



Last Name: _____	First Name: _____	MI: _____
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: _____	<input type="checkbox"/> Single <input type="checkbox"/> Married

Social Security Number: _____	Date Form Completed: _____
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Address: _____ Apt # _____	Employment Status: <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time <input type="checkbox"/> N/A
City: _____ State _____ Zip: _____	Student Status: <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time <input type="checkbox"/> N/A

Contacting You:
Home Phone: _____ OK to leave message?
Cell Phone: _____ OK to leave message? OK to text?
Work Phone: _____ Ext: _____ OK to leave message?
Email Address: _____
 OK to create web account for you? (Web account for teens ages 11-18 are handled differently than for other patients).
Best Time of Day to Contact You: Morning Afternoon Evening

Employer Name: _____
Address: _____
Pharmacy Name: _____
Pharmacy Phone: _____
Emergency Contact Name: _____
Daytime Phone: _____ Relationship: _____
Address: _____

Responsible Party/Guarantor: *must be completed for all children*
In Maryland, both parents are legally responsible for their children unless a court order states otherwise.
Name: _____
Relationship to patient: _____ Date of Birth: _____
SSN: _____ Home Phone: _____
Work Phone: _____ Ext: _____ Cell Phone: _____
Address: (if different than patient's address)

Additional Responsible Party:
In Maryland, both parents are legally responsible for their children unless a court order states otherwise.
Name: _____
Relationship to patient: _____ Date of Birth: _____
SSN: _____ Home Phone: _____
Work Phone: _____ Ext: _____ Cell Phone: _____
Address: (if different than patient's address)

Primary Insurance check if self-pay
Insurance Company Name: _____
 Referrals required for any services?
Claims Address: _____
ID/Member/Subscriber #: _____ Group # _____
Copay \$ _____ Effective Date: _____
Subscriber Name (person through which insurance was obtained)
_____ Dt of Birth _____ Relation _____

Secondary Insurance check if no secondary insurance
Company Name: _____
 Referrals required for any services?
Claims Address: _____
ID/Member/Subscriber #: _____ Group # _____
Copay \$ _____ Effective Date: _____
Subscriber Name (person through which insurance was obtained)
_____ Dt of Birth _____ Relation _____

Meaningful Use
The following questions are helpful for our practice to achieve 'Meaningful Use' of our electronic healthcare records system. Your answers are entirely voluntary.
Primary language: English Indian (includes Hindi & Tamil) Spanish Russian Other
Ethnicity: Hispanic Non-Hispanic Not Disclosed
Race: American Indian or Alaskan Native Asian Native Hawaiian Black or African American White Hispanic Other

Patient Name:	Date of Birth:	Today's Date:
Occupation:	Home Phone:	Work Phone:

Reason for seeing the doctor? (primary complaint):

Your Existing Medical History, Hospitalization or Surgeries
(please list reason and approximate dates):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Total # Pregnancies _____ # Living Children _____ # Miscarriages _____

Family History of Medical Problems

(list family members who have had any of these problems? (M)other, (F)ather, (B)rother (S)ister, (GM)randmother, etc...)

Alcoholism:	Mental Illness:
Asthma:	Depression:
High Blood Pressure:	Glaucoma:
Kidney Disease:	Epilepsy/Seizures:
Heart Attack/Heart Disease:	Alzheimer's Dementia:
Thyroid Disorders:	Diabetes:
Arthritis:	Osteoporosis:
Cancer:	Migraines
Strokes:	Other:

Medications, Vitamins, Supplements, & Birth Control (complete for all you use)	Dosage	Frequency

Lifestyle (please describe your habit and diet)

Alcohol Use (how many drinks in a typical week?) _____
Does your drinking worry you? Yes No

Tobacco Use – how much daily? _____
For how many years have you used tobacco? _____
Are you interested in quitting tobacco use? Yes No
Have you previous tried to quit using tobacco? Yes No

Caffeine Use: (how many caffeinated beverages do you drink daily?) _____
Any illicit drug use? Yes No

Describe your typical exercise routine? _____

Hours of sleep per night: _____
Do you have daytime drowsiness? Yes No
Are you pregnant or think that you might be? Yes No
Do you use seatbelts? Yes No
Do you wear a helmet while biking? Yes No
Any loaded weapons in your home? Yes No
Do you have a "Living Will" or "Advance Directives"? Yes No

Medication Allergies or Drug Reactions You Have Experienced
(e.g. penicillin may cause rash)

1. _____
2. _____
3. _____

List Any Seasonal or Environmental Allergies:

Menstrual Cycle (check all that apply)

Length: _____ Regular Irregular Painful Discharge
 Recurring Hot Flashes Rashes Hives Gout Anemia
 Lactose intolerance

Previous Immunizations/Vaccines/Tuberculosis Testing or Screening
(indicate approximate AGE last given)

Tetanus booster: _____ Cholesterol testing: _____
Vision Test: _____ Tuberculosis skin test (PPD): _____
Pneumonia shot: _____ Pap Smear: _____ Chest X-Ray: _____
HIV Test: _____ Hepatitis B shot: _____ Flu Shot: _____
Mammogram: _____ Rectal/Prostate Exam: _____
Other: _____

Frequent or Recurring Symptoms in the Following Areas: (check all that apply)

<input type="checkbox"/> Ringing in the ears	<input type="checkbox"/> Phobias (fears)	<input type="checkbox"/> Chronic back pain	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Recurring fevers	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Headaches
<input type="checkbox"/> Urine infections	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Stomach ulcers	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Depression	<input type="checkbox"/> Urine decrease force/flow	<input type="checkbox"/> Prostate problems	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Tingling/where? _____	<input type="checkbox"/> Seizures
<input type="checkbox"/> Trouble swallowing	<input type="checkbox"/> Dizziness/fainting	<input type="checkbox"/> Numb feet	<input type="checkbox"/> Constipation	<input type="checkbox"/> Leg pain	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Appetite loss	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Joint/muscle pain	<input type="checkbox"/> Gallbladder pain
<input type="checkbox"/> Painful intercourse	<input type="checkbox"/> Sex-related infections	<input type="checkbox"/> Abdominal pains	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Muscle weakness
<input type="checkbox"/> Severe moodiness	<input type="checkbox"/> Breast lump or bump	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Tremors	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Other concerns:
<input type="checkbox"/> Skin infections	<input type="checkbox"/> Visual changes	<input type="checkbox"/> Eczema	<input type="checkbox"/> Asthma	<input type="checkbox"/> Snoring	
<input type="checkbox"/> Weight loss/gain	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Blood in stools	<input type="checkbox"/> Urine frequency	
<input type="checkbox"/> Urethral discharge	<input type="checkbox"/> Vaginal discharge	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Osteoporosis	



Acknowledgment and Consent Form

Please review carefully and initial to the left of each item. Do not make changes to the content of this form.

____ I authorize MedPeds, LLC to apply for insurance benefits on my behalf. I authorize my insurance company to make payment directly to MedPeds, LLC. I am aware that I may revoke this authorization at any time in writing.

____ I understand and agree that if it is later determined that I am not eligible to receive benefits through the insurance company I provided on the date of service, I am personally responsible for payment in full for services rendered to myself and/or my dependant(s).

____ I have received a copy of the Notice of Privacy Guidelines from MedPeds, LLC.

____ I have received a copy of, and agree to abide by, MedPeds' Policies and Procedures. Among other things, these policies require that:

- Co-pays and patient balances are paid before services are rendered
- It is my responsibility to confirm demographic and insurance information before each visit.
- MedPeds charges and I agree to pay \$25 fee for each missed appointment and for appointments cancelled with less than 4 business hours notice.
- MedPeds charges a fee to complete forms or write letters on my behalf. The fee must be paid before the forms/letters will be released.

Please list the names of any and all persons with whom your MedPeds provider may discuss your/your child's medical information. *(Without this consent no medical information will be released to anyone not addressed in the Privacy Guidelines brochure, including spouses, parents, etc...)*

First Name Last Name Date of Birth

Parents: Please list all persons who may give MedPeds, LLC permission to treat your child.

First Name Last Name Date of Birth

Patient/Guardian Signature: _____ Date: _____

Print Name: _____



OFFICE POLICIES

- **Respect** - Patients, providers, and staff are expected to treat each other with respect.
- **Proof of Identity** – Patients must provide proof of identity. To ensure against health insurance fraud, appointments may be rescheduled if identity cannot be confirmed.
- **After-Hours Calls to On-Call Physicians** - **Always call 911** if there is a life-threatening emergency. For urgent (but not life-threatening) situations, call our office and follow the prompts to reach the on-call physician.
- **Prescriptions** – Prescription refills are provided through the date of your next required follow-up for the related condition. An appointment is required if your follow-up date has passed.
- **Forms and Letters** – We charge a small fee for most forms and letters, but the fee is waived if you bring the form(s) to your appointment. We do not charge for forms required for treatment, nor do we charge Medicaid recipients. Fees must be paid before forms and letters are released.
- **Specialist Referrals** – We require 3-5 days to complete specialist referrals. Referrals can be either picked up at the front desk or faxed directly to the specialist. We do not mail referrals.
- **Secure Online Patient Portal** – Gives patients email access with our office and access to medical records. Please complete an “Instant Health History” before every visit. In compliance with HIPAA laws, passwords are issued only when you are present in our office. Accounts for adolescents (ages 11-18) are handled differently than accounts for other patients.
- **Medical Records Requests** – A signed authorization and nominal fee must be received before medical records are released. Records are released on paper, fax, CD or patient-supplied thumb drive. Please allow 30 days.
- **Scheduling** – Appointments are required for all visits, including urgent care. Urgent care slots are released each weekday beginning at 8:00 am. Saturdays at 7:45 am. Limit 2 family appointments per day.
- **Inclement Weather** – When PG County schools are closed, MedPeds opens late at 9:00 am at the earliest. Please check our website, phone line, Facebook or Twitter for weather-related closing information.
- **Late Arrival** – Appointments may be rescheduled to avoid delaying the care of other patients.
- **Cancellations and No-Shows** – We charge \$25 for “no-shows” or cancellations made with less than 4 hours notice.
- **Valid Insurance and PCP Policy** – Insurance ID’s are required before each appointment. If a PCP selection is required, your card must list a MedPeds provider. If eligibility and/or PCP cannot be confirmed before your appointment, you will be given the choice to self-pay or reschedule.
- **Co-pays and Balances** – Co-pays, deductibles, and patient due balances are due before you are seen. We accept cash, Visa, MasterCard, money orders, and personal checks (approved by Telecheck). Ask our staff if you need a nearby ATM.
- **Patient Statements** – We bill you according to your insurance company’s instructions. Please contact your insurance company regarding any disputes. After 90 days, unpaid secondary claims become patient responsibility.
- **Payment Plans** – Please speak with the billing manager if you need to establish a payment plan. Payments must be received as agreed or the payment plan will end, and payment in full required.
- **Self-Pay Policy** – A “deposit” of \$75 must be paid prior to each appointment. If you pay any remaining amount due before you leave the office we will discount 30% of the office visit portion only. Discounts are not applied to other charges.
- **Collection Policy** – We charge an additional 30% of the balance to cover collection agency fees.
- **Discharge Policy** – We don’t like to do it, but occasionally it is necessary to discharge a patient from the practice. We mail a notice to patients 30 days in advance of any discharge from the practice.

Request Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager stating which information is incomplete or inaccurate and the reasoning supporting your request.

We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:

- The information was not created by us or the person who created it no longer available to make the amendment.
- The information is not part of the record which you are permitted to inspect and copy.
- The information is not part of the designated record set kept by this practice or if it is the opinion of the health care provider that the information is accurate and complete.

Request Restrictions. You have the right to request a restriction of how we use or disclose your medical information for treatment, payment, or health care operations. For example, you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to our practice manager.

We are not required to agree to your request if we that it is in your best interest to use or disclose that information. If agree, we will comply with your request, except for emergency treatment.

Accounting of Disclosures. You have the right to request a list of the disclosures we have made of your health information that were not for treatment, payment, or healthcare operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003, nor for a period of time greater than six years (our legal obligation to retain information).

Your first request for a list of disclosures within a 12-month period will be free. If you request an addition list within 12-months of the initial request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how we communicate with you to preserve your privacy. For example –you may request that we call you only at your work number or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

File a Complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice or directly with the Secretary of Health and Human Services.

To file a complaint with our Privacy Officer you must make your request in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it directly to our Privacy Officer (office manager).

Uses or Disclosures Not Covered

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may be made only with your written authorization. You may revoke such authorization in writing at any time. time and we will no longer disclose health information about you fur the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

For More Information

If you have questions or would like additional information, you may contact our Privacy Officer.

Last Revision: 04.07.2011



Notice of Privacy Practices

MedPeds, LLC
7350 Van Dusen Road #130
Laurel, MD 20707

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.

We are required by law to provide you with this notice explaining our privacy practices, with regard to your medical information, and how we may use and disclose your protected health information for treatment, payment, health care operations and other purposes permitted or required by law. You have certain rights regarding the privacy of your protected health information. Those rights are also described in this notice.

The following paragraphs describe different ways that we use and disclose your protected health information.

We have provided an example for each category, but these examples are not meant to be exhaustive. All of the ways we are permitted to use and disclose your health information fall within one of these categories:

Treatment - We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally, we may, from time to time, disclose your health information to another physician whom we have requested to be involved in your care. For example, we would disclose your health information to a specialist we have referred you to for diagnosis or treatment

Payment - We will use and disclose your protected health information to obtain payment for the health care services we provide you. For example, we may include information with a bill to a third-party payer that identifies you, your diagnoses, procedures performed, and supplies used in rendering the service.

Health Care Operations - We will use and disclose your protected health information to support the business activities of our practice. For example, we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription, or other services for our practice.

Other Ways We May Use and Disclose Your Protected Health Information:

To remind you about upcoming **scheduled appointments** or treatment.

To make recommendations to you about possible **alternative treatments and options** that might be of interest.

To a family member, relative, or close friend that is involve in your **medical care**, or with **payment** for care.

To researchers, provided the research has been approved by an institutional review board that has reviewed the research and established protocols to ensure the privacy of your health information.

To federal, state, or local law officials, as required by law.

To public health authorities - to avert a serious threat to public health or safety (e.g. controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

To Worker's Compensation purposes - and to similar programs that provide benefits for work-related illnesses and injuries.

To a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care, to protect the health and safety of others; or for the safety and security of the correctional institution.

Your Health Information Rights

Although your health record is the physical property of the practitioner or facility that compiled it, the information belongs to you.

You have the right to:

1. **A paper copy of this notice** upon request - by asking our receptionist at your next visit or by calling and asking us to mail you a copy.
2. **Inspect and Copy** the protected health information we maintain about you in our designated record set for as long as we maintain that formation. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying, by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, submit your request in writing to:

MedPeds, LLC
7350 Van Dusen Road, Suite 130
Laurel, MD 20707
Attention: Privacy Officer

Your request may be mailed or hand-delivered to our office. We have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.