Maryland Medical First, P.A.
COMPLETE MEDICAL CARE

8901 Clement Ave
Parkville, Maryland 21234
Phone: 410-661-4670
Fax: 410-661-4671

We would like to take this opportunity to welcome you as a new patient and thank you for choosing Maryland Medical First P.A. Our mission is to provide our patients accessible, affordable, and high quality health care service. We accomplish this by working as a team throughout the community, by seeing patients in the hospital setting, acute and sub-acute rehabilitation setting and in our outpatient clinic.

Please complete the enclosed Registration Form and Medical History Form. Our Notice of Privacy Practices can be obtained at the office.

To help acquaint you with our office procedures, we ask that you:

1. Please give 72 hour notice when requesting referrals or pre-authorizations.
2. Kindly give us 24 hour notice when requesting prescription refills.
3. Please provide us 24 hour notice if you will not be able to maintain your appointment, missed appointments are charged a $25.00 fee.
4. If you have a co-payment your insurance company requires that you pay this at the time of your visit. We accept cash, check and credit cards.

Please do not hesitate to call after hours if you have an emergent issue. The office phone system will allow you to leave a message and the on-call provider will call you back.

Thank You,

Maryland Medical First P.A.

Maryland Medical First, P.A.
COMPLETE MEDICAL CARE

8901 Clement Ave
Parkville, Maryland 21234
Phone: 410-661-4670
Fax: 410-661-4671

Patient Registration Form

Patient Information

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address: Apartment:	City/State/Zip:		
Home Phone:	Cell Phone:	Work Phone w/ext:	
Family Physician:	Date of Birth:	Sex: ☐ Male ☐ Female	
Marital Status:	Social Security #:		
Employer Name:	Employer Address:		
Emergency Contact:	Phone:	Relationship to Patient:	

Insurance & Payment Information

Person responsible for the bill (**ONLY IF DIFFERENT THAN THE INSURED**): Name:		
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		City/State/Zip:
Employer of Person Responsible:		Relationship to Patient:

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Address if not same:	Policy Holder's Address if not same:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:
Employer Name:	Employer Name:

Additional Information

Physical Address (if different than mailing):	City/State/Zip:
Email Address:	Can we leave a message regarding your medical care & test results? ☐ Yes ☐ No

Race (please select one): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Decline

Ethnicity (please select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil) ☐ Russian ☐ Sign Language ☐ Spanish ☐ Other

Preferred Pharmacy Name & Location:

Maryland
Medical First, P.A.
COMPLETE MEDICAL CARE

8901 Clement Ave
Parkville, Maryland 21234
Phone: 410-661-4670
Fax: 410-661-4671

Please note: A copy of your health plan identification card(s) and a photo ID is required. Your cards must be available at each visit. Your co-payment must be paid at the time of visit.

Insurance Authorization and Assignment

I assign payment to and authorize Maryland Medical First P.A. to file a claim with my insurance for payment of service or to accept assignment of any government benefits due to me. I authorize the release of all information necessary to process these claims. I understand that if it is later determined that I am not eligible to receive benefits for these services, I will personal be responsible for payment to Maryland Medical First P.A.

Privacy Practices and Advance Directive

Do you have an Advance Directive of Living Will? _____Yes _____No

I acknowledge that I can obtain a copy of the Maryland Medical First P.A. Notice of Privacy Practices from the office. This notice refers to how Maryland Medical First P.A. and/or its employed physician/contractors may use and disclose protected health information, though certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Signature: _____ Date:_____

Maryland
Medical First, P.A.
COMPLETE MEDICAL CARE

8901 Clement Ave
Parkville, Maryland 21234
Phone: 410-661-4670
Fax: 410-661-4671

REPORTING OF TEST RESULTS & SCHEDULING APPOINTMENTS

In order to better meet your needs, as well as maintain confidentiality, please let us know the ways that we may contact you regarding scheduled appointments, test results and other information that may be personal in nature. Please note that all options, such as e-mail, may not be currently available at Maryland Medical First P.A.

Patient Name: _____ Date of Birth:_____

PLEASE CHECK ALL THE WAYS WE MAY CONTACT YOU

Home _____yes _____no Phone:_____
Work _____yes _____no Phone:_____
Cell _____yes _____no Phone:_____

Mail results: _____yes _____no
Non-Secure E-Mail _____yes _____no
E-Mail Address:_____

Leave a message with:

_____	_____	_____
Name of Person	Phone Number	Relationship

_____ _____
Patient Signature Date

Maryland Medical First Pa
8901 Clement Ave
410-661-4670 (Phone)
410-661-4671 (Fax)

Authorization for Release of Medical Records

Patient Information:

Name_____

DOB_____

Request Release from:

I hereby authorize you to release to Maryland Medical First Pa a copy of my medical records to be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Furthermore, I understand that this Protected Health Information may be re-disclosed by the recipient and thus, is no longer protected under privacy rules.

By signing this authorization, I understand that medical records released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol use, etc. I understand that release of psychotherapy notes requires an additional authorization.

_____ _____

Patient or Guardian Signature Date

Please include the following items:

- ☐ Admission notes
- ☐ Discharge summary
- ☐ Operative reports
- ☐ EKGs
- ☐ X-ray reports
- ☐ Progress notes
- ☐ Pathology reports
- ☐ Consultations notes
- ☐ Laboratory tests
- ☐ Stress tests
- ☐ Other:

Remarks: _____

This authorization will expire on:

_____

Maryland
Medical First, P.A.
COMPLETE MEDICAL CARE

8901 Clement Ave
Parkville, Maryland 21234
Phone: 410-661-4670
Fax: 410-661-4671

OFFICE POLICY

Regarding Insurance: You are required to sign the assignment of insurance benefits clause before your initial visit. The balance is your responsibility. We can not bill your insurance company unless you give us your complete and correct information. Your insurance policy is a contract between you and your insurance company. We are a party to the contract. If your insurance company has not paid your account in full within 60 days, the balance can be considered your responsibility. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. It is the patient's responsibility to know their insurance policy coverage on visits, labs, tests, referrals, and medication. Regarding insurance plans where we are a participating provider. All co-pays and deductibles are due prior to treatment.

Usual and Customary Rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our services. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Misses Appointment: Unless cancelled at least 24 hours in advance, missed appointments are charged $25.00

Bounced Checks: All bounced checks result in a $25.00 fee. If a patient bounces 2 or more checks we reserve the right to not accept their check anymore. They must pay with cash or credit.

Request For Medical Records: Records are copied in the order that they are received and can take 7 to 10 business days. The charge is $.25 per page plus postage.

Interest: We reserve the right to charge interest in the amount of 1.5% per month on any outstanding balance as provided by State Law.

Lost Items: Our office is not responsible for any items that are left behind in the exam room or waiting room area.

Controlled Substance Prescriptions: Our office does not replace any narcotic or controlled substance prescription in the event that they are lost, stolen, misplaced, or destroyed.

Doctors Right To Terminate Medical Services: Maryland Medical First has the right to terminate the doctor/patient relationship if the patient repeatedly and consistently misses scheduled appointments, refuses to pay outstanding balances, refuses to follow the doctor's orders/treatment, or behaves in an inappropriate manner to the doctor and or staff.

I have read the policy and I am aware of its legality. I understand and agree to all the above policies.

_____ _____

Signature of Patient Date

Maryland Medical First, P.A.
COMPLETE MEDICAL CARE

8901 Clement Ave
Parkville, Maryland 21234
Phone: 410-661-4670
Fax: 410-661-4671

Name: _____ Date of Birth: _____

Past Medical History: Check appropriate box

Do you have or have you ever had	Yes	No
Chest Pain		
Angina		
Heart Attack		
Congestive Heart Failure		
High Blood Pressure		
Blood Clots/ Thrombosis		
Anemia		
CVA/Stroke		
Heart Murmur		
High Cholesterol		
Seizure/ Epilepsy		
Parkinson's Disease		
Headaches		
Dizziness/ Fainting		
Memory Loss		
Numbness/Tingling Sensation		
Ringing in Ears		
Depression		
Anxiety		
Glaucoma		
Sinusitis		
Sore Throat		
Cataract		
Allergic Rhinitis		
Asthma		
COPD		
Pneumonia		
Shortness of Breath		
Tuberculosis		
Cancer/Type:		
Heartburn		
Abdominal Pain		

Do you have or have you ever had?	Yes	No
Indigestion		
Abdominal Pain		
Appendicitis		
Hepatitis		
Irritable Bowel Syndrome		
Colitis		
Cirrhosis		
Ulcer		
Gallbladder Disease		
Pancreatitis		
Renal Failure		
Kidney Stones		
Bladder Infection		
Constipation		
Prostate Problems		
Kidney Infection		
Herpes		
Chlamydia		
Aids/HIV		
Syphilis		
Gonorrhea		
Genital Warts		
Thyroid Disease		
Lyme Disease		
Lupus		
Gout		
Skin Rashes		
Arthritis		
Osteoporosis		
Herniated Disc/ Disc Disease		
Difficulty Sleeping		

Maryland Medical First, P.A.
COMPLETE MEDICAL CARE

Personal Habit:

Tobacco Use:
Do you use tobacco? _____yes _____no
Number of packs per day_____
Have you attempted to stop? ____yes ____no If so how many time have you attempted to stop? _____

Alcohol Use:
Do you use alcohol I any form (liquor, beer wine)? ____yes ____no
Amount consumed in a day _____

Recreation Use:
Do you use any recreational drug? _____yes _____no
Type of drug _____
How often do you use? _____

Family History:

	Mother	Father	Sibling's
Heart Disease			
Lung Disease			
Diabetes			
Kidney Disease			
Thyroid Disease			
Hypertension			
Arthritis			
CVS/Stoke			
Mental Disease			
Alcoholism			
Obesity			
Cancer (give type)			

Maryland
Medical First, P.A.
COMPLETE MEDICAL CARE

Preventative Care: When was your last:
Tetanus Shot:_____ Flu Shot:_____
Pneumonia Vaccine:_____ Hepatitis Vaccine:_____
Colonoscopy:_____

Female Only:
How often do you examine your breasts ?_____
When was your last Mamogram?_____
Do you see an OB/GYN?_____
When was your last PAP smear?_____

Male Only:
Do you have any problems with erections?_____
When was your last prostate blood test (PSA)?_____

Allergies: Please list your allergies

	Allergic To:	Reaction:
Food:		
Medication:		
I.V. Contrast: Yes or No		

Hospitalization: Please list the reason for hospitalizations with the approximate date and the place.

Reason:	Date & Place
1.	
2.	
3.	
4.	
5.	

Connected to CRISP

We are Participating in the Regional Health Information Exchange

What is Health Information Exchange and why is it important?

Health Information Exchange, or HIE, is a way of instantly sharing health information among doctors' offices, hospitals, labs, radiology centers, and other health organizations. HIE allows delivery of the right health care information to the right place at the right time, providing safer, more timely, efficient, patient-centered care. CRISP, an independent nonprofit organization, is responsible for developing and maintaining the HIE in Maryland and the District of Columbia.

What are the benefits of having an HIE?

Through an HIE, providers will have immediate access to important information in order to make more informed treatment decisions. Having access to the HIE will help to avoid repeat tests, unneeded procedures, medical mistakes, and costly medical bills.

How is my medical information kept private?

The Regional HIE follows HIPPA laws and protects your medical information and overall privacy. You can choose to opt-out of CRISP. Opting out will prevent providers from accessing your data through CRISP. In accordance with the law, public health reporting and controlled dangerous substances information will still be available through CRISP.

How do I opt out?

You can pick up an opt-out form in the office today and return it to CRISP, or you can opt-out by calling or visiting our website listed below. Patients are responsible for returning the opt-out form to CRISP.

How do I learn more about CRISP?

To learn more about CRISP, The Regional Health Information Exchange, visit the CRISP website at www.crisphealth.org, or call 1.877.952.7477, or email support@crisphealth.org. There are several fact sheets and brochures available to view or download on our website.

CRISP

Connecting Providers With Technology to Improve Patient Care Across the Region

www.crisphealth.org