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

Family HealthCare, P.C.

9420 Key West Avenue, Suite 4 - 3
Rockville, MD 20850
301-947-e816 ■ 301-217-0358 Fax

19851 Observation Drive
Suite 250
Germantown, MD 20876
301-972-0400 ■ 301-916-1453 Fax

18 - 1 Prince Philip Drive, Suite 12
Olney, MD 20832
301-570-1545 ■ 301-570-3[illegible] Fax

Financial Policy Agreement

Welcome to Family HealthCare. We are pleased you have chosen our practice for your primary medical care. We are committed to providing you with the highest quality of services available. Please carefully read our financial policy agreement and sign your understanding of the agreement below.

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 an 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. If a prescription refill is requested on a Friday, it may not be refilled until Tuesday. 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 balances owed are due at the time of service.
- We are happy to address any questions 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 balances owed will result in the account being turned over to a collections agency and may result in additional fees, fines and penalties allowed.

Completion of Forms:

All forms to be completed by medical staff members will be subject to a $10 charge that will be due at the time in which the form is dropped off for completion. There is no charge for forms completed at the time of an office visit.

No-Show for Appointment and Late Policy:

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. We will provide a 15 minute time period if you are running late to your appointment. If you arrive later than 15 minutes for a scheduled appointment, we must reschedule your appointment. 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.

Insurance:

While filling 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.
- Complete our Patient Registration Form.
- Notify our office of any changes to your insurance or demographic information.
- Be familiar with your copay and be prepared to pay at each visit.
- Make sure one of our providers is selected as your Primary Care Physician with your insurance company.
- It is your responsibility to know coverage of your particular plan. Although we check benefits, there is never a guarantee of payment.
- We participate in many insurance plans, however, it is your responsibility to check with your insurance company to ensure we participate.

I have read and understand the Financial Policy Agreement and agree to abide by its guidelines.

Signature: _____ Date: _____

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Consents and Acknowledgements

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 at Family HealthCare to access and utilize this information in making medical decisions regarding your health.

Signature: _____ Date: _____

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 provider 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 an Opt-Out form to CRISP by mail, fax or through their website www.crisphealth.org.

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

Signature: _____ Date: _____

Notice of Privacy Practices:

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

Signature: _____ Date: _____

NO SHOW/MISSED APPOINTMENT OFFICE POLICY FORM

We, at Family HealthCare understand there will be times you need to cancel an appointment and emergencies do happen. If you are unable to keep your appointment, please call us as soon as possible. You can call the office at (301) 972-0400.

We like to make sure every patient is given the proper time for their visit and to provide the highest quality care. We want to ensure that patients have appointment slots available for sick visits and no-shows make it harder for other patients to be seen. It is very important for every scheduled patient to attend their visit on time. As a courtesy, we offer an appointment reminder call which is attempted (2) business days prior to your scheduled appointment. However, it is the patient's responsibility to arrive on time for their appointment.

Please review the following policy:

1). If you miss or no-show for your appointment there will be a $25.00 charge.

2). To avoid any being assessed please cancel as soon as you can.

I have read and understand Family HealthCare's No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Family HealthCare appropriately if I cannot keep my scheduled appointment.

_____ _____ _____

Patient Name Date of Birth Date

_____ _____

Patient Signature or Parent/Guardian if minor Relationship to Patient

19351 Observation Drive, Suite 250
Germantown, Md 20876

9420 Key West Avenue, Suite 410
Rockville, Md 20850

18111 Prince Philip Drive, Suite 121
Olney, Md 20832

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. This information may be released to:

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

( ) 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 your 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.

In order 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.

Print Name and Date of Birth:

_____

Current Email Address (Please Print):

_____

Signature:

_____

Date:

_____

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_____

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

Name: **Family HealthCare** Phone Number: **301-972-0400** Fax Number: **301-916-1453**

Address: **19851 Observation Drive Suite 250** City: **Germantown** State: **MD** Zip: **20876**

Information to be released:

- o From & To Dates_____
- o Lab Report_____
- o X-Ray Report_____
- o Consultation Report_____
- o Other_____

Purpose of Disclosure

- o Changing Physicians
- o Continuing Care
- o At my (patient) request
- o Workers Compensation
- o Legal
- o 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 Patent 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 two 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 be 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)