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 Notice of Privacy Practices, effective 3/25/2019.
Initial Here

Maryland Primary Care Physicians, LLC

7580 Buckingham Boulevard
Suite 220
Hanover, MD 21076

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

March 25, 2019

This Notice of Privacy Practices applies to the following organizations.

Maryland Primary Care Physicians, LLC
Physicians Management Group, LLC
7580 Buckingham Boulevard
Suite 220
Hanover, MD 21076

Privacy Officer: Colleen Ceradini, CEO
cceradini@mpcp.com
(410) 729-2065

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