CATONSVILLE PRIMARY CARE CENTER, PA

PATIENT NAME:____

LAST FIRST MIDDLE INITIAL

PREFIX: Mr. / Mrs. / Ms. / Dr. SUFFIX: JR. / SR. / I, II, III GENDER: Male / Female

PATIENT ADDRESS:____

CITY:____________________________ STATE: ______________________ ZIP:________

DO YOU WISH TO PROVIDE US WITH AN ALTERNATE ADDRESS: YES NO

ADDRESS: ____

DOCTOR YOU PLAN TO SEE: __________________ REFERRED BY: ______________________

PATIENT DATE OF BIRTH: ____________ SS#___________________ MARITAL STATUS:_______

HOME PHONE: _____________ CELL PHONE: ______________ WORK PHONE:____________

RACE: ___________ ETHNICITY: _____HISPANIC OR LATINO _____NON-HISPANIC OR LATINO

PREFER NOT TO ANSWER: _______

LANGUAGE PREFERRED: ___________ E-MAIL ADDRESS:_________________

MODE OF REMINDER: PHONE E-MAIL MAIL DO NOT CORRESPOND

IN CASE OF EMERGENCY WHO WOULD YOU LIKE US TO CONTACT?

NAME: ______________________________ RELATIONSHIP TO PATIENT: ________________

HOME PHONE: ____________________CELL PHONE: _________________

ADDRESS:____

NEXT OF KIN:
NAME:____

RELATIONSHIP: _________________PHONE: _______________ CELL PHONE: ____________

ADDRESS:____

GUARANTOR: (To be completed by the person who will be responsible for paying bills)

NAME:________________________________RELATIONSHIP TO PATIENT: _______________

SS#:_______________ HOME PHONE: ____________________CELL PHONE:____________________

ADDRESS:____

CITY: ____________________STATE:__________ZIP: ________________ DOB: ____________

PRIMARY INSURANCE:
NAME OF INSURANCE CO: _________________________MEMBER/POLICY #:________________

GROUP #:_________________ ADDRESS: ____

CITY: ____________________ STATE: _______ ZIP:_________ EFFECTIVE DATE: ____________

POLICY HOLDERS NAME:_______________________ DOB:__________ SS#:_______________

SECONDARY INSURANCE:
NAME OF INSURANCE CO: _________________________________POLICY #:________________

GROUP #:_________________ ADDRESS: ____

CITY: ____________________ STATE: ________________ ZIP:________________

EFFECTIVE DATE: ______________ POLICY HOLDERS NAME:______________________________

SIGNATURE REQUIREMENT

I understand that the physicians of Catonsville Primary Care Center, PA are participating providers under my health insurance plan. I authorize that payment of medical benefits be made to the above physicians for services rendered. I also understand that I will be responsible for any deductible and/or co-payment/coinsurance not covered under my plan. I further agree to accept full financial responsibility for medical expenses incurred at Catonsville Primary Care Center, PA if it is subsequently determined that I am deemed ineligible for health plan benefits through my employer or that I have not selected a physician of Catonsville Primary Care Center, PA as my primary care physician or that I am ineligible to be placed on Catonsville Primary Care Center, PA's patient panel. I also authorize the release of any and all medical information necessary to process my claim. ______ (initial)

Patients with non-participating commercial insurances or without health insurance will be responsible for making payment at the time services are rendered. Upon request a claim form will be given to the patient to be submitted to his or her insurance company. Should your insurance carrier require Catonsville Primary Care Center, PA to release any medical information necessary in processing your claim, you authorize such requests. In addition, should Catonsville Primary Care Center, PA directly bill your insurance carrier, you authorize payment of medical benefits directly to the practice. ____(initial)

PATIENT SIGNATURE: ____ DATE: ____________

PARENTS SIGNATURE: ____(IF CONSIDERED A MINOR)

ADULT DATABASE HISTORY FORM

Patient Name:________________________ Date of birth: ___/___/___ Date completed: ___/___/___

MEDICAL PROBLEMS: (ie: high blood pressure, diabetes, surgical procedures, etc.)

____

____

____

____

MEDICATIONS: (include self administered medications)

____

____

____

____

ALLERGIES: (include reaction to medication)

____

____

FAMILY DISEASES: Check all that are present in your close family members.

[ ] Colon Cancer/Polyp	[ ] Heart Disease	[ ] Thyroid disease
[ ] Breast Cancer	[ ] Stroke	[ ] Psychiatric illness
[ ] Prostate Cancer	[ ] Diabetes	[ ] Other cancer: ____________

HEALTH BEHAVIORS:

1) Have you ever smoked? [ ]Yes [ ]No Do you smoke now? [ ]Yes [ ]No How many packs/day? _____
2) Do you drink alcohol regularly? [ ]Yes [ ]No Drinks/day = _____
3) Do you wear sunblock when outside? (spring and summer) [ ]Yes [ ]No
4) Do you exercise regularly? (at least one hour or more per week) [ ]Yes [ ]No
5) <u>Women</u>-Do you examine your breasts monthly? [ ]Yes [ ]No
6) <u>Women</u>-Do you get mammograms? [ ]Yes [ ]No Last one = (m/y) ___/___
7) <u>Women</u>-Do you get regular Pap smears? [ ]Yes [ ]No Last one = (m/y) ___/___
8) <u>Women</u>-Do you take supplemental calcium to lessen risk for osteoporosis? [ ]Yes [ ]No
9) <u>Men</u>-Do you examine your testicles monthly? [ ]Yes [ ]No

VACCINATIONS:

1) When was your last Tetanus shot? (m/y) ___/___
2) Did you have the <u>M</u>easles<u>M</u>umps<u>R</u>ubella booster if born after 1956? [ ]N/A [ ]Yes [ ]No (m/y) ___/___
3) Did you have the pneumonia vaccine?(over 65 or certain diseases) [ ]N/A [ ]Yes [ ]No (m/y)___/___
4) Do you get the influenza vaccine yearly?(over 65 or certain diseases) [ ]N/A [ ]Yes [ ]No

HOME/AUTO SAFETY:

1) Do you always wear seatbelts? [ ]Yes [ ]No
2) Do you have and use a car seat for all children under 40 lbs? [ ]N/A [ ]Yes [ ]No
3) Do you have a <u>working</u> smoke detector in your home? [ ]Yes [ ]No
4) Do you own a handgun? [ ]Yes [ ]No, (kept unloaded? [ ]Yes [ ]No, safe from children? [ ]Yes [ ]No)

Catonsville Primary Care Center, P.A.

405 Frederick Road, Suite 210
Catonsville, Maryland 21228
410-788-6565

To Our Patients:

Privacy regulations prohibit us from communicating healthcare related messages with anyone other than the patient.

If it is agreeable with you that we may leave a message regarding all healthcare related issues on your recorder, voicemail or with another family member please initial and sign below giving us permission to do so. The doctor will address any issue that needs explanation directly with you.

_____ **You may leave a message on my home recorder or voicemail.**

_____ **You may leave a message on my cell phone voicemail.**

_____ **You may leave a message with the following family member(s):**

1. ______________________________
2. ______________________________
3. ______________________________

_____ **You may discuss healthcare related issues with the following individuals:**

1. ______________________________
2. ______________________________
3. ______________________________

_____ **I understand that this authorization will expire five (5) years from the date signed below:**

Patient's Name (printed): ______________________________ **DOB:** ______________

Patient's Signature: ______________________________ **Date:** ______________

HIPAA Notice of Privacy Practices

CATONSVILLE PRIMARY CARE CENTER, P.A.
405 FREDERICK ROAD, SUITE 210
CATONSVILLE, MARYLAND 21228
410-788-6565

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: Public Health issues as required by law; Communicable Diseases; Health Oversight;
Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; Organ Donation; Research; Criminal Activity; Military Activity; National Security and Workers' Compensation. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses snd Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right, to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_________________________ Signature_________________________ Date________