FAMILY HEALTHCARE OF ELKTON
Patient Registration

Name (Last)_____ (First)_____(MI)_____

If Child/Parent's Name_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone _____Cell phone_____

E-mail address _____In the future, may we send you office publications and notices via this address? _____

Please indicate your preferred method of communication (i.e. e-mail, cell phone, home phone) _____

Sex_____ Married/Single/Widowed/Divorced _____

Race (circle one) Asian Black Hispanic White Mixed Other

Language Spoken: _____

Date of Birth_____ Employer _____

Emergency Contact_____Relationship_____
Phone_____

Billing and Insurance Information:

Primary Insurance Company_____
Membership ID#_____Group#_____
Name of Policy Holder_____ Date of Birth_____
Employer Name_____

Secondary Insurance Company_____
Membership ID#_____Group#_____
Name of Policy Holder_____ Date of Birth_____
Employer Name_____

Medicare Beneficiaries please complete the following:
Are you: Retired____Disabled____Employed full time_____Employed part time____
Do you or your spouse have insurance through an employer group health plan that is primary over your Medicare? _____

Family Healthcare of Elkton
Pediatric Health History Form

Child's Name_____ Date of Birth_____ Age:_____
Child's Previous Doctor/Primary Care Provider:_____
Present Health Concerns:_____
Medicines/Vitamins: _____
Herbs/Home Remedies:_____
Allergies/Reactions to Medicines or vaccinations: _____

Pregnancy & Birth

Where was your child born?_____
Is the child yours by: Birth Adoption Stepchild Other:_____
Please indicate any medical problems during pregnancy None Specify:_____
_____
Delivery by Vaginal birth Caesarean If Caesarean, why?_____
Birth weight: _____ Birth Length:_____ APGAR score 1 min._____ 5 min._____
Please indicate any medical problems during the baby's newborn period:
None If premature, how early?_____ Other problems:_____

Nutrition & Feeding

Was your child breastfed? No Yes If yes, how long? _____
Has your child had any feeding/dietary problems? No Yes if yes, specify_____
_____
_____
Milk Intake now: Type: Cow's milk (Nonfat 1%fat 2%fat Whole milk) Soy milk Rice Milk
Average ounces per day (note: 8 ounces = 1 cup) _____

Sleep

Hours per night _____Naps (number and length) _____
Any sleep problems?_____

Development

At what age did your child:
Sit alone _____ Walk alone _____ Say words _____ Toilet train (daytime) _____
Girls only: Age at first menstrual period _____

Dental History

Has child been seen by a dentist? No Yes If so, how often?_____
Date of last visit?_____
Water Source: Well City/Town = _____ On Fluoride No Yes

Immunizations/Infectious Diseases

Please bring your child's immunization records to your appointment.
Has your child had: Chickenpox Measles Mumps Rubella Meningitis Tuberculosis (TB)

Exposures/Habits

Any concerns about lead exposure? (old home/plumbing/peeling paint) No Yes
Do any household members smoke? No Yes
TV-hours per day _____ Computer hours per day _____Video game hours per day _____

Past Medical History: please describe any major medical problems and their dates:

_____

_____

_____

Hospitalizations/operations (with dates):_____

Broken bones or severe sprains: _____ Concussions? No yes

Family History: Please indicate the current status of your immediate family members:
Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism _____ High Cholesterol_____
Cancer, specify type _____ High Blood Pressure _____
Heart Attack _____ Stroke _____
Depression/Suicide _____ Other _____
Diabetes _____ Other_____

Social History:
Who lives at home?
Name Age Relationship Highest Education Level

_____

_____

_____

_____

_____

Are your child's parents Married Unmarried Separated Divorced
If divorced or separated, when? _____ Who has custody? _____
Mother's Occupation _____ Mother's Employer _____
Father's Occupation _____ Father's Employer _____
Child Care situation Parents Others (specify who and hours per day) _____
Concerns about your child: Alcohol use Tobacco Sexual Activity Aggressive behavior
Is violence at home a concern? No Yes Are there guns in the home? No Yes

School History:
Did/does your child attend school or preschool? No Yes
Current grade _____ Name of school _____
Any concerns about school performance? _____
Any concerns about relationships with: Teachers No Yes
Students No Yes If more than 4 years old: does your child have a best friend? No Yes
Sports/exercise: Type _____ How Often? _____ How long (minutes)?

Safety:
When your child is in the car does he use:
An infant seat
A booster seat
A seat belt only
Do you have smoke detectors in your home? Yes No
Does your child wear a helmet for Bike, scooter or ATV? Yes No

Please list those individuals to whom we are permitted to disclose medical information on your behalf:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

I have reviewed the practice administrative and financial policies and understand them.

I certify that the information given on this form is true and correct. I have been given a copy of the *Privacy Notice* for this practice and understand the contents and hereby authorize the release of information in the manner described.

Signed_____ Date_____

Witness_____

Picture ID obtained _____

Family Heathcare of Elkton

Patient Portal Agreement Form

Family Healthcare of Elkton offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our physicians and staff. Secure messaging can be valuabe communication tool, but has certain risks. This form is intended to show that you hav been informed of these risks and understand the condition required to participate.

How our Portal Works: A secure web based portal is a type of webpage that applies encryption to keep unauthorized persons from reading communication and/or attachments. Encrypted message are secure and can only be read by someone who knows the right passwords needed to log onto the website. The information is "scrambled" during the transmission betwee devices, but is readable between the website and your computer.

Your Protected Health Information: It is imperative that you always provide our practice with your correct e-mail address and keep us informed of any changes. You must also keep track of who may gain access to your e-mail accounts. You are responsible for keeping your password private, and for making any changes should you suspect that someone has used it.

Online communication should never be used for emergency communications . If you have an emergency or urgent need, you should contact our office via telephone. If there is information that you don't want transmitted via the portal, please inform us.
Please complete our Practice Privacy Notice outline . It's availabe at your request.

Patient Acknowledgement and Agreement: I acknownledge that I have read and fully understand this consent form and the risk indicated. I understand and agreee with the information provided.

Print Patient Name

_____

Print Date of Birth

_____

Responsible Party/Legal Guardian

_____

Phone

_____

Personal E-mail address-Print Clearly

_____

Signature

_____

Date

_____

NOTICE TO NEW PATIENTS:

The physicians here at Family Healthcare of Elkton will not, under **NO CIRCUMSTANCES,** prescribe controlled substances at your first office visit. Complete medical history will be required from your prior physicians/specialists before we will continue any previously prescribed controlled medications or narcotic drugs. Furthermore, we do not handle pain management and will not prescribe any controlled medications on an ongoing basis. If we find that you are not honest with information regarding your current active prescriptions, or seek similar or like prescriptions from another physician, you will be immediately discharged from our practice.

I understand this policy and the statement above.

Patient Signature _____

Date_____

FAMILY HEALTHCARE OF ELKTON
111 W. High Street, Suite 214
Elkton, MD 21921

Thank you for choosing us for your family medical care. We are pleased to welcome you to our practice. Our goal will be to ensure that you and/or your family receive the finest care and service.

We will ask you to complete a registration form that will include your billing information. We understand that some patients may experience financial difficulties at times. It is our hope that you will bring these situations to the attention of our billing department or office manager so that your account can be managed in an effective manner. We will file a claim to your health insurance for payment on your behalf, however please understand that your insurance company has a contact with you and/or your employer. Final responsibility for payment is the sole liability of you as the patient or guarantor.

In an effort to run an ethical and efficient office, policies and procedures are necessary. It is important to understand that we must enforce these policies among all patients.

Our administrative and financial policies are as follows:

1. Your co-payments and payment for noninsured services are due at the time of service.
2. We accept cash, checks, Visa, MasterCard, Discover and American Express.
3. If we do not contract with your insurance, payment is due at the time of service.
4. If we do participate with your insurance company we are contracted to adjust your account by amounts known as "contractual write-offs". This does not mean that you will not have a balance. Any questions you may have in regards to insurance payments should be directed to your carrier or human resources representative.
5. We do not accept auto insurance claims. Any services related to an automobile accident must be paid for at the time of service. We will assist you in providing whatever you may need to seek reimbursement. We will not bill your health insurance carrier unless we are provided written proof of denial or nonpayment.
6. Retuned checks are subject to a $30.00 service charge.
7. Most insurance companies limit the number of physicians or "well visits" payable per coverage or calendar year. We will try to assist you in maintaining your scheduled visits; however any services denied for this reason are ultimately your responsibility. It is recommended that you check with your insurance company or representative regarding your benefits before scheduling any appointments.
8. You are financially responsible for any services not pain by your insurance company.
9. We will not reduce your office charge just because you are uninsured. If you are experiencing financial difficulties, you may apply for a hardship adjustment; however a $30.00 co-payment must be paid at the time of service. Consideration for a write-off or reduction will be given for any balance, based on the outcome of your application. If you fail to complete or return the financial aid application within 30 days of your visit, you forfeit consideration for an adjustment.
10. Any accounts not paid within 90 days may be turned over an outside collection agency. If your account is placed, you will be responsible to pay a collection fee of 35% of the debt changed. You also risk being discharged from our care if there is a complete disregard for your balance.
11. If you have an overdue balance: When scheduling an appointment, a collection flag will appear by your name indicating a debt. You will be asked to bring payment with you. If you fail to do so, and your

appointment is of a non-urgent nature, you may be asked to reschedule until such time you are able to satisfy your debt.

12. Any forms needing completed outside a regular office visit will be charged a completion fee, equal to $10 per 2-sided page. Request for personal narrative letters for medical necessity, special circumstances, appeals, etc., will also be assessed the $10 administrative charge.

13. As a courtesy to our patients leaving the practice, we will be happy to supply your new physician a copy of your medical record at no charge. Any copying of the chart other than a transfer will be assessed associated copy and retrieval fees payable before the records are released.

14. As a courtesy, we request 24 hours notice when canceling an appointment. However, if you fail to cancel an appointment less than 2 hours before your scheduled time, you will be subject to a $30 missed appointment fee. If you consistently fail to cancel missed appointments, you and your family may be discharged from our practice after 3 or more within a single calendar yr.

15. If your insurance company requires referrals, it is your responsibility to contact our office with any appointments that have been scheduled with a specialist. You must allow 48 business hours for the completion of your referral. We do not fax paper referrals; they must be picked up from our front desk in person. If you have not allowed ample time for us to file the referral, you may be asked to reschedule your appointment.

16. Prescription refill requests will be processed as soon as possible; however you must provide 48 hours notice to allow for any delays. We participate, under federal recommendation, with an electronic prescribing system. There are certain sub category drugs that the physicians are required to either have you or a designated family member give a signature of receipt and ID verification when picking up at the office.

17. Late arrivals: In an effort to avoid delays in our patient schedules, if you are 10 minutes or more late for your appointment, you will be required to reschedule. We will make every effort to get you rescheduled as early as possible, but it may be another day if the schedule is full.

18. No cell phone use is permitted beyond the waiting room door.

19. Parents with children, not sharing financial or physical custody: We are legally permitted to seek financial reimbursement from either parent, without regard to any separation or divorce agreements. Disputes in this responsibility are strictly between the parents, and the practice refuses to get involved.

Family Healthcare of Elkton

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations 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 is related to your past, present or future physical or mental health and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with the revised Notice by mail or present to you in person at the time of your next appointment.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

When registering with our office, you will be asked to sign a consent form. By signing the consent, you have consented to the use and disclosure of your protected health information for treatment, payment and health care operations. 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 medical care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

We may need to share your protected health information with third party business associates that perform various activities (billing, scanning and collection services, etc) for the practice. We may also utilize and train medical students from various and local medical training programs or schools. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected heath information.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization:

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. 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.

Other Permitted and Required uses and Disclosures That May be Made With Your Consent, Authorization or Opportunity to Object:

We may use and disclose your protected health information in certain instances. You have the opportunity to agree or object to the use or disclosure of all or part of your information. If you are not present or able to agree or object to the use or disclosure, then your physician may, using his own professional judgment, use or disclose your protected information when there are:

Others involved in your healthcare: unless objections are noted, we may disclose to a member of your family, a relative or close friend, your information that is directly related to that person's involvement to your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If the physician is required by law to treat you and the attempt to obtain your consent was made but not successful, he or she may still use or disclose your information to coordinate your treatment.

Communication Barriers: We may use and disclose your information if your physician or another physician attempts to obtain consent from you but is unable to do so due to substantial communication barriers, and the physician determines, using professional judgment, that you intend to consent to use and disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures that May Be Made Without Your Consent, Authorization, or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization; by law. These include:

1. When Required by Law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified of any such uses or disclosures.
2. Public Health Activities: We may disclose your health information for public health purposes requested by the Public Health Authority for the purpose of controlling disease, injury or disability.
3. Communicable Disease: We may disclose protected health information, if authorized by law to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
4. Health Over-site: We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.
5. Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
6. Food and Drug Administration: We may disclose your protected health information to a person or company required by the FDA to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.
7. Legal Proceedings: We may disclose protected health information in the course of judicial or administrative proceeding, in response to an order of a court or administrative tribunal in certain conditions in response to a subpoena, discovery request or other lawful process.
8. Law Enforcement: We may disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include legal processes required by law; limited information requests for identification and location purposes pertaining to victims of crime; suspicion that death has occurred as a result of criminal conduct; in the event that a crime occurs on the premises of the practice, and medical emergencies where it is likely that a crime occurred. Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
9. Coroners, Funeral Directors and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaver organ, eye or tissue donation purposes.
10. Research: we may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
11. Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel for activities deemed necessary for appropriate military command authorities; for the purposes of determination by the Department of Veterans Affairs of your eligible benefits, or to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.
12. Workers Compensation: your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs

Also be known:
"We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers."

Your Rights

The actual medical record remains property of the practice. You however have the right to inspect and receive a copy of your protected health information for as long as we maintain the 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. Depending on the circumstances, a decision to deny access may be reviewable.

You have a 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 a family member or friend who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. **Your request must be in writing** and state the specific restriction requested and to whom you want the restriction to apply.

The physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your information will not be restricted. If the restriction is agreeable with the physician, the information may not be disclosed in violation of that restriction unless it is needed to provide emergency treatment.

You may have the right to have your physician amend your protected health information for as long as that information is maintained. In certain cases, we may deny this request and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

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 electronically or previously.

For more information or to report a problem:
If you have questions about this notice or would like additional information, you may contact the practice at the information listed below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer/ Office Manager, Susan Cahill, or with the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you by doing so.

Family Healthcare of Elkton
111 W. High Street, Suite 214, Elkton, MD 21921
410-996-9490 (phone)
410-996-9493 (fax)

U.S. Department of Health and Human Services, Office of the Secretary
200 Independence Avenue, S.W.
Washington, DC 20201
202-619-0257 (phone)
http://www.hhs.gov/contacts

This notice was published and became effective on April 14th, 2003.
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