

Montgomery Family Medicine Associates, P.C.

2415 Musgrove Road, Suite 105

Silver Spring, MD 20904

(301) 989-0193

Patient Registration Form

If patient is a MINOR, parent or legal guardian must answer and sign this form

Patient's Last Name	First Name	Middle Initial	Age	Date of Birth	MALE FEMALE
Patient's Address	Apt #	City	State	Zip Code	
Home #	Cell #	Work #			
Social Security #	Patient's Employer	Employer Address	Patient's Occupation		

Insurance Information

Insurance Company Name	Insurance Company's Address	City	State	Zip Code
Insurance's Subscriber (Last Name, First Name, Middle Initial)	ID Number	Group Number		
Subscriber's Social Security	Date of Birth	MALE FEMALE	Relationship to Patient	Subscriber's Employer
2 nd Insurance Company Name	2 nd Insurance Company's Address	ID Number	Group Number	

Personal/Emergency Contact Information

Marital Status	Spouse's Name (if applicable)	Spouse's Date of Birth	Spouse's Phone #
Emergency Contact Person	Relationship to patient	Emergency Contact Person's Phone Numbers Home: Cell: Work:	
Emergency Contact Person's Address	Apt #	City	State Zip Code
Patient Allergies	How were you referred to Montgomery Family Medicine?		

I, _____, hereby authorize Montgomery Family Medicine to apply for benefits on my behalf for services rendered to me (or my child) and request that payment be made by _____ Insurance Company and that payment be sent directly to Montgomery Family Medicine Associates, P.C. I understand that this, in no way, relieves me of my primary responsibility to pay for services rendered to me (or my child), and if my account is turned over for collection, I agree to pay any reasonable collection fees (25% is deemed reasonable). If a suit is filed, I agree to pay reasonable attorney fees (33.3% is deemed reasonable for court costs and other expenses incurred as a result of said collection). The undersign agrees that if a suit were to be filed, venue (location of suit) shall be in Montgomery County, Maryland. Venues in any other counties are waived hereby.

I certify that the information I have reported with regard to my insurance coverage is correct and I authorize the release of any information relating to any claims for benefits, in order to process any claims for benefits. Furthermore, I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. All of the information filled out above is completely and accurately fill out.

Signature of patient (or parent/legal guardian)

Relationship to patient

Please print name

Date

Montgomery Family Medicine Associates, P.C.
2415 Musgrove Road, Suite 105
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Disclosure

Patient Name: _____ Date of Birth _____

I authorize the providers and professional staff of Montgomery Family Medicine Associates, P.C. to leave messages regarding my medical information (lab results, reports, appointments etc.) at the following phone numbers:

- ☐ Home _____
- ☐ Cell _____
- ☐ Work _____

Disclosure to Family/Friends:

☐ I **DO NOT** wish for Montgomery Family Medicine Associates to disclose any information concerning my care or treatment to individuals without my expressed written consent or legal authorization.

☐ I **AUTHORIZE** providers/staff to disclose information related to my care and treatment to the following named individuals:

Name	Relation
_____	_____
_____	_____
_____	_____
_____	_____

The authorization provided to the above persons are subject to the following limitations and/or restrictions.

X _____
Signature of Patient (or Parent/Responsible Party)

Relationship to Patient

Printed Name of Signee

Date

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Brief Medical History

Patient name _____ Date of birth _____

1. Check the following medical conditions that you have now or previously had

___ High Blood Pressure

___ Liver or Gallbladder Disease

___ Heart Disease

___ Stomach or Intestinal Problems

___ Asthma or Lung Disease

___ Seizures or Fainting

___ Diabetes or Kidney Disease

___ Major Surgeries: _____

___ List any other serious illnesses or medical conditions

2. Are you sensitive or allergic to any drugs?

___ Yes

___ No

If yes, which drugs? _____

3. Do you go to any other doctors?

___ Yes

___ No

If yes, which doctor? _____ Specialty _____

4. Are you taking any medications now or have recently? ___ Yes ___ No

What medications? (Include doses and frequency) _____

5. Please list medicines or drugs you sometimes take that are bought without a prescription (such as aspirin, antacids, sleep medicine, allergy medicine, cold medicine, vitamins, etc.)

6. Do you smoke?

___ Yes

___ No

If yes, how often? ___ Once a month ___ Once a week ___ Daily

7. Do you drink alcoholic beverages?

___ Yes

___ No

If yes, how often? ___ Once a month ___ Once a week ___ Daily

8. Please use the space below to tell us anything about you or your health that you think would be helpful or useful to us

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Please print name

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Use & Disclosure of Protected Health Information Patient Acknowledgement & Consent Form

Acknowledgement of Notification

The education pamphlet entitled "Notice of Privacy Practices" provides information about how Montgomery Family Medicine Associates, P.C. may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Program and Accountability Act of 1996 (HIPAA).

Our notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, you will be notified on your next visit to our office.

In addition, the terms listed in our Notice of Privacy Practices have been revised or amended, as follows:

We will contact you one to three (1-3) business days prior to your appointment and leave a message on your behalf, with the date and time of your upcoming appointment.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions; but if we do, we are bound by our agree with you.

By signing below, you acknowledge receipt of Notice of Privacy Practices

Signature of patient (or parent/legal guardian)

Date

Consent for Use & Disclosure of Information

By signing below, you consent to our use and disclosure of protected health information about your treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Montgomery Family Medicine Associates, P.C. for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services, its agents and/or any other insurance carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier Agreements. As a reminder, a surcharge of \$5.00 will be added to each missed co-pay (to cover billing costs if we have to bill you for your co-pay).

Signature of patient (or parent/legal guardian)

Relationship to patient

Please print name

Date

For more information or to report a problem: If you have any questions or would like additional information, please contact the HIPAA Policy Officer for this practice. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health & Human Services. There will be no retaliation for filing a complaint.

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Office Policies

Welcome to Montgomery Family Medicine Associates, P.C. We are pleased that you have chosen us to be your primary care physicians. Below are some important office policies that we would like for you to review.

Missed Appointments

The office requires a 24-notice for all appointment cancellations during our office hours.

- \$30 for regular missed appointments.
- \$50 for missed appointments on Saturdays and any appointments after 3:30pm or before 8:30am (including Echo & Vascular studies).
- \$100 for missed appointments for complete physical exams/well check-ups for women and children.
- \$205 for missed Nuclear Exercise Stress Test (the cost of the isotope).

If this courtesy is not extended to the office, the fees listed above will be imposed. This fee is your responsibility and will not be covered by your insurance. Should you incur this fee, it must be paid by your next office visit. **Please do not call our answering service to cancel appointments.** When making appointments, please provide a valid phone number where you be reached directly to confirm your appointments.

Co-Payments

Your co-pay is a fee imposed by your insurance company. Your co-pay must be paid at the time of your visit. If you have to be billed for your copayment, a surcharge of \$5 will be added to each missed co-pay (to cover for billing costs).

Prescription Refill Policy

Please remember to have your provider refill all your prescriptions at the time of your office visit to last you until your next scheduled visit.

Please note:

- No prescription refills can be done by the on-call provider.
- We may **not** be able to continue to honor refill requests via telephone.
- Long term/chronic medication refills will be managed by the provider that sees you for that condition and/or by the provider that sees you for your complete physical.
- **No controlled drugs** can be given by covering providers. In extreme circumstances, the covering provider may be able to prescribe a small quantity of medication to last you until your provider is available.

Referrals

If your insurance company requires a referral for specialist care, allow three (3) business days for completion, for non-emergency referrals. Referrals that require prior authorization by your insurance company may take longer. You will be financially responsible for service received without a referral from our office. Non-emergency referrals will not be faxed to any specialist. We prefer that you pick up your completed referrals since we have extended office hours. Please obtain your referral before seeing the specialist, due to the fact that we are not allowed to back date referrals.

Delinquent Account/Returned or Bounced Checks

Payments must be made at the time of service. This includes payments for the current visit and any balance due. Returned checks are subjected to a **\$25 returned check fee** and suspension of check writing privileges. You may **not** be seen for non-emergency care until your account is paid in full. If you are unable to settle your account, payment arrangements can be made. If your payments are not made as promised, we reserve the right to pursue recovery through legal action and/or you may be discharged from Montgomery Family Medicine Associates, P.C. All patients will be responsible for legal fees (25% of account balance, court costs, and other expenses incurred as a result of collections).

Inclement Weather Policy

Please call the office's main phone line at **(301 989-0193)** before leaving your home to see if the office is open on time. Message will be updated by 7am if there is any change in the office hours.

By signing below, I have read, acknowledged, and will adhere to the above policies

Signature of patient (or parent/legal guardian)

Relationship to patient

Please print name

Date

Montgomery Family Medicine Associates, PC
2415 Musgrove Road, Suite 105
Silver Spring, MD 20904
Office: 301-989-0193

Rosie Singh, MD
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Nicole Koch, PA-C
Robyn Neches, PA-C

Melissa Friedland, MD
Emily Bagby, PA-C
Reshma Lalwani, PA-C
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Preventative/Physical Appointment

We want to inform you of our billing policy regarding preventative visits and consultations that may arise during those visits.

We bill for preventative visits that include specific services. The services we provide at a preventative visit include: an age-appropriate history, physical examination, general age-appropriate recommendations, and ordering related laboratory tests.

Preventative visits are covered by most health insurances. For the most part, the cost of the visit does not go through a deductible and does not involve a copayment.

Preventative visits **do not** include evaluation and management of substantial problems, concerns or questions on topics such as management of chronic medical conditions, injuries, or any other acute medical issues that may have come up.

During the course of a preventative visit, if patients need these additional services, we do our best to accommodate addressing these concerns, to avoid scheduling a separate visit and to be able to be able to give comprehensive care.

Please understand, however, that our policy is to bill for this additional service beyond the preventative visit. Please consult your insurer regarding your coverage for additional service, as it may incur a separate cost to you including a copayment.

Patients are also welcome to schedule a separate visit to address these similar topics not covered by a preventative visit.

Please sign below to verify that you have read and understand this policy.

Printed Name: _____

Signed: _____

Date: _____