Primary Care Associates of Hagerstown, LLC
Where Communication and Quality Count
354 Mill Street
Hagerstown, MD 21740
(301) 797-0210

Important information regarding your initial office visit

We hope this information will help answer some of the questions you may have about your upcoming appointment. Please feel free to call us if you have any further questions that we may not have covered.

Insurance

The insurance you have is a "contract" between you and the insurance company. Our billing company will submit the charges to your insurance company, but we have no way of knowing what and how much your insurance company will cover. If your plan requires that your primary care doctor be listed on the insurance card; you are responsible to have this updated to our office and/or one of our providers **prior** to you being seen. You will need to have a reference number or the new card at your appointment or we may need to reschedule your appointment. *Payments are expected at the time of your visit* unless prior arrangements have been made.

You must bring your insurance card with you to each appointment. We take most major insurances, but it is your responsibility to verify with your insurance carrier that our office is a participating provider. If we are not a participating provider; you are responsible to pay for the entire office visit at the time of service and then you may submit the bill yourself to your insurance carrier for possible reimbursement.

Please arrive 20-30 minutes prior to your scheduled appointment time so we may review your insurance and verify your personal information. Please make sure to bring all your medications, supplements, eye drops along with your completed forms to your visit. In addition, please bring a copy of your Maryland MOLST form, Living Will, Durable Power of Attorney for health care if applicable.

Thank you!

Christine Feathers, CRNP

Lauren Kessler, CRNP

Mary Money, MD

Ever Ponciano, MD

Primary Care Associates of Hagerstown, LLC
Where Communication and Quality Count
354 Mill Street
Hagerstown, MD 21740
(301) 797-0210

Cancellations and missed appointments
A fee will be charged for any missed appointments unless we have received notice more than 24 hours prior to the visit. We do have a no-show policy; if you have 3 no shows within a year, you will be dismissed from the practice.

Change of address, phone, insurance
It is your responsibility to report any changes in address, insurance, telephone number, etc. to the office staff.

Co-Payments
All co-payments are expected at the time of service unless prior arrangements have been made.

Insurance Cards
New patients cannot be seen without insurance cards unless paying for the services themselves. All patients must present their current insurance card at *each office visit*.

Insurance Denials
Some insurances do not cover preventative services or diagnostic tests done for screening purposes. It is the responsibility of each patient to handle any questions of coverage. Please remember that all insurance contracts are between you and your insurance company. A diagnosis cannot be changed retroactively.

Letters / Forms
There is a charge for completion of any form or letter. Please allow at least 5 business days for completion.

Office Visit Charges and Annual Wellness Examinations
Office visit charges are based upon the complexity of the medical problems evaluated and time spent by the provider. If there is a medical problem you want addressed while here for your wellness exam there may be a separate charge billed to your insurance for the management of that medical problem or you may be required to make a separate appointment to address the medical problem.

Photo ID required (per federal regulations)
To prevent identity theft, a copy of a photo ID must be in every patient's chart and updated yearly.

Billing / insurance payment inquiries
We use STI in Hagerstown as our billing company. If you have any questions regarding billing please contact them directly at 1-877-698-1700 extension 109.

After hours health advice

One of our providers is always available to answer questions after hours; there may be a charge for the use of this service. This is not to be used for prescription refills. Also if it is a medical **EMERGENCY DO NOT** call this service- *seek immediate medical attention at the closest hospital or dial 911.*

Blood pressure checks

If it is necessary to have a blood pressure recheck done by the staff, we do bill your insurance company for this visit.

Medication Assistance / Samples

We carry a limited supply of some newer medications that can be given as samples. These are only samples and are not to used as your actual prescription. For medications you may need assistance in purchasing; there are some assistance programs available if you meet certain criteria. Western Maryland MedBank 301-393-3441 or 301-393-3443 or Community Free Clinic 301-733-9234.

Medication Refills

We do not accept faxed refill requests from pharmacies. You need to call the office 301-797-0210 extension 4 to request refills. The refill line is checked several times daily; but you need to still give the office a 48-72 hour notice. All controlled substances can take up to 5 business days.

Controlled Substance Prescriptions

All patients will be asked to sign a controlled substance agreement; this is to cover if you are ever given a controlled substance prescription by this office. Additional details will be on this agreement.

Diabetic Patients

Please bring blood sugar logs to all your appointments, you will be asked to remove your socks for all visits, and you will need to be seen by an eye care professional yearly for a diabetic eye exam. We need to have a copy of these eye exams for our records.

Medicare Wellness Visits

Medicare has determined that it is important to help each patient reduce risk for falls and health complications by asking primary care physicians to conduct this important exam annually. There is no physical exam, it does not replace of your regular office visits to address medical problems. There is no charge for this visit; it is billed directly to Medicare.

Insurance referrals to other medical professionals

The office requests at least 5 business days to complete any referral needed by your insurance.

Test results

Test result times may vary; if you do not hear from our office within 2 weeks please call the office to check on the status of your result. All results; except normal mammograms, will be called or emailed to the patient.

Regular phone hours
Monday – Friday
8:00 a.m. to 12:30 p.m.
1:30 p.m. to 4:00 p.m.
The office is open 8:00 a.m. to 4:30 p.m.

DATE______________ Patient Nar ______________________________

REVIEW OF SYSTEMS (please identify which of the following medical symptoms you have recently experienced)

Constitutional:	Ears, Nose, Throat, Mouth	Eyes	Skin	Endocrine
☐ Unintentional Weight loss ☐ Weight gain ☐ Fever ☐ Chills ☐ Increased fatigue ☐ Loss of appetite ☐ Night Sweats ☐ Other__________	☐ Hearing change ☐ Ear pain or ringing ☐ Worsening nasal congestion ☐ Sore throat ☐ Mouth ulcers / dental problem ☐ Nose bleeds ☐ Trouble swallowing ☐ Other__________	☐ Vision loss ☐ Vision change ☐ Pain with the eyes ☐ Double vision ☐ Increased itching ☐ Last eye exam__________ ☐ Other__________	☐ Skin rashes ☐ Change of moles ☐ New lumps ☐ Change in color ☐ Increased bruising ☐ Other__________	☐ Increased thirst ☐ Increased urination ☐ Change of heat or cold Tolerance ☐ Increased sweating ☐ Hot flashes ☐ Other__________
Hematologic/ Lymphatic	**Musculoskeletal**	**Respiratory**	**Cardiovascular**	**Gastrointestinal**
☐ Increased bruising ☐ Increased Bleeding ☐ Swollen lymph nodes ☐ Frequent infections ☐ Anemia ☐ Other__________	☐ Increased joint tenderness ☐ Joint swelling ☐ Increased muscle aching ☐ Increased foot/ankle swelling ☐ Other__________	☐ Cough ☐ Shortness of breath ☐ Wheezing ☐ Chest pain with breathing ☐ Sleeping on more pillows ☐ Coughing up blood ☐ Other__________	☐ Chest pain or pressure ☐ Heart racing or skipping ☐ Trouble breathing with exercise ☐ Heart murmur ☐ Other__________	☐ Nausea/Vomiting ☐ Heartburn ☐ Diarrhea ☐ Change in stools ☐ Constipation ☐ Abdominal pain ☐ Blood in stools ☐ Other__________
Genitourinary	**Neurologic**	**Psychiatric**	**New Complaints**	
☐ Increased urination/ frequency ☐ Incontinence ☐ Increased night time urination ☐ Blood in urine ☐ Sexual dysfunction ☐ Change in menses pattern ☐ Other__________	☐ Increased dizziness ☐ Loosing consciousness ☐ Increased arm/leg weakness ☐ Numbness or arm/leg ☐ Memory problems ☐ Increased headaches ☐ Other__________	☐ Depression ☐ Anxiousness ☐ Panic episodes ☐ Trouble sleeping ☐ Loss of concentration ☐ Increased mood swings ☐ Other__________		

Reviewed During Examination __________ Space for Comments by the reviewer______________________________

____

____

____

CURRENT MEDICATIONS & DOSAGES (please list in the space provided all of your medications including nonprescription agents you are taking)

FAMILY HISTORY (Please identify the appropriate information in the space provided)

MEMBER	Age	Alive	Dead	Current health or cause of death	MEMBER	Age	Alive	Dead	Current health or cause of death
Mother					Father				
Grandmother					Grandmother				
Grandfather					Grandfather				
Sisters 1.					Brothers 1.				
2.					2.				
3.					3.				
4.					4.				
5.					5.				
6.					6.				

Family members who had the following conditions:

Cancer	Diabetes	Stroke
Hypertension	Heart Disease	Sudden Death
Kidney Disease	Thyroid problems	Blood Clots

SOCIAL / OCCUPATIONAL / PERSONAL INFORMATION (Please provide the information requested)

What is your current relationship status: ___single; ___married; ___widowed; ___separated; ___divorced; ___living with a significant other but not married

What is your current occupation______________________________?

If you are retired, what was/were your previous occupation(s):______________________________

Please identify how many other persons are immediately related to you: _____children _____grandchildren _____great grandchildren

Please use the space below to identify your current interest or hobbies: ______________________________

____

HISTORY AND PHYSICAL DATA

Name____________________ **Date of Birth**____________ **Age**______ **Date of Exam**____________

CURRENT HEALTH CONCERNS (Please identify in the space below the purpose for this examination and any problems or current medical conditions that you wish to have evaluated at this time.)

____
____
____

MEDICAL PROBLEMS (Please identify which medical problems you have now or have experienced in the past)

☐ Hypertension ☐ Hives ☐ Heart Disease ☐ Diverticulosis ☐ Cancer________(type)
☐ Stroke ☐ Allergy symptoms ☐ Heart Failure ☐ Gastric Ulcer ☐ Rheumatoid arthritis
☐ Migraine ☐ Sinusitis ☐ Atrial Fibrillation ☐ Acid Reflux ☐ Osteoarthritis
☐ Stroke ☐ Asthma ☐ Elevated cholesterol ☐ Kidney Stones ☐ Gout
☐ Seizures ☐ Chronic Bronchitis ☐ Heart Valve Disease ☐ Kidney Disease ☐ Blood Clots
☐ Depression ☐ Emphysema ☐ Diabetes ☐ Hepatitis ☐ Fractures
☐ Panic Attacks ☐ Glaucoma ☐ Thyroid Diseases ☐ Prior use of IV Drugs ☐ Prior Blood Transfusions
☐ Chronic Anxiety ☐ Sleep Apnea ☐ Other Conditions ____________________

SURGICAL HISTORY (please list all of the surgeries you have ever had either Hospitalized or as an outpatient)

DATE	Surgery	Location (city)	Complication / Other

OTHER HOSPITALIZATIONS (Please list any other hospitalizations including pregnancy, illness or other procedures)

DATE	Hospitalization purpose	Location	Complication / Other

IMMUNIZATION HISTORY / **FOOD or DRUG Allergies or Intolerances**

IMMUNIZATION HISTORY		FOOD or DRUG Allergies or Intolerances	
DATE	Tetanus / Diptheria Booster	Food item or drug	Allergic reaction
DATE	Pneumococcus Vaccine		
DATE	Hepatitis B series		
DATE	Hepatitis A series		
		Latex allergy: __yes __no	

SOCIAL / DIET / EXERCISE HABITS

Have you smoked at any time in your life? ___yes ___no. Formerly or currently using _____# of cigarettes daily for _____years. How many times have you tried to stop smoking______? Completely stopped smoking in ________.
Do you drink any alcohol?. ___yes ___no. If yes, do you use alcohol ____daily, ______x/week, or ______x/year.
Do you follow any special diet? If yes, please identify: ____________________
How often do you get 30-60 minutes of aerobic exercise? _____daily _____x/week _____x/month
Please identify your sexual preference: ________opposite sex ________same sex

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

THE UNDERSIGNED ACKNOWLEDGES REVIEW OF A COPY OF THE CURRENTLY EFFECTIVE NOTICE OF PRIVACY PRACTICES FOR THIS HEALTHCARE FACILITY. A COPY OF THIS SIGNED, DATED DOCUMENT SHALL BE AS EFFECTIVE AS THE ORIGINAL.

PRIMARY CARE ASSOCIATES OF HAGERSTOWN, LLC

DATE: ______________________________

PATIENT NAME: ______________________________

DATE OF BIRTH: ______________________________

SIGNATURE: ______________________________

EMAIL: ______________________________

PLEASE LIST ANY PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

NAME: ____________________ RELATIONSHIP/PHONE: ____________________

NAME: ____________________ RELATIONSHIP/PHONE: ____________________

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

_____ CELL PHONE _____ MESSAGES WITH FAMILY MEMBERS

_____ HOME PHONE _____ MESSAGES ON MACHINE

_____ WORK PHONE _____ ANY OF THE ABOVE

IN SIGNING THIS HIPAA PATIENT ACKNOWLEDGEMENT FORM, YOU ACKNOWLEDGE AND AUTHORIZE THAT THIS OFFICE MAY RECOMMEND PRODUCTS OR SERVICES TO PROMOTE YOUR IMPROVED HEALTH. THE OFFICE MAY OR MAY NOT RECEIVE THIRD PARTY REMUNERATION FROM THESE AFFLIATED COMPANIES. WE, UNDER CURRENT HIPAA OMNIBUS RULE, PROVIDE YOU THIS INFORMATION WITH YOUR KNOWLEDGE AND CONSENT.

Primary Care Associates of Hagerstown
Patient Registration Form & Billing Agreement

Date______________ Patient Name____________________________________ Birthdate: ____________________

__Male; __Female; __Minor; ___Single; ___Married; ___Divorced; ___Widowed; ___Separated; ___Living w/partner

Address________________________________ City_____________________ State_______ Zip________

Home phone: ________________ Mobile: ____________________ Email: ____________________________

SSN________________________ Spouse or Parent's name ____

Patient's or Parent's employer __________________________ Work phone ____________________ EXT_______

Business Address ________________________ City______________________ State _______ Zip___________

If patient is a student, name of school/college______________________________ City_____________ State___

How did you learn about the practice? ____Friend /doctor (name)__________________ Internet search____________

Person to contact in case of emergency__________________________ **Phone** ____________________ **home/cell**

Responsible Party

Name of person responsible for this account ______________________________ Relationship to patient ____________

Address ____ Home phone_________________

Driver's license #__________________ Birthday_________________________ Financial Institution____________

Employer____ Work phone_________________

Is this person currently a patient at our office? ___yes; ___no.

I consent to treatment necessary for the care of the above named patient.
I authorize the release of all medical records to the referring physician and to my insurance company, if applicable.
I allow fax transmittal of my medical records, if necessary.
I acknowledge full financial responsibility for services rendered and I agree to payment for services if insurance has not paid within 120 days,
I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payments be made directly to Primary Care Associates of Hagerstown, should they elect to receive such payment.

This agreement will remain in effect while the patient is under the medical treatment of this office.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

______________________ ____

Date **Signature**

Controlled substance patient agreement for PCA of Hagerstown

I,____, understand and voluntarily agree to the following. My initials confirm my acceptance of each of these requirements.

1. I will keep and be on time for all my scheduled appointments with the doctor and other members of the treatment team. ________

2. I will not call the office at night or on the weekends looking for refills. Refills will be made only during regular business hours- Monday through Friday 9:00am- 4:00pm.._______

3. I must request refills 5 working days ahead (M-F) for my medicine. _______

4. I understand prescriptions will not be given to me more than 2 days prior to the due date._______

5. I must keep track of my medications. No early or emergency refill may be made._______

6. I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients I will no longer be welcomed as a patient in this practice._______

7. If medications are lost or stolen, I understand they may or may not be replaced._______

8. I will take my medication as instructed and not change the way I take it without first talking to the doctor or other members of the treatment team._______

9. I will not sell this medication or share with others. I understand that if I do, Police will be alerted and I will no longer be a patient of this practice ._______

10. I will sign a release form to let the doctor speak to all other doctors or providers that I see._______

11. I will tell the doctor all other medicines that I take, and let him/her know right away if I have a prescription for a new medicine._______

12. I understand that I may lose my right to treatment in this office if I break any part of this agreement._______

13. I agree that I will submit to a blood or urine test if requested by my provider to determine my compliance at my expense. _______

Patient signature ________________________ Date_____________

Print name _____________________________

Witness signature ________________________ Date_____________

Print name _______________________________

Patient has received a copy (Patient initials _______)