Massoud Saberinia, MD

Endocrinology & Metabolism
Clinical Assist. Professor of Medicine, Georgetown University

1715 North George Mason Drive, Suite 408
Arlington, VA 22205
Phone: (703) 526-0666 | Fax: (703) 526-0361

9001 Digges Road, Suite 208
Manassas, VA 20110
Phone: (703) 530-7888

OFFICE POLICY

Appointments/Cancelations: We respect your time and will make every effort to see you on schedule; however, unexpected emergencies can occur. If you arrive more than 10 minutes late, we will attempt to see you but your appointment may have to be rescheduled which will result in a missed appointment fee. The Office requires that every patient schedule their follow-up appointment at each visit. We kindly ask for a three-day advance notice if you need to cancel or reschedule your appointment. A no show fee will be charged for any appointment canceled less than 24 hours in advance, or canceled after hours on weekends and holidays for an appointment scheduled the next business day ($250 for new patient, $50 for follow-up). Follow-up appointments may only be canceled or rescheduled two consecutive times. New patients may only cancel or reschedule one time without incurring a fee. A $250 fee will be charged if you cancel or reschedule a new appointment for a second time. Repeated no shows or cancelations will result in dismissal from the practice.

Billing/Insurance: Office billing is handled by Athena Health. The Office requires that every patient has a Visa or MasterCard on file. Athena Health will send a notice to the patient by email about any balance due prior to charging the card on file. If we are contracted with your insurance company, we will file a claim on your behalf; however you are responsible for copays, deductibles, co-insurance, or non-covered services at the time of your appointment. Uninsured or out-of-network patients are expected to pay in full at each appointment. Unpaid balances will be sent to a collection agency (Suburban Credit Corp.).

Prescriptions: The Office requires a 48-hour notice for any medication refills. We do not fill medications on the weekend. You will need to contact your pharmacy and ask that a refill request be submitted to the office. We will not issue any refills if you cancel or miss your appointment or if you reschedule your appointment more than one month out. If you have a scheduled appointment and run out of medication, we can only send enough medication until your appointment date. You should only call the office for a refill if the medication is new or if you changed your preferred pharmacy. Patients who use a mail order pharmacy must be seen every three months.

Labs/Radiology: The Office's preferred lab is Quest Diagnostics. If you need to use an alternate lab, it is your responsibility to have your lab order and ensure the results are sent to the Office. Lab and radiology procedures should be completed 1-2 weeks in advance of your appointment. Please note that some lab results can take a full seven days to report. If you go to the lab or radiologist without your order, you may have to wait up to 30 minutes for the doctor to issue a new order (we cannot interrupt the doctor for your lost order).

Medical Records: In accordance with Virginia law, there is a charge for copying medical records. Please contact the office for the price based on your records. The Office requires a medical record release form to be completed and signed by the patient. Please allow one week to process and send the records. There is a $15.00 fee for any forms that need to be completed by the doctor (Disability, FMLA, Patient Assistance, Letter of Care, etc.).

Initial: ______ I understand that I need to bring my insurance card, photo ID, Visa/MasterCard, and Referral (if referral is required by your insurance) to each appointment.

I have read and agree to the above policy.
Name: ____ Date: _______________
Signature: ____

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NEW PATIENT DEPOSIT AGREEMENT

I ____ hereby agree to the following policy to be seen as a new patient with Dr. Saberinia.

1. I will pay a deposit of $155.00 to secure my appointment.

2. I understand that if I do not give a 48-hour notice to cancel my appointment the deposit of $155.00 will be applied as a missed appointment fee. Please note canceled appointments must be made during office hours; not on weekends or holidays.

3. I understand that my deposit will be applied to any balances for my first visit and that any remaining credit can be refunded.

____
Signature of Patient or Guardian Authorizing Service

____ __________________
Print Name Date

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PATIENT WAIVER FORM

I, ____ fully understand and agree to pay for all services provided by Dr. Saberinia due to the following:

- ☐ I do not have a valid referral from my primary care physician. I understand that my primary care physician has 5 days from the date of my visit to submit a referral to the office but this will not guarantee payment from my insurance.
- ☐ I choose to be seen out-of-network and will pay for each visit at the time of service.
- ☐ As of ____/_____/____, I will be seen as a Self-Pay Patient.
- ☐ I authorize the Athena health system to charge my credit card for any outstanding balance from an office bill(s) or my insurance company.
- ☐ My insurance plan has a deductible/percentage and I am responsible for the portion not covered by my insurance for **every** visit including any outstanding balances.
- ☐ I understand that my secondary insurance will not be billed and I am responsible for any balances not paid by my primary insurance plan.
- ☐ I am a new patient and I canceled my original appointment. I agree to be charged $250.00 if I cancel my appointment a second time.

CC# XXXX-XXXX-XXXX-_________ Exp: _____/______ CVV: ________

NOTE: Our office no longer handles billing. Our health system Athena will send two e-mail notices to you prior to charging your card on file. In the case of a declined credit/debit card, a paper statement will be mailed to you. If no payment is made, a late fee will be added to your bill.

_____________________________________ Patient Signature

_____________________________________ Cardholder Signature (if other than the patient)

_____________________________________ Date

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PATIENT REGISTRATION FORM

Patient Information

Last Name: ____ First Name: ___________________ Middle Initial: ____

Date of Birth: ________/_______/________ Age: _______ Social Security #: ___________- _______ - ___________

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated/Divorced ☐ Widowed

Home Phone: ______________________________ Cell Phone: ______________________________

Work Phone: ___________________________ Number to leave messages on: ☐ H ☐ C ☐ W

Home Address (Street, City, State, and Zip Code): ____

____

Email: ____ Occupation: ______________________________________

Employer Name and Address: ____

____

Referring Doctor: ____ Phone Number: __________________________

Primary Care Doctor: ____ Phone Number: __________________________

Allergies to Medications (if known): ____

Spouse Information (if applicable)

Last Name: ____ First Name: ___________________ Middle Initial: _____

Phone Number: ____________________________________

Emergency Contact Information – Please list two contacts in case of emergency

Name: ______________________________ Relationship to Patient: ______________ Phone #: ___________________

Name: ______________________________ Relationship to Patient: ______________ Phone #: ___________________

Authorized Access to Medical Records

I have received and reviewed the HIPAA Notice of Privacy Practices of Northern Virginia Physicians Services.
I understand that if I have any questions related to the HIPAA Notice of Privacy Practices, I can request to speak directly with the Office Manager (Privacy Contact).

I authorize the following individual(s) to have access to my medical records:

____

Name Phone Number Relationship to Patient

____

Name Phone Number Relationship to Patient

Primary Insurance

Insurance Carrier's Name: ____________________________________ ID Number: ________________________

Insurance Address: ____

Group Number: ___________________________ Policy Holder's Name: ____________________________________

Policy Holder DOB: ________/_______/________ Financially Responsible Person: ☐ Patient ☐ Spouse ☐ Parent

☐ Other: ____________________________

Secondary Insurance (if applicable_

Insurance Carrier's Name: ____________________________________ ID Number: ________________________

Insurance Address: ____

Group Number: ___________________________ Policy Holder's Name: ____________________________________

Policy Holder DOB: ________/_______/________ Financially Responsible Person: ☐ Patient ☐ Spouse ☐ Parent

☐ Other: ____________________________

Payment Policy: All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments; however, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for the services when rendered unless other arrangements have been made in advance with our office. In the event my account is turned over to an attorney for collections, I will pay any fee/costs incurred during the collection process.

Insurance Authorization and Assignment: I hereby authorize Massoud Saberinia, M.D. to furnish information to insurance carriers (including Medicare/Medigap) concerning my illness and treatments. I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurances.

I certify that the information I provided above is correct.

____ ___________________________

Signature of Patient or Guardian Date