLETED.

PART I

1. Is the patient receiving Black Lung benefits?
   - ❑ Yes; Date benefits began: ____ / ____ / ____ [enter cond code 02]
     Black Lung is primary only for claims related to Black Lung, then select plan code 215.
   - ❑ No.
2. Are the services to be paid by a government program such as a research grant?
   - ❑ Yes; Government program will pay primary benefits for these services.
   - ❑ No.
3. Has the Department of Veteran Affairs (DVA) authorized and agreed to pay for care at this facility?
   - ❑ Yes; DVA IS PRIMARY FOR THESE SERVICES [enter cond code 01]
   - ❑ No.
4. Was the illness/injury due to a work related accident/condition?
   - ❑ Yes; Date of illness or injury: ____ / ____ / ____ [enter date and] [cond code 02 and] [acc type 04] WC IS THE PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESSES. SELECT WC INSURANCE PLAN AND ENTER COMPLETE INFO ON WC INSURANCE SCREEN.
   - ❑ No; GO TO PART II. ❑ Yes; GO TO PART III.

PART II

1. Was the accident due to a non-work related accident?
   - ❑ Yes; Date of illness or injury: ____ / ____ / ____ [enter acc type 05]
   - ❑ No; GO TO PART III.
2. What type of accident caused the illness/injury?
   - ❑ automobile [acc type 01]
   - ❑ non-automobile [acc type 05]

   Name and address of no fault liability insurer: _____
   _____

   Select appropriate insurance plan and enter info on insurance screen.
   NO FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.
3. Was another party responsible for this accident?
   - ❑ Yes; LIABILITY INSURER IS PRIMARY ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT.
     Name / address of liability insurance: _____
     _____
     Claim #: _____
     GO TO PART III.
   - ❑ No; GO TO PART III.

PART III

1. Is the beneficiary entitled to Medicare based on:
   ❑ Age. GO TO PART IV ❑ Disability. GO TO PART V ❑ ESRD. GO TO PART VI

PART IV - AGE

1. Is the patient currently employed?
   - ❑ Yes; collect and enter employer info
   - ❑ No; Date of retirement: ____ / ____ / ____ [occur code 18 with date]
2. Is the spouse currently employed?
   - ❑ Yes; Select appropriate insurance plan and enter name/address of spouse's employer.
   - ❑ No; Date of retirement: ____ / ____ / ____ [occur code 19 with date]
     IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II. DO NOT PROCEED ANY FURTHER.
     If neither pt. or spouse work, [enter cond code 09]
3. Does the patient have Group Health Plan coverage based on his/her own, or a spouse's current employment status?
   - ❑ Yes.
   - ❑ No; STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.

PART IV *(CONTINUED)*

4. Does the employer that sponsors the patient's GHP employ 20 or more employees, or is the GHP a multiemployer plan or multiple employer plan with at least one participating employer that employs 20 or more employees?
   - ❑ Yes; STOP. GROUP HEALTH PLAN IS PRIMARY. SELECT APPROPRIATE INSURANCE PLAN AND ENTER INFO ON INSURANCE SCREEN.
   - ❑ No; STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.

PART V – DISABILITY

1. Is the patient currently employed?
   - ❑ Yes; collect and enter info on CREG 1 screen.
   - ❑ No; Date of retirement: ____ / ____ / ____ [occur code 18 with date]
2. Is a family member of the patient currently employed?
   - ❑ Yes; Enter info in WP window.
   - ❑ No; [Is spouse, occ code 19 with date of retirement: ____ / ____ / ____]
     IF THE PATIENT ANSWERS NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II. DO NOT PROCEED ANY FURTHER.
3. Does the patient have GHP coverage based on his/her own, or a family member's current employment status?
   - ❑ Yes; SELECT APPROPRIATE INS PLAN AND ENTER COMPLETE INFO ON INS SCREEN.
   - ❑ No; STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.
4. Does the employer that sponsors the patient's GHP employ 100 or more employees?
   - ❑ Yes; GROUP HEALTH PLAN IS PRIMARY. SELECT APPROPRIATE INS PLAN AND ENTER COMPLETE INFO ON INS SCREEN.
   - ❑ No; STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.

PART VI – ESRD

1. Does the patient have group health plan coverage?
   - ❑ Yes; SELECT APPROPRIATE INS PLAN AND ENTER COMPLETE INFO ON INS SCREEN.
   - ❑ No; STOP. MEDICARE IS PRIMARY.
2. Is the patient within the 30-month coordination period?
   - ❑ Yes; [cond code 06]
     [OCC CODE 33 AND DATE BEGINNING ESRD COORDINATION PERIOD]
   - ❑ No; STOP. MEDICARE IS PRIMARY.
3. Has the patient received a kidney transplant?
   - ❑ Yes; Date of transplant: ____ / ____ / ____ [occur code 36]
   - ❑ No.
4. Has the patient received maintenance dialysis treatments?
   - ❑ Yes; Date dialysis began: ____ / ____ / ____
     If the patient participated in a self dialysis training program, provide date training started: ____ / ____ / ____
   - ❑ No.
5. Is the patient entitled to Medicare on the basis of either ESRD and age or ESRD and disability?
   - ❑ Yes.
   - ❑ No; STOP. GHP IS PRIMARY DURING THE 30 MONTH COORDINATOR PERIOD.
6. Was the patient's initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?
   - ❑ Yes; STOP. GHP IS PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.
   - ❑ No; MEDICARE CONTINUES AS PRIMARY.
7. Does the working aged or disability MSP provision apply, i.e. is the GHP primary based on the age or disability entitlement?
   - ❑ Yes; STOP GHP CONTINUES TO PAY PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.
   - ❑ No; MEDICARE CONTINUES TO PAY PRIMARY.

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