GERMANTOWN- 19851 Observation Dr., ST 250, Germantown, MD 20876
KEY WEST – 9420 Key West Ave., ST 410, Rockville, MD 20850
OLNEY – 18111 Prince Philip Dr., ST 121, Olney, MD 20832
301-972-0400 www.familyhealthcaremd.com

Patient Registration Form

First Name	MI	Last Name		Gender
Home Address		City	State	Zip Code
Home Phone	Work Phone	Cell Phone	Preferred Method of Contact	
Date of Birth	Age	Social Security Number	Marital Status	Email Address
Race ☐Asian ☐Black ☐Hispanic ☐White ☐Other: _____		Ethnicity ☐ Hispanic ☐ Non- Hispanic		Language
Financially Responsible Person Name	Financially Responsible Person Address			Phone Number
Emergency Contact	Relationship to Patient			Phone Number

1) I authorize Family HealthCare to leave messages (that may contain my health information) on:
Home Phone Cell Phone None- Speak to me only Initial:_____
2) I authorize Family HealthCare to disclose my health information (medical and billing) to:
Name: _____ Relationship: _____ Initial:_____

Insurance Information

Primary Insurance

Carrier Name	Address	Phone Number
ID#	Group#	Effective Date
Policyholder Name	Policyholder SSN	Policyholder Date of Birth

Secondary Insurance

Carrier Name	Address	Phone Number
ID#	Group#	Effective Date
Policyholder Name	Policyholder SSN	Policyholder Date of Birth

13451 Observation Drive, Suite 250
Germantown, Md 20876

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HIPAA RELEASE FORM

Name:_____ DOB:_____

Release of Information

( ) I authorize the release of my medical information, including diagnosis, records, examination rendered to me and claims information. Also, please release my labs results as well as prescriptions. This information may be released to:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

( ) Information is NOT to be released to ANYONE.

The following information may NOT be released to anyone other than myself:

_____

Messages

Please call: ( ) My Home ( ) My Work ( ) My Cell phone

If unable to reach me:

( ) You may leave a detailed message

( ) Leave a message asking me to return you call

( ) You may leave a message with:_____ Relationship:_____

This release of information will remain effective through one year from the date of my signature below.

Patient Signature:_____ Date:_____

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In step with becoming a patient centered home medical office, Family HealthCare will be utilizing a patient portal. This patient portal will allow patients to communicate with the office via email. Patients will be able to request appointments, request medication refills and correspond with Family HealthCare personnel.

For you to have access to the portal, Family HealthCare will need a current email address.

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

If you are interested in having access to the Family HealthCare portal, please include your name, date of birth, email address, signature and today's date at the bottom of this release.

Patient Name and Date of Birth:

Current Email Address (please print):

Signature and Date:

***If you already have a portal account, please check here_____**

***If you <u>USED</u> to have a portal account but need the account reset, please check here_____**

HEALTH QUESTIONNAIRE

PATIENT NAME:_____ DATE OF BIRTH:_____

Do you have an Advance Directive: _____ If so, does this office have a copy? _____

Please list your medication allergies:_____

Please list your current medications, including over the counter meds. Please include dose and directions for each medication.

1._____ 2._____

3._____ 4._____

5._____ 6._____

7._____ 8._____

Are you a smoker? _____ Cigarettes or Cigars? _____ How many per day? _____

Do you consume alcoholic beverages? _____ How often? _____Do you use illegal drugs?_____

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

1._____

2._____

3._____

4._____

Please list any past surgeries:

1._____

2._____

3._____

4._____

Please list any family health history (heart problems, breathing issues, cancers, chronic diabetes, etc)

Mother_____

Father_____

Brother_____

Sister_____

When was your last:

Mammogram_____ Pap Smear_____

Colonoscopy_____ Dental Exam_____

Eye Exam_____

Family HealthCare
Policies and Procedures

Office Hours

Germantown

Monday, Tuesday and Wednesday	8 am to 7 pm
Thursday and Friday	8 am to 5 pm
Saturday	8 am to 11:15 am

Rockville

Monday through Friday	8 am to 5 pm

Olney

Monday, Tuesday, Wednesday and Friday	8:30 am to 5 pm
Thursday	8:30 am to 7 pm

Saturday Hours

Saturday appointments are for sick visits only. Please call the office at 301-972-0400 after 8 am to be seen that morning. Appointments are scheduled on a first call basis. No appointments are scheduled after 11 am. Since we only have one provider who works the Saturday session each week, we are unable to accept walk-in appointments.

Walk-In Appointments

Walk-in appointments, for sick visits only, are available in our Germantown office for existing patients Monday through Friday from 8 am to 3 pm.

Insurance

While filing of insurance claims is a courtesy we extend to our patients, it is your responsibility to bring your valid and up to date proof of insurance coverage and a photo ID to each appointment. Please be familiar with your copay, which is to be paid at each visit.

We participate with most major insurance plans; however, it is your responsibility to check with your insurance company to ensure we participate. It is your responsibility to know your plan's coverage. Although we check benefits, we do NOT guarantee payment.

**ALL COPAYMENTS AND ANY OUTSTANDING BALANCES ARE DUE AT EACH VISIT.

Appointment Cancellations, No-Shows and Late Arrivals

In order to provide the greatest access to care for all our patients, it is essential that you arrive on time for all scheduled appointments. If you arrive later than 15 minutes past your appointed time,

please know we will have to reschedule your appointment unless we are told to do otherwise by your provider. Anyone who does not notify the office prior to a missed visit will be charged $25 for a regular appointment and $50 for a Complete Physical or Pre-Operative Exam.

Workman's Comp and MVA

If you are being seen due to a motor vehicle accident or a workman's comp injury, you must provide all pertinent information at the time of your visit so that we can submit the claim. We do not bill your health insurance for these types of visits. If you do not have the appropriate information at the time of service, you will be responsible for paying for the visit.

Preventative vs Problem-Oriented Exams

Insurance companies distinguish office visits as either preventive or problem oriented. If a patient is seen for a preventive exam (i.e., a complete physical, a well-child exam) and also has new, or established problems and/or significant new concerns, this is billed as both a preventive exam and a problem-oriented exam. Some insurance companies now cover a "free yearly preventive exam." 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.

Patient Portal Access

Our patient portal can be utilized by our patients to request appointments, request medication refills, update patient demographics, update medical history and to correspond with our providers. Upon check in, our front desk staff will provide you with a portal authorization form. If you are interested in participating in our patient portal, please complete the form and return it to the front desk. You will receive an email from the Portal Registrar to help you set up your account.

Care of Minors

No child under the age of 18 will be seen without the written consent of a parent or legal guardian.

Completion of Forms, Letters and Statements

Please allow 7 days for the completion of any forms. It is up to the discretion of the provider as to whether an adult patient needs to be seen for an appointment in order for a form to be completed. FHC requires that a child be seen within the previous year for a complete physical exam in order for school and/or camp forms to be filled out without an appointment. Family HealthCare charges $25 for the completion of any form, statement or letter, regardless of whether an appointment is also required.

Medication 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. Otherwise, call and leave a message on our prescription line, which is a prompt off our main line. We require at least 2 business days for the completion of refills. Requests for new medications require an appointment. Antibiotics will not be prescribed without an office visit.

Authorization for Use or Disclosure of Protected Health Information

Name of Patient_____

Date of Birth_____ Daytime Phone Number_____

Address_____

City_____ State_____ Zip_____

I hereby authorize _____

(Facility Name) (Facility Address) (Facility Phone/Fax #)

to use or disclose my protected health information as indicated below to:

Family HealthCare at 19851 Observation Drive Suite 250 Germantown, MD 20876 Phone-301-972-0400

Information to be released:

- From & To Dates _____
- Lab Report_____
- X-Ray Report_____
- Consultation Report_____
- Other_____

Purpose of Disclosure

- Changing Physicians
- Continuing Care
- At patient request
- Workers Compensation
- Legal
- Other_____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and by signing this form I am specifically authorizing the release of information relating to Substance Abuse (including alcohol/drug abuse), mental health, psychotherapy notes and HIV related information (including AIDS related testing)

The confidentially of this record is required under Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statuses.

X_____ X_____

Signature of Patient or Legal Guardian **Date**

-I agree to pay the fee associated with the request of medical records at the time of this request.
-I understand that this authorization will expire 2 years from my last date of service visit. A photocopy of this will be considered as valid as the original.
-I understand that I may revoke this authorization at any time by notifying the Privacy Officer at the address indicated, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
-I understand information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer e protected by federal privacy regulations, however, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information and psychiatric/mental health information.
-I understand my health care and payment for my health care will not be affected if I do not sign this form.
-I understand my refusal to sign this authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
-I understand I will get a copy of this form after I sign it, if desired.

By signing below, I acknowledge that I have read and understand this authorization.

X_____ **(signature of patient/legal guardian)** X_____**(date)**