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

Addiction Medicine New Patient Consultation 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 #	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 Transgender FEMALE (Write pronoun)	Relationship to Patient	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

_____ Relationship to Patient

_____ Print Name

_____ Date

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

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

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

ADDICTION MEDICINE AND/OR CONTROLLED SUBSTANCE DEPRESCRIBING: CONSENT FOR TREATMENT

Patient Name: _____ Date of Birth: _____

Street Address: _____

_____Phone Number: _____

I, the Patient, understand that in order to receive safe and effective Addiction Medicine and/or Controlled Substance Deprescribing care, which includes care related to my use of alcohol or other drugs, behavioral addictions, and/or physical dependence on a controlled substance medication (even if taken only as prescribed), care coordination is essential. I understand that Montgomery Family Medicine Associates (MFMA) will provide focused care related to my Addiction/Deprescribing needs. For all other medical issues, I agree to continue following with my same Primary Care Provider (PCP), as well as any Specialists to whom my PCP may refer me. I hereby authorize MFMA to discuss my Addiction Medicine care with my other health providers, as listed below. Discussion may include both verbal and written communication. I understand that, should I choose to decline to sign this form, MFMA may not be able to render services to me.

My Other Health Providers (leave blank if Patient has not received care from specified type of provider):

1. Primary Care Provider Name/Facility: _____
   Phone Number: _____ Fax Number: _____
2. Psychiatrist Name/Facility: _____
   Phone Number: _____ Fax Number: _____
3. Therapist Name/Facility: _____
   Phone Number: _____ Fax Number: _____
4. Pain Management Specialist Name/Facility: _____
   Phone Number: _____ Fax Number: _____
5. Other Provider who may Perform Surgery and/or Prescribe a Controlled Substance: Name/Facility:
   _____
   Phone Number: _____ Fax Number: _____
6. Alcohol/Drug Treatment Facility: _____
   Phone Number: _____ Fax Number: _____

_____ *My initials here indicate my understanding that this Authorization is valid for the duration of treatment at MFMA. If in future I wish to revoke it, I may not be able to continue to receive care at MFMA.*

Patient Signature: _____ Date: _____

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

ADDICTION MEDICINE AND/OR CONTROLLED SUBSTANCE DEPRESCRIBING HISTORY FORM

Patient Name: _____ DOB: _____

SUBSTANCES USED (PLEASE CHECK ALL THAT APPLY):

[ ] ALCOHOL [ ] CANNABIS [ ] OPIOIDS [ ] COCAINE [ ] METHAMPHETAMINES [ ] BENZODIAZEPINES

[ ] TOBACCO (see also below) [ ] E-CIGARETTES/VAPING

TOBACCO SMOKING STATUS: [ ] NEVER SMOKED [ ] FORMERLY SMOKED, QUIT [ ] CURRENTLY SMOKE

IF CURRENTLY SMOKE, HOW MANY PACKS PER DAY?_____

ALLERGIES TO MEDICATIONS: _____

CURRENT MEDICATION LIST: _____
Use second page if needed

CURRENT VITAMINS, IF ANY: _____

HISTORY OF OVERDOSE: [ ] YES [ ] NO

HISTORY OF SEVERE WITHDRAWAL REQUIRING EMERGENCY OR HOSPITAL SERVICES: [ ] YES [ ] NO

HISTORY OF LIVER CIRRHOSIS: [ ] YES [ ] NO

HISTORY OF CHRONIC KIDNEY DISEASE: [ ] YES [ ] NO

PRIOR ADDICTION TREATMENT: [ ] MEDICATION [ ] INPATIENT/REHAB [ ] OTHER [ ] NONE

PRIOR PEER MEETINGS: [ ] NA/AA [ ] SMART RECOVERY [ ] WOMEN FOR SOBRIETY [ ] OTHER [ ] NONE

MENTAL HEALTH HISTORY: [ ] DEPRESSION [ ] BIPOLAR DISORDER [ ] OTHER [ ] NONE

FAMILY HISTORY OF ADDICTION: [ ] YES [ ] NO

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

Patient Name: _____ DOB: _____

MEDICATION LIST

Please list all medications that you are currently taking

Be sure to include any over-the-counter medications and vitamins/supplements not listed on the previous page

NAME	DOSE	FREQUENCY

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

Patient Name: _____ Date of Birth: _____

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

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

OFFICE POLICIES - GENERAL

Welcome to Montgomery Family Medicine Associates, P.C. We are pleased that you have chosen us for your Addiction Medicine Consultation. 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

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 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 of any change in our hours. If you do not hear this recording, you may ask the Answering Service.

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

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

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

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

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.