Plotsky Medical Associates PC

15225 Shady Grove Rd, Suite 102
Rockville, MD 20850-3281
Phone 301-330-0661 Fax 301-977-6940

Patient Registration

Please Print Clearly

Today's Date:

Patient Name: Last	**First**	**Middle Initial**		**Patient Date of Birth:**
Home Street Address:	**Apt. No:**	**City:**	**State:**	**Zip Code:**
Sex: Male or Female	**Marital Status:** [ ]Single [ ]Married [ ]Divorced [ ] Widowed		**Social Security Number:**	
Email:	**Referring Doctor:**			
Home Number: **Work Number:** **Extension:** **Cell / Other Number :**				
Preferred Phone: [ ] Home [ ] Work [ ] Cell [ ] Other	**Confidential Information Preference**: [ ] Preferred Phone [ ]Email [ ] Patient Portal			
Preferred Language:	**Ethnicity:**	**Race:**		
Emergency Contact:	**Relationship:**	**Phone #:**		
Patient Employer : **Employer's Address:**		**Phone Number:** **Position:**		
Primary Insurance Details **Name:** **Address:** **City:** **State, Zip:**	**Policy Number:** **Group Number:**	**Policy Holder Full Name:** **Policy Holder Social Security Number:** **Policy Holder's Birth Date:**		
Secondary Insurance Details: **Name** **Address :** **City:** **State. Zip:**	**Policy Number:** **Group Number:**	**Policy Holder Full Name:** **Policy Holder Social Security Number:** **Policy Holder's Birth Date:**		

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Patient Name: _____ DOB:_____

Is this visit due to a **Workman's Compensation Case?** YES NO

Employer Name: _____ Phone: _____

If yes;

*Date of accident_____ *W/C Ins. Company_____

Where:_____ When _____

Did you file claim? YES NO

*Claim #_____

Is this visit due to an **Auto Accident**? YES NO

If yes, please provide YOUR auto insurance info – not the third party.

*Date of accident_____ *Auto Insurance_____

Where: _____ When _____

Did you file claim? YES NO

*Claim # _____

*Name of Claim Adjuster/Representative: _____

*Phone Number of Adjuster/Representative: _____

***Required fields if you answered "Yes" to either Workman's Compensation or Auto Accident Case**

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Office Policy Information Sheet

NAME OF PATIENT: _____

PLEASE NOTE: All charges and/or fees are due at the time of service, when applicable. Please present your insurance card(s) and driver's license to the office staff with this completed form. We will copy them for your records and return them to you immediately.

YOUR INSURANCE: We will bill your insurance carrier for you. Please note that we **do not take assignment on auto-related claims** or insurance carriers that we do not participate in. Co-payments/co-insurance is due at the time of service. In the event your health plan determines a service to be "not covered" or it has been over sixty (60) days with no payment from your insurance; then you will be responsible for the complete charge. In that event, we will bill you, and **payment is due upon receipt of that statement.** I agree and understand that any funds I receive from my insurance company in connection with medical services and care rendered by Plotsky Medical Associates PC will be immediately signed over and sent directly to Provider. This is a direct assignment of my rights and benefits under my medical policy/plan. This payment will not exceed my indebtedness to Provider, and I agree to pay, in a timely manner, any balance of professional service charges over and above the payments made to Provider pursuant to this assignment of benefits.

INSURANCE AUTHORIZATION: I request that payment of authorized insurance benefits be made directly to Plotsky Medical Associates PC (PMA) for any services furnished to me by that physician. I authorize PMA, and its employees and agents to release all information, reports and records if necessary to secure the payment of my account, including a discussion of my medical condition, to the insurance plan, hospitals, and/or other health care providers. If "other health insurance: is indicated in item 9 of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In insurance assigned cases, PMA agrees to accept the charge determination of the insurance carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, co-pay, and for non-covered services. Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

MINOR PATIENTS: For all services rendered to minor patients, the adult accompanying the patient is responsible for payment

CANCELATIONS: We require a twenty-four (24) hour notice for all cancellations; otherwise, there will be a $25.00 charge for all routine appointments and a $50.00 charge for all physical appointments that are not cancelled in advance.

RETURNED CHECKS: It is our office policy to charge a fee of **$35.00 for any returned checks.**

COMPLETION OF FORMS: PMA can complete attending physician's statement, insurance, disability, and/or other forms for our patients. The patient is responsible for payment of any fee prior to completion of the forms**. Please allow 7 business days for completion of forms.**

DELIQUINT ACCOUNTS: We reserve the right to add reasonable collection charges to any account over 60 days past due.

DECLARATION: I have read and I understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____
SIGNATURE & NAME of patient / insured / guarantor / responsible party DATE

_____ _____
SIGNATURE & NAME of Co-Responsible Party DATE

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Privacy Policy

Plotsky Medical Associates PC is required by law to protect the privacy of your personal health information (PHI) and to inform you, the patient, of our policies to do so. In order to comply with HIPAA regulations and to comply with Federal and State laws, we adhere to the below Privacy Policy. We reserve the right to change this policy and if we do so, we will post written notification of the policy changes and effective dates. The following is a guideline of how we currently handle PHI:

- We do not fax patient PHI other than to other physician offices, hospital, health care facilities, and/or insurance carriers. We will not send PHI to the patient's home or place of employment.

- We do not discuss patient information with anyone either over the phone or in person without the written authorization of the patient (this includes family members of minors).

- We will not give out patient demographical information/referrals without the patient's written consent unless it is for treatment, payment, or part of ongoing health care operations for the patient. When requested by other health care providers, we will confirm the information that have listed against our information and release the phone number of the patient for further information

- We will speak in soft or low tones when we are in earshot of patients or others in the office to minimize the possibility of being overheard.

- We will not release patient information such as referrals, test copies, prescriptions, or orders to anyone other than the patient unless written authorization is given from the patient.

I, _____, date of birth _____ hereby authorize Plotsky Medical Associates PC to speak to the following individuals on my behalf. These individuals are also permitted to pick up lab slips, referrals, prescriptions and copies of results that I request:

NAME & RELATIONSHIP	TELEPHONE

Plotsky Medical Associates PC also has my permission to include information that may pertain to AIDS, ARC, HIV-related disease, blood alcohol content, and alcohol/substance abuse.

This authorization does not expire. I understand that I have the right to withdraw this authorization at any time except to the extent that action has been taken based on this authorization.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Printed name and relationship of Guardian Witness

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Patient Consent for use and Disclosure of Protected Health Information

I hereby give my consent for Plotsky Medical Associates PC to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (HCO). (The Notice of Privacy Practices provided by Plotsky Medical Associates PC described such uses and disclosures more completely). I too have the right to review the notice of Privacy Practices prior to signing this consent.

With this consent, Plotsky Medical Associates PC may contact me through the preferred contact method or other alternative location and leave a message on voice mail, secure patient portal message, or in person in reference to any items that assist the carrying out of HCO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, results and labs.

With this consent, Plotsky Medical Associates PC, may mail to my home or other alternative location any items that assist the practice in carrying out HCO, such as appointment reminders and patient statements. I have the right to request that Plotsky Medical Associates PC restrict how it uses or disclose to carry out HCO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Plotsky Medical Associates PC to use and disclose my PHI to carry out HCO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Plotsky Medical Associates PC may decline to provide treatment to me.

Signed By: _____ Date: _____
Signature of Patient or Legal Guardian

_____
Print Patient's Name

_____
Print Name of Legal Guardian, if applicable

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Today's Date: _____

PLEASE FILL OUT THE PHARMACY INFORMATION SO THE MEDICATION REFILLS CAN BE SENT ELECTRONICALLY INTO YOUR PHARMACY. IT IS THE PATIENTS RESPONSIBILITY TO INFORM THE OFFICE REGARDING ANY CHANGES. PLEASE SPECIFY IF YOUR INSURANCE REQUIRES ONLY HAND WRITTEN PRESCRIPTIONS.

PATIENT'S NAME: _____ DOB:_____

LOCAL PHARMACY NAME:_____

PHARMACY TEL NO: _____

PHARMACY ADDRESS: _____

MAIL ORDER PHARMACY NAME: _____

PHARMACY TEL NO: _____

OTHER: _____

ADMINISTRATIVE COMMENTS:

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Medical Questionnaire

NAME: _____ **TODAY'S DATE:** _____

DOB: _____ **REASON FOR TODAYS VISIT:** _____
AGE: _____ _____
GENDER: _____ **ETHNICITY/ORIGIN:**_____

MEDICAL HISTORY: (check all that apply)

_____High Blood Pressure
_____Diabetes
_____Blood Disorder
_____Heart Attack
_____Stroke
_____Arthritis
_____Migraine Headaches
_____Intestinal Disorders
_____Gynecological Disorders
_____High Cholesterol
_____Cancer
_____Asthma
_____Other, Please Specify

Specialists You See:

1)
2)
3)
4)

MEDICATION/FOOD ALLERGIES: Please list with reaction **None**

_____
_____

CURRENT MEDICATIONS:

Name Dose How Often Reason for taking this medication

_____
_____
_____
_____
_____
_____

SURGICAL HISTORY:

Procedure Date

_____
_____

FAMILY HISTORY: (circle all that apply)

	Alive (Y/N)	Heart Disease	Diabetes	Stroke	Cancer -Type	Other
Mother						
Father						
Siblings						
Other						

SOCIAL HISTORY:

Marital Status	Single	Married	Divorced	Widowed
Children	Yes/No	How many		
Occupation				
Tobacco Use	Yes	No	Amount	
Alcohol	Yes	No	Amount	
Illegal Drugs	Yes	No	If yes: What and How Often	
Exercise	Yes	No	If yes: What and How Often	

HEALTH MAINTENANCE:

Procedure	**Year of Last:**
Pap Smear	
Mammogram	
Colonoscopy	
Bone Density	