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

## Patient Registration Form: 17 and younger

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

| Patient's Last Name | First Name | Middle Initial | Age | Date of Birth | MALE TRANSGENDER *(Write pronoun):* FEMALE _____ |
|---|---|---|---|---|---|
| Patient's Address | | APT # | City | State | Zip Code |
| Primary # - HOME CELL (Circle One) | Secondary # - HOME CELL (Circle One) | | **EMAIL ADDRESS (Important for portal access!)** | | |
| Social Security # | Parent's Employer | Employer Address | | Parent'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 Transgender *(Write pronoun)* _____ | Relationship to Pt | Subscriber's Employer |
| 2nd Insurance Company Name | 2nd 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 filled out.

_____ Signature of patient (or parent/legal guardian)

_____ Relationship to patient

_____ Print Name

_____ Date

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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:

☐ Primary Phone _____

☐ Secondary Phone _____

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 | Relationship to Patient | Contact Phone Number |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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

_____

_____

_____

_____ _____

Signature of Patient (or Parent/Responsible Party) Relationship to Patient

_____ _____

Printed Name of Signee Date

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# PEDIATRIC CONSENT FORM

Date: _____

I, _____, authorize Montgomery Family Medicine Associates, P.C.
(Parent Name)

to treat my child _____ in the event of an emergency.
(Child's Name)

_____ _____
Signature of Patient (or Parent/legal guardian) Relationship to Patient

_____ _____
Print Name Date

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**2415 Musgrove Road, Suite 105**
**Silver Spring, MD 20904**
**301-989-0193**

Patient Name: _____ Date of Birth: _____

## MEDICATION LIST

*Please include over-the-counter medications and vitamins/supplements*

| NAME | DOSE | FREQUENCY |
|---|---|---|
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# PREVENTATIVE SCREENING QUESTIONNAIRE

Date: _____

Patient Name: _____

Date of Birth: _____

## Tuberculosis Screening

| | | |
|---|---|---|
| Was your child born in or ever lived in a foreign country? | YES | NO |
| Has your child been exposed to anyone with either active tuberculosis or past infection with tuberculosis? | YES | NO |
| Has your child been exposed to anyone who has AIDS, a drug addiction, or is a resident of a correctional facility? | YES | NO |

## Lead Screening

| | | |
|---|---|---|
| Has your child ever (including now or in the past) lived in a house or apartment older than thirty (30) years? | YES | NO |
| Is any adult exposed to lead in their occupation or hobby? | YES | NO |
| Has anyone at home been diagnosed with lead poisoning? | YES | NO |
| Do you have any reason to believe your child may have been exposed to lead? | YES | NO |

## Cholesterol Screening

| | | |
|---|---|---|
| Is there a family history of males under the age of 50 or females under the age of 40 with high cholesterol, sudden death, heart attack, diabetes, or strokes? | YES | NO |

## Fluoride Screen

| | | |
|---|---|---|
| Do you have non-fluoridated well water? | YES | NO |

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# CONFIDENTIAL PEDIATRIC HEALTH QUESTIONNAIRE

Child's Name: _____ Date of Birth: _____ Date: _____

Please allow us to help you assess and take care of your child's health by answering the following questions.

1.

| | Name | Date of Birth | Occupation | Living at home? | |
|---|---|---|---|---|---|
| Father | _____ | _____ | _____ | YES | NO |
| Mother | _____ | _____ | _____ | YES | NO |
| Sibling | _____ | _____ | _____ | YES | NO |
| Sibling | _____ | _____ | _____ | YES | NO |
| Sibling | _____ | _____ | _____ | YES | NO |

If any of the above answers is **NO**, please explain:

_____

2. Is your child adopted? YES NO
   If yes, age at adoption _____

3. Was the pregnancy disease-free and uneventful? YES NO
   If no, please explain:
   _____

4. Was the delivery at term and normal? YES NO
   If no, please explain. Also, provide birth weight and length of gestation:
   _____

5. Was your child's development normal? YES NO
   If no, please explain. Also, provide birth weight and length of gestation:
   _____

6. If your child has had any major illnesses, please specify here:
   _____
   _____
   _____
   _____

7. Was your child ever admitted to a hospital (i.e. stayed overnight)? YES NO
   If yes, indicate date, hospital(s), reason(s):
   _____
   _____

8. Has your child developed any allergic reaction to medications? YES NO
   If yes, which medications, and what were the reactions?
   _____

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Child's Name: _____ Date of Birth: _____

9. Do you have any Ipecac at home? YES NO

10. Do you have smoke detectors at home? YES NO

11. Does your child use seatbelts or car seats (as appropriate and required by law)? YES NO

12. Does anyone living in the home smoke tobacco or marijuana, or use e-cigarettes (vaping devices)? YES NO

13. Are there presently any problems or stresses in the family (financial, marital, etc)? YES NO

14. If any blood relative (grandparents, parents, siblings, aunts, uncles) has any of the following illnesses, please check:

____ Alcohol/Drug misuse
____ Blood disease
____ Asthma/Hay fever
____ Jaundice
____ Diabetes
____ Tuberculosis
____ Early death
____ Cancer
____ AIDS
____ Hypertension
____ Early heart trouble
____ Mental/Nervous illness
____ Hearing defect
____ Convulsions
____ Thyroid disease
____ Kidney disease
____ Gastrointestinal disease

If there are any additional information or comments you would like to add, please describe below:

_____

_____

_____

_____

_____

## ATTESTATION

My signature below indicates that the above information is accurate and complete to the best of my knowledge.

_____ _____
Signature of Patient (or Parent/Responsible Party) Relationship to Patient

_____ _____
Printed Name of Signee Date

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## PREVENTATIVE/PHYSICAL APPOINTMENT

Annual Preventative Visits (APVs, formerly known as Physicals) are for Prevention and Screening. This includes age-appropriate health maintenance, such as vaccines and cancer screenings. We also order routine laboratory tests and EKGs as indicated.

Please schedule your APV when you are well.

As per insurance guidelines, APV are not for addressing acute problems.

If for some reason you have a new problem that arises after you have scheduled your APV, please call to CHANGE your appointment to a problem-based visit, and reschedule your APV.

Please note that the first appointment will be a problem-based visit and not an APV.

My signature below indicates that I have read, acknowledged, and will adhere to the above policies:

_____ _____
Signature of Patient (or Parent/legal guardian) Relationship to Patient

_____ _____
Print Name Date

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# OFFICE POLICIES - GENERAL

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

**MISSED APPOINTMENTS**

The office requires a 24hr notice for all appointment cancellations during our office hours. If this courtesy is not extended to the office, the fees listed below will be imposed:

- $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 Annual Preventive Exams

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 can be reached directly to confirm your appointments.

**CO-PAYMENTS**

Your co-payment 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 co-pay a surcharge of $10 will be added to each missed co-pay (to cover for billing costs).

**PRESCRIPTION REFILL POLICY**

At the time of your office visit, please remember to have your provider refill any prescriptions you need to last you until your next scheduled visit. We monitor most chronic conditions every 6 months and send 90 day supplies plus 1 additional refill. We request you not to call or send portal messages with refill requests except under exceptional circumstances. For medication safety reasons, we do not accept refill requests from pharmacies.

**Please note:**

- No prescription refills can be done by the Answering Service on-call provider
- **NO CONTROLLED DRUGS** can be prescribed by covering providers. Under extenuating circumstances, the covering provider may be able to prescribe a small quantity of medication to last you until your usual provider is available.

**PORTAL POLICY**

We highly encourage all patients to sign up for the portal. You will receive a link to the email address you provided after your first visit. If you do not see it, please check your Spam folder.
Please be aware that if you are being seen by a Physician Extender (i.e. PA or NP), you may receive a portal message from the Extender or supervising physician after your visit, with additional recommendations.

**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 **$37.50 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% or 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. You will hear a recorded message informing you if there has been any change in the office hours. If you do not hear this recording, you may ask the Answering Service.

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

_____ _____
Signature of Patient (or Parent/Responsible Party) Relationship to Patient

_____ _____
Printed Name of Signee Date

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## STATEMENT OF COMMITMENT TO MAINTAIN A RESPECTFUL ENVIRONMENT

Our clinic is committed to maintaining a safe, respectful, and inclusive environment for patients, staff, and visitors. We reserve the right to terminate the patient-provider relationship and discharge a patient for conduct that is disruptive, threatening, abusive, discriminatory, harassing, or otherwise interferes with the provision of care, including but not limited to the use of hateful or discriminatory language directed at staff, providers, or other patients, consistent with applicable laws and ethical obligations. Discriminatory language may include, but is not limited to, derogatory, demeaning, hostile, or exclusionary remarks, made verbally and/or in written form, based on a person's race, color, ethnicity, national origin, ancestry, religion, creed, sex, gender, gender identity or expression, sexual orientation, age, disability, medical condition, genetic information, marital status, pregnancy, veteran or military status, socioeconomic status, or any other characteristic protected by applicable federal, state, and/or local law(s).

My signature below indicates that I have read, acknowledged, and will adhere to the above policies:

_____ _____
Signature of Patient (or Parent/Responsible Party) Relationship to Patient

_____ _____
Printed Name of Signee Date

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## OFFICE CONTROLLED SUBSTANCES POLICY

Due to new regulations in Maryland, it's harder to get prescriptions for certain pain medications, sleep aids, and attention-deficit hyperactivity disorder (ADHD) drugs. We're still prescribing these medications to patients who are already taking them to avoid issues like withdrawal from abruptly stopping them. At the same time, we are carefully following both state and federal rules.

**Controlled Substance Medications include (but are not limited to):**

Opioids (e.g. oxycodone, hydrocodone, oxycodone-acetaminophen/Percocet)
Benzodiazepines (e.g. lorazepam/Ativan, alprazolam/Xanax, clonazepam/Klonopin)
Z-drugs (e.g. zolpidem/Ambien, eszopiclone/Lunesta, zaleplon/Sonata)
Stimulants (e.g. dextroamphetamine-amphetamine/Adderall, lisdexamfetamine/Vyvanse, methylphenidate/Ritalin)

**Risks of these medications include:**

Overdose, dependence, drowsiness, driving impairment, and falls.
They can also affect your heart rhythm and interfere with other medications.

**Managing Your Existing Controlled Substance Medication:**

**Safety:** We'll ask you to count your pills and get a refill for only the amount needed. This helps keep your home safe. Per regulations, opioid refills (except buprenorphine and tramadol) are for 30 days max and require an in-office visit. Other controlled medications depend on the medication and can be up to 90 days max.

**Appointments:** To get a refill, you'll need a scheduled appointment. We can accommodate certain virtual appointments. In-office visits are required at least twice a year. It is your responsibility to schedule each appointment at least 5-7 days before you run out of medication.

**Running Out Early:** If you run out before your appointment, call us during business hours for a short-term supply to last until your next appointment. This should happen rarely.

**Controlled Substance Agreement:** You'll need to sign an agreement acknowledging potential drug screenings and other safety items. This agreement is renewed yearly.

**Safety Measures:** If there are safety concerns, your provider may prescribe a lower dose, wean you off the medication, or suggest a safer alternative. We have expertise in Addiction Medicine and are glad to help you taper off.

**Specialist Referrals:** If you disagree with your provider's decision, you can seek a second opinion from a Pain Management or Psychiatry specialist. Your provider may also recommend this Specialty consultation.

**New Prescriptions:**

We won't start new prescriptions for opioids, benzodiazepines, or Z-drugs unless you need them for a short time for a specific reason (like severe pain due to an injury, or situational anxiety due to a transient or rare event). We may or may not start a stimulants for ADHD on a case-by-case basis.

If you're prescribed a new controlled substance medication, we will fill it for up to 30 days. You will need to schedule appointments before you run out of medication. We will make a plan together for safe long-term management of your condition.

Thank you for your understanding. Maintaining compliance with regulatory requirements allows us to sustainably provide safe, effective care.

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

_____ _____
Signature of Patient (or Parent/Responsible Party) Relationship to Patient

_____ _____
Printed Name of Signee Date

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Use & Disclosure of Protected Health Information

## PATIENT ACKNOWLEDGEMENT & CONSENT FORM

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). You will have access to this pamphlet at the time of your first appointment.

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:

If you do not confirm via text message (preferred method for appointment confirmation), we will call 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 agreement with you.

My signature below indicates that I have read, acknowledged, and will adhere to the above policies:

_____ _____
Signature of Patient (or Parent/Responsible Party) Relationship to Patient

_____ _____
Printed Name of Signee 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 $10.00 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

_____ _____
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.