Maryland Primary Care Physicians

Patient Information Sheet

Patient Demographics

Name: _____
LAST FIRST MIDDLE

Sex: _____ Birth Date: _____

Social Sec. # _____

Maiden Name/Nickname _____

Address: _____ Home Phone: _____

City: _____ Mobile Phone: _____

State: _____ Work Phone: _____

Zip Code: _____ Email: _____

Country: _____

General Information

Preferred Language: _____

Written & Spoken Language: _____

Need Interpreter? ☐ No ☐ Yes

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Ethnicity: ☐ Declined to state ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Country of Birth: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Declined to answer ☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Unknown ☐ White

Contact

Emergency Contact:

Name: _____
LAST FIRST MIDDLE

Phone: _____ Relationship: _____

Guarantor Demographics (If Not Patient)

Name: _____
LAST FIRST , MIDDLE

Address: _____
STREET

_____
CITY, STATE, ZIP CODE

Social Sec. # _____

Sex: _____ Birth Date: _____

Home Phone: _____ Fax: _____

Email: _____

Guarantor Employment

Employer: _____

Address: _____
STREET

_____
CITY, STATE, ZIP CODE

Employment Status _____ Employment Date: _____

Occupation: _____

Phone: _____ Work: _____

Maryland Primary Care Physicians

Patient Information Sheet

Patient Name: _____ Birth Date: _____

Coverage Detail Primary

Insurance Company: _____

Claim Address: _____

Member Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance ID: _____ Member Effective From: _____

Subscriber ID: _____ Group Number: _____

Auth phone: _____ Name on Card: _____

Subscriber Demographics (If Not Patient)

Name: _____
LAST FIRST MIDDLE

Address: _____

Social Sec. # _____

Sex: _____ Birth Date: _____

Home Phone: _____ Fax: _____

Email: _____

Subscriber Employment

Employer: _____

Address: _____

Employment Status _____

Employment Date: _____

Occupation: _____

Phone: _____ Work: _____

Coverage Detail Secondary

Insurance Company: _____

Claim Address: _____

Member Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance ID: _____ Member Effective From: _____

Subscriber ID: _____ Group Number: _____

Auth phone: _____ Name on Card: _____

Subscriber Demographics (If Not Patient)

Name: _____
LAST FIRST MIDDLE

Address: _____

Social Sec. # _____

Sex: _____ Birth Date: _____

Home Phone: _____ Fax: _____

Email: _____

Subscriber Employment

Employer: _____

Address: _____

Employment Status _____

Employment Date: _____

Occupation: _____

Phone: _____ Work: _____

Rx Local Pharmacy: _____ Mail Order Pharmacy: _____

How did you hear about MPCP? ☐ Family/Friend ☐ Internet ☐ MPCP Website ☐ Facebook ☐ Print Ad ☐ Insurer Info ☐ Hospital Referral ☐ Righttime Referral ☐ Other: _____

RELEASE: I assign payment to and authorize Maryland Primary Care Physicians, LLC to file a claim with my insurance for payment of services 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 personally be responsible for payment to Maryland Primary Care Physicians, LLC. Photocopies of this form are valid.

Signature of Patient or Responsible Party if Minor _____ Date _____

_____ I have read, understand, and agree with MPCP Financial Policy, ver 2.0 and accept responsibility for payment of all fees/charges incurred with Maryland Primary Care Physicians, LLC.
Initial Here

_____ My signature above also acknowledges receipt of MPCP/PMG Notice of Privacy Practices, ver 4.1, effective 12/1/2018.
Initial Here

HIPAA NOTICE OF PRIVACY PRACTICES

Maryland Primary Care Physicians, LLC

Effective Date: December 1, 2018

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Marshall Scott, COO, Privacy Official at (410) 729-5100.

WHO WILL FOLLOW THIS NOTICE:

- Maryland Primary Care Physicians, LLC

This HIPAA Notice of Privacy Practices (this "Notice") describes our privacy practices.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This Notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information;
- abide by the terms of this Notice that are currently in effect; and
- notify affected individuals following a breach of unsecured protected health information.

CRISP

We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide health information 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 disable all access to 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 at www.crisphealth.org.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and provide some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at the following locations when it is related to your care and treatment: our offices, at the hospital, at another doctor's or health care provider's office, a clinical lab, pharmacy, radiology office or similar places where you may receive treatment or care. For example, a physician treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the physician may need to tell the dietitian at the hospital if you have diabetes so that appropriate meals can be arranged. We may also disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

For Payment. We may use and disclose health information about you so that the treatment and services you receive from us may be billed to, and payment collected from, you, an insurance company, or a third party. For example, we may need to disclose information about your office visit so your health plan will pay us or reimburse you for the visit. We may also inform your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to manage our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer; what services are not needed; whether certain new treatments are effective; or to compare our services with others to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning the identity of our specific patients.

Portal. If you sign up to use our self-service portal, we may use and disclose health information to: contact you; provide you with test results; refill medications; provide education about your illness; and schedule office appointments.

Appointment Reminders. We may use and disclose health information to contact you as a reminder that you have an appointment. Please let us know if you do not wish to have us contact you concerning your appointment, or if you wish to have us use a different telephone number or address to contact you for this purpose.

Research. Under certain circumstances, we may use and disclose health information about you for the following research purposes:

- Research in General. We may use or disclose your health information for a research project. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with patients' need for privacy of their health information. Before we use or disclose health information for this type of research project, the project will have been approved through this research approval process.

- Reviews Preparatory to Research. We may use and disclose health information about you to people preparing to conduct a research project. For example, we may help potential researchers look for patients with specific health needs, so long as the health information they review does not leave our facility. We will always ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are, or who will be involved in your care.

- Limited Data Set. We may use or disclose a limited data set for research purposes if we enter into a data use agreement with the limited data set recipient. A "limited data set" is your health information that excludes certain direct identifiers of you, your relatives, employers or household members. For example, the following types of identifiers would be excluded: names, postal information other than town, city, State and zip code; fax numbers, telephone numbers, e-mail addresses, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, certificate/license numbers; vehicle identifiers and serial numbers including license plate numbers, device identifiers and serial numbers, Web Universal Resource Locators (URLs), internet protocol (IP) address numbers, biometric identifiers including finger and voice prints, and full face photographic images and any comparable images.

As Required by Law. We will disclose health information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans. If you are a member of the Armed Forces or have been separated or discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

Workers' Compensation. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose health information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; or
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits; civil, administrative or criminal investigations; inspections; licensure or disciplinary actions; and civil, administrative or criminal proceedings or actions or other activities necessary for the appropriate oversight of the health care system, government benefit programs, government regulatory programs and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by

someone else involved in the dispute if we receive satisfactory assurance that you have been given notice.

Law Enforcement. We may release health information if asked to do so by a law enforcement official:

- as required by law to report certain wounds or physical injuries;
- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at our facilities; or
- in emergency circumstances to report a crime; the location of the crime or victim(s); or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

Organ or Tissue Donation. We may use or disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of cadaveric organs, eyes or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Correctional Institutions, Law Enforcement Custodial Situations. We may disclose to a correctional institution or law enforcement official having lawful custody of an inmate or other individual health information about such inmate or individual provided the information is necessary for health care, the health or safety of the person or other inmates, the health or safety of officers or employees at the correctional institution or those involved in transporting the individual, or for the administration, safety, security and good order of the correctional institution.

National Security and Intelligence Activities. We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:

You have the following rights regarding health information we maintain about you.

Right to Inspect and Copy. You have the right to inspect and to obtain a copy of your health information that may be used to make decisions about your care. Usually, this includes health and billing records.

To inspect and to obtain a copy of your health information that may be used to make decisions about you, you must submit your request in writing to the Practice Manager or Billing Manager. If you request a copy of the information, we will charge a fee for the costs of copying, mailing, or other supplies and services associated with your request. However, if your health information is kept electronically and you request an electronic copy of your health information, we will provide access in the electronic form and format requested by you if it is readily producible in such form and format; or, if not, we will provide a readable electronic form and format as agreed to by you and us.

We may deny your request to inspect and to obtain a copy of your health information in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our practice, but who did not participate in the original decision to deny access, will review your request and the denial. We will comply with the outcome of the review.

Right to Amend. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment your request must be made in writing and submitted to the Privacy Official. You must provide a reason that supports your request for an amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the health information kept by or for our practice;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

If you elect to exercise your right to amend your health information, you will be provided with our office's *Form to Request Amendment to Health Information.*

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting for Disclosures. You have the right to request a list accounting for any disclosures of your health information we have made, except for: uses and disclosures for treatment, payment, and health care operations, as previously described; disclosures to you; disclosures incident to a use or disclosure otherwise permitted or required by the Privacy Rule; disclosures pursuant to a valid authorization; disclosures to persons involved in your care; disclosures for national security or intelligence purposes; disclosures to correctional institutions or law enforcement officials; and disclosures that occurred prior to April 14, 2003.

To request this list of disclosures, you must submit your request in writing to the Privacy Official. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists we will assess a fee of $30.00. You may choose to withdraw your request at this point if you do not wish to pay the fee. We will mail you a list of disclosures in paper form within 30 days of your request or notify you if we are unable to supply the list within that time period and by what date we can supply the list. This date will not exceed a total of 60 days from the date you made the request.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we restrict a specified nurse from accessing your information, or that we not disclose information to your spouse about a surgery you had.

We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. If the information is disclosed to a health care provider for emergency treatment, we will request that the health care provider not further use or disclose the information. **However, we must agree to your request to restrict disclosure of health information to your health plan if: (i) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (ii) the health information pertains solely to a health care item or service for which you, or a person on your behalf, has paid us in full.** To request a restriction, you must make your request in writing to the Privacy Official on our *Form to Request Restrictions*. For example, in your request, you must tell us what information you want to limit and to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box.

To request confidential communications, you must make your request in writing to the Privacy Official on our form, *Request for Confidential Handling of Health Information*. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to obtain a paper copy of this Notice at any time. To obtain a copy, please request it from the Practice Manager or Designated Administrative Staff.

Changes to this Notice. We reserve the right to change this Notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date.

Complaints. All complaints must be submitted in writing to the Privacy Official on the *Privacy Complaint* form. ***You will not be penalized for filing a complaint*.** If you believe your privacy rights have been violated, you may file a complaint with:

Maryland Primary Care Physicians, LLC
Marshall Scott, COO, Privacy Official
1111 Benfield Blvd.
Suite 200
Millersville, MD 21108

A complaint may also be filed with the Secretary of the Department of Health and Human Services. The complaint must be filed with the Secretary within 180 days of when you know or should have known of the act or omission, unless this time limit is waived by the Secretary for good cause shown.

Authorization and Other Uses of Health Information. You will be required to sign an authorization to use or disclose your health information for certain marketing activities unless the communication is made face-to-face or involves a promotional gift of nominal value. Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. Please be aware that we are not able to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

.

Maryland Primary Care Physicians

PATIENT HIPAA COMMUNICATION FORM

Patient Name: _____ Date of Birth: _____

FAMILY & FRIENDS: It is the policy of MPCP not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caregivers, please indicate that below, so that we may best serve you. By signing below, you authorize the following persons to receive information, as requested, regarding your care and treatment. **Updates to this form must be made in person.**

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

ALTERNATIVE COMMUNICATION: I wish to be contacted in the following manner (check all that apply):

Home Phone _____

_____ Okay to leave message with details

_____ Leave a call back number only

Cell Phone _____

_____ Okay to leave message with details

_____ Leave a call back number only

Work Telephone _____

_____ Okay to leave message with details

_____ Leave a call back number only

Written Communication

_____ Okay to mail to home address

Patient or Representative Signature	**Relationship to Patient**	**Date**

Financial Policy

Maryland Primary Care Physicians, LLC

Thank you for choosing **Maryland Primary Care Physicians, LLC** ("MPCP") as your healthcare provider. We realize that the cost of healthcare is a concern for our patients and we are available to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our relationship. The following is a statement of our Financial Policy, which you must read, agree to, and sign prior to treatment. Carefully review the following information and please ask if you have any questions about our fees, policies, or your responsibilities.

Provide Accurate Information: You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes-name, address, phone, insurance coverage, etc.- you must inform this practice immediately. Insurance denials or billing errors due to patient supplied information will result in the immediate transfer of the account balance to the patient's immediate financial responsibility.

Know Your Insurance Coverage and Benefits: Your health insurance coverage is a contract between you and your health insurance carrier. ***Patients are responsible for understanding their health insurance coverage(s) and benefits.*** There may be limitations and exclusions to coverage. ***You are responsible for any charges not covered by your plan.***

Insurance Accounts: We ask that you present your insurance card at **every visit.** If you fail to provide us with the correct insurance information at each visit a waiver must be signed and you may be responsible for payment for all services provided.

- Co-payments are due at the time of service, as it is a requirement placed on you by your insurance carrier. Please help us by paying your co-payment at each visit.
- If your insurance company requires you to pick a Primary Care Physician (PCP) one of our physicians must be the PCP listed on your insurance card.
- We will file claims to the insurance companies we contract with, provided that you authorize the "assignment of benefits" for payment directly to our practice. For plans that we participate in, the practice will accept payment based on contractual agreements. You agree to pay any portion of charges not covered by insurance.
- For insurance plans we do not contract with, we will file claims as a courtesy, provided that you authorize the "assignment of benefits" for payment directly to our practice. If your insurance does not pay within 60 days, you will be responsible to pay the balance of unpaid charges and follow-up with your insurance directly.

Self-pay Accounts: Self-pay accounts are patients without insurance coverage or who are unable to provide us with valid insurance information. If a patient is able to provide valid insurance information **within 30 days of the original date of service** a claim will be filed with the insurance carrier. If the insurance carrier issues payment for services rendered the patient will be issued a refund based upon the insurance payment. ***Self-pay patients are responsible for paying 100% of charges at the time services are rendered.***

Worker's Compensation and Motor Vehicle Accident: In the case of a worker's compensation injury, motor vehicle accident and/or other third-party liability you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier **PRIOR** to your visit. Failure to provide worker's compensation, motor vehicle accident and/or other third-party liability information **within 30 days of the date of service** may result in any unpaid balances transferring to patient responsibility. ***Payment for any services that we provide will ultimately be your responsibility if not paid promptly by another party.***

Statements: A statement will be sent to you once a balance becomes patient responsibility and will continue every 30 days thereafter. Unless you notify our office within 30 days of receiving your statement that you dispute the validity of the balance or any portion thereof, we will assume the balance is correct and valid.

Collection of Outstanding Balances: All outstanding balances shall be due within 14 days unless prior monthly payment arrangements have been made in writing. Balances that remain outstanding after 90 days or more may be referred to an outside collection agency/attorney and may result in termination of medical care by MPCP. If your account is referred to an outside collection agency/attorney you may be responsible for paying any incurred collection agency/attorney's fees.

Types of Payments: Our practice accepts Debit, Visa, Mastercard, American Express, and Discover. Cash, check or money orders are also acceptable methods of payment. If your check is dishonored (returned for non-sufficient funds) you will be required to pay an additional fee of $35.00.

Missed Appointments: It is important that you appear for all scheduled appointments. By way of courtesy, we usually (but need not) call to confirm your appointment a day or two before the scheduled visit. If speaking to you is not possible for any reason, we attempt to leave a reminder message on an answering machine or voice mail. Your failure to appear for a scheduled appointment or to cancel an appointment **at least 24 hours prior to the visit** may result in a missed appointment fee of $50.00 for a physical or $35.00 for any other type of visit. This policy is aimed at minimizing waiting time and ensuring availability of medical care for all of our patients. We recognize the fact that there may be circumstances which may not permit you to give 24 hours prior notice but such occurrences are exceptionally rare and shall be considered on a case by case basis.

Treatment of Minors: The parent(s) or legal guardian(s) is responsible for full payment and will receive the billing statements. A signed release will be required to treat unaccompanied minors.

Miscellaneous Fees: Certain services (e.g. family conferences, completing forms, producing narrative reports, personal letters, etc) may entail additional fees not covered by insurance. Payment in full is expected at the time such services are rendered.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of service. Our office will not bill any other personal party.

AUTHORIZATION

I have read, understand and agree to the financial policy stated above and accept responsibility for payment of all fees/charges incurred with Maryland Primary Care Physicians, LLC.

Patient Printed Name	Patient Date of Birth
Patient/Responsible Party Signature	Date