Family HealthCare

Patient Information

			/ /
Last Name	First Name	Middle Int.	Date of Birth

\- - | ☐Male ☐Female | ☐single ☐married ☐divorced ☐other

Social security number Gender Marital Status

☐Asian ☐Black ☐Hispanic ☐White ☐Other:_____ | ☐Hispanic or ☐Non-hispanic

Race Ethnicity

Home address: Street address City State Zip

\- - | - - | - -

Home phone Cell Phone Work Phone

*Preferred contact Method: ○ Cell ○ Home ○ Work

1) I authorize Family HealthCare to leave messages (that may contain my health information) on:
☐Home phone ☐Cell Phone ☐ None – speak only with me Initial:_____

2) I authorize Family HealthCare to disclose my health information (medical and billing) to:
Name: Relationship: Initial:_____

Patient's Occupation: Name of Employer:

Name of responsible party (if <18yr):

Emergency contact: Name: Relationship:

Phone number - -

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Insurance Information

Carrier name:

Policy ID # Group #

This is the only insurance I have ☐Yes ☐No *if "No" please complete **Additional Insurances**

This policy is through my employer ☐Yes ☐No *if "Yes" please complete **Policy Holder Information**

Policy holder information:

		/ /
Last name	First name	Date of birth

☐Male ☐Female | - - | - -

Gender Social Security Number Contact Phone number

Street address	City	State Zip

Relationship to patient: ☐Wife ☐Husband ☐Child ☐Other:_____

Name of employer:

Additional Insurances:

Secondary Insurance:

Carrier name:

Policy ID # Group #

Tertiary Insurance:

Carrier name:

Policy ID# Group #

Family HealthCare has my permission to bill the insurance companies listed above for services rendered to me or my dependent. I am certifying that the insurance information is accurate.

Date: / / Signature:

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Health Questionnaire

Do you have an Advance Directive? ☐No ☐Yes *If "yes" does this office have a copy* ☐No ☐Yes

Do you have any allergies to medications? ☐No ☐Yes

If "yes" please list:

List your current medications (including over-the-counter medications) with dose and frequency:

1) Medication:		Dose:	Frequency:
2) Medication:		Dose:	Frequency:
3) Medication:		Dose:	Frequency:
4) Medication:		Dose:	Frequency:
5) Medication:		Dose:	Frequency:
6) Medication:		Dose:	Frequency:
7) Medication:		Dose:	Frequency:
8) Medication:		Dose:	Frequency:
9) Medication:		Dose:	Frequency:
10) Medication:		Dose:	Frequency:

Do you use cigarettes or cigars? ☐currently ☐formerly ☐never

↳ How many per day? How many years have you smoked?

Do you consume alcohol? ☐No ☐Yes → How many? → How often?

Do you use illegal drugs? ☐No ☐Yes

List any chronic medical conditions/past illnesses (e.g. asthma, high blood pressure, diabetes, etc.)

1)	2)
3)	4)
5)	6)

List any past surgeries and the dates when they occurred:

1)	Date: / /
2)	Date: / /
3)	Date: / /

Family History		**Medical History**	**Cause of death**
Mother	☐Alive ☐Deceased		
Father	☐Alive ☐Deceased		
Sibling(s)	☐Alive ☐Deceased		
Child(ren)	☐Alive ☐Deceased		
Maternal Grandmother	☐Alive ☐Deceased		
Maternal Grandfather	☐Alive ☐Deceased		
Paternal Grandmother	☐Alive ☐Deceased		
Paternal Grandfather	☐Alive ☐Deceased		

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Consents and Acknowledgements

Notice of Privacy Practices:
I acknowledge that I have received and review a copy of Family HealthCare's Notice of Privacy Practices which describes how medical information about you may be used and disclosed.

Date: / / Signature:

Patient Portal:
Family HealthCare utilizes a Patient Portal enable patients to request appointments, request medications, and correspond with Family HealthCare personnel. In order for you to have access to the portal, Family HealthCare will need a current e-mail address, as well as a signed consent for its use. This consent has no expiration and will be valid indefinitely until revoked by written request.

By signing this release you, the patient, agree to abide by the guidelines put forth by Family HealthCare regarding the use the Patient Portal. Additionally, you agree to the disclaimers listed on the portal website regarding emergency conditions.

Last Name: First Name: Date of birth: / /

E-mail address:

Date: / / Signature:

CRISP:
Family HealthCare has chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide health information exchange. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and prevent searching of your health information available through CRISP by calling 1-877-952-7477 or completing and submitting and Opt-Out form to CRISP by mail, fax, or through their website at www.crisphealth.org.

Please sign below to verify that you have read and understand the information above.

Date: / / Signature:

Prescription history
In compliance with Meaningful Use (CMS) Objectives regarding the utilization of electronic health record systems, our providers have the capacity to access limited historical information regarding the medications prescribed for you from other providers. Registry information may include: medication name, dose, instructions, prescribing physician, filling pharmacy, and date filled. By signing below, you consent for the physicians to access and utilize this information in making medical decisions regarding your health.

Date: / / Signature:

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Policies and Practices

Preventive vs Problem-oriented exams:
Insurance companies distinguish office visits as either preventive or problem-oriented. If a patient is seen for a preventive exam (ie, a complete physical, a well-child exam) and also has new or established problems and/or significant new complaints, **this is billed as both a preventive exam and a problem-oriented exam.** Some insurance companies now cover a "free: yearly preventive exam for each patient. Please know that this includes only your preventive care. It does not cover any new concerns or chronic conditions. New problems and chronic conditions may be billed to the insurance company as a problem-oriented visit.

Prescription refills:
- Routine medication refills should be discussed with your provider at the time of your visit.
- Should you need a refill of medications between visits, please first contact your pharmacy to request the medication.
- Requests for new medications require an appointment. Antibiotics will not be prescribed without an office visit.
- Please allow 48 hours for prescription refills (Monday-Friday). If a prescription refill is requested on a Friday, it may not be refilled until Monday. Please understand, however, each prescription is individually reviewed and may, rarely, require extra time.

Billing and copayments:
- It is your responsibility to keep all insurance and demographic information up-to-date.
- Co-payments and any additional monies owed are due at the time of visit
- We are happy to address any question you may have about billing for your visit. However, we are not responsible for charges due to non-covered benefits, deductibles, or co-payments. Please review your insurance benefits package to ensure you are familiar with all non-covered services, limitations, and exclusions.
- Non-payment on monies owed will result in the account being turned over to a collections firm and may result in additional fees, fines, and penalties as allowed.

Completion of forms:
All forms to be completed by medical staff members will be subject to a $10 charge that will be paid at the time in which the form is received. There is no charge for forms completed at the time of an office visit.

No-show for appointment:
In order to provide the greatest access to care for all of our patients, it is essential that you present on-time for all of your scheduled appointments. Family HealthCare requests at least 24 hours notification of the need to cancel or reschedule an appointment. Repeated no-shows or late cancellations may result in discharge from care at Family HealthCare.

Date: / / Signature:

Continue to page 6 (optional)

Authorization to Release Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

This form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law (45 C.F.R. parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. part 2), federal law pertaining to Early Childhood Intervention (34 C.F.R. part 300), and state confidentiality law governing mental health, developmental disabilities, and substance abuse services (N.C.G.S. 122C).

Patient information:

			/ /
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Release to:

Family HealthCare	301 - 972 - 0400	301 - 916 - 1453	
Physician name	Phone Number	Fax Number	
20528 Boland Farm Rd, Ste 104	Germantown	MD	20876
Street address	City	State	Zip

Release from:

	- -	- -	
Physician name	Phone Number	Fax Number	
Street address	City	State	Zip

Specify description of information (including dates):

Purpose of the disclosure:

I understand that this authorization will expire on _____ (date) or one year from the date it is signed, whichever is earlier. Initials: _____

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do so it will not have any affect on any actions taken before the revocation was received. Initials: _____

I understand that I am authorizing the release of substance abuse, AIDS, HIV, or other communicable diseases, if such information is present in my record. Initials: _____

_____ Date: / /

Signature of Patient or Patient's Representative (Form MUST be completed before signing).