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!

PRIMARY CARE ASSOCIATES

Ever Ponciano, M.D.
Christine Feathers, CRNP
Teresa Dumpe, CRNP

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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.

Primary Care Associates of Hagerstown, LLC

Patient Registration and Billing Agreement

Date: _____

PATIENT INFORMATION

Patient Name: First _____ MI _____ Last _____ SS# _____

DOB: _____ Sex: ☐ M ☐ F ☐ Other _____ Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Life Partner

Parent / Legal Guardian name if patient a minor Name: _____ DOB: _____

Race: ☐White ☐Black/African American ☐Asian ☐American Indian/Alaska Native ☐Native Hawaiian/Pacific Islander ☐Declined

Ethnicity: ☐Not Hispanic/Latino ☐Hispanic/Latino ☐Declined

Preferred Language: ☐English ☐Spanish ☐Other _____

Address: _____ City _____ State _____ Zip _____

Phone: Home _____ Cell _____ Work _____

Email: _____

Best Contact Method: ☐Home ☐Cell ☐Work ☐Email ☐Mail

Employment Status: ☐Full-Time ☐Part-Time ☐Unemployed ☐Student ☐Disabled ☐Retired Employer / School: _____

FINANCIALLY RESPONSIBLE PARTY

☐ **Same as patient** (If different please complete this section)

Name: First _____ MI _____ Last _____

Relationship to patient: ☐Spouse ☐Parent ☐Guardian ☐Other _____

Address: _____ City _____ State _____ Zip _____

Phone: Home _____ Cell _____ Work _____

Email: _____

Employer: _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Phone: Home _____ Cell _____ Work _____

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 allow emailed 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.

Signature: _____ Date: _____

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

_____ HOME PHONE

_____ WORK PHONE

_____ MESSAGES WITH FAMILY MEMBERS

_____ MESSAGES ON MACHINE

_____ 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.

History and Physical
Primary Care Associates of Hagerstown, LLC

Todays Date: _____ Name: _____ DOB: _____

MEDICAL HISTORY - please identify any problems you have been diagnosed with			
☐ Allergies	☐ Blood Transfusions	☐ GERD (reflux)	☐ Lupus
☐ Anemia	☐ Cancer: type	☐ Gout	☐ Migraine Headaches
☐ Angina	☐ CVA / Stroke	☐ Glaucoma	☐ Myocardial Infarction
☐ Anxiety	☐ Coronary Artery Disease	☐ Hepatitis	☐ Osteoporosis
☐ Arthritis	☐ COPD (Emphysema)	☐ Hives	☐ Panic Attacks
☐ Asthma	☐ Crohn's Disease	☐ Hyperlipidemia	☐ Peptic Ulcer Disease
☐ A-Fib	☐ Depression	☐ Hypertension	☐ Renal Disease
☐ Benign Prostatic Hypertrophy	☐ Diabetes: type	☐ Irritable Bowel Disease	☐ Seizure Disorder
☐ Bi-Polar Disorder	☐ Diverticulosis	☐ IV Drug Use	☐ Sleep Apnea
☐ Blood Clots	☐ CHF (congestive heart failure)	☐ Liver Disease	☐ Thyroid Disease

SURGICAL HISTORY – List all surgeries, including inpatient and outpatient			
YEAR	PROCEDURE / SURGERY	LOCATION (CITY / STATE)	ANY COMPLICATIONS

OTHER HOSPITALIZATIONS – including pregnancy, illness, other procedures, accidents, etc.			
YEAR	REASON FOR HOSPITALIZATION	LOCATION (CITY / STATE)	ANY COMPLICATIONS

IMMUNIZATION HISTORY		DRUG / FOOD ALLERGIES	
Date:	Tetanus / Diphtheria / Pertussis Booster	DRUG OR FOOD ITEM	REACTION
Date:	☐ Pneumovax 23 ☐ Prevnar 13		
Date:	Hepatitis B Series		
Date:	Hepatitis A Series		
Date:	Last Flu vaccine		
Date:	☐ Shingrix ☐ Zostavax		
Date:	COVID Vaccine- Manufacturer _____	LATEX ALLERGY: ☐ YES ☐ NO	

SOCIAL HISTORY		
Tobacco Use ☐ NO	How much daily? ☐ ½ Pack ☐ 1 Pack ☐ other _____ How many years? _____ ☐ Former-Year Quit _____	☐ Cigarettes ☐ Smokeless ☐ Pipe ☐ Vaping ☐ Cigars
Alcohol Use ☐ NO	☐ Daily ☐ Weekly ☐ Occasionally How many drinks? _____ ☐ Former- Year Quit _____	☐ Beer ☐ Wine ☐ Liquor
How often do you get 30 – 60 minutes of aerobic exercise?	☐ Daily ☐ x _____Weekly ☐ x _____ Monthly	
Drug Use ☐ NO	☐ Marijuana ☐ IV drugs ☐ Prescription Drug Abuse ☐ Other _____	

REVIEW OF SYSTEMS – Please identify which of the flowing medical symptoms you have recently experienced

CONSTITUTIONAL	EARS, NOSE, THROAT, MOUTH	EYES	SKIN
☐ Unintentional Weight Loss	☐ Hearing Change	☐ Vision Loss	☐ Rashes
☐ Weight Gain	☐ Ear Pain / Ringing	☐ Vision Change	☐ Change in Moles
☐ Fever	☐ Worsening Nasal Congestion	☐ Pain with the Eye(s)	☐ New Lumps
☐ Chills	☐ Sore Throat	☐ Double Vision	☐ Change in Color
☐ Increased Fatigue	☐ Mouth Ulcers / Dental Problems	☐ Increased Itching	☐ Increased Bruising
☐ Loss of Appetite	☐ Nose Bleeds		
☐ Night Sweats	☐ Trouble Swallowing		
ENDOCRINE	**HEMATOLOGIC / LYMPHATIC**	**MUSCULOSKELETAL**	**RESPIRATORY**
☐ Increased Thirst	☐ Increased Bleeding	☐ Increased Joint Tenderness	☐ Cough
☐ Increased Urination	☐ Swollen Lymph Nodes	☐ Joint Swelling	☐ Short of Breath
☐ Change in Heat / Cold Tolerance	☐ Frequent Infections	☐ Increased Muscle Aches	☐ Wheezing
☐ Increased Sweating	☐ Anemia	☐ Increased Foot / Ankle swelling	☐ Chest Pain with Breathing
☐ Hot Flashes			☐ Sleeping on more Pillows
☐			☐ Coughing up Blood
CARDIOVASCULAR	**GASTROINTESTINAL**	**GENITOURINARY**	**NEUROLOGIC**
☐ Chest Pain / Pressure	☐ Nausea / Vomiting	☐ Increased Urination / Frequency	☐ Increased Dizziness
☐ Heart Racing / Skipping	☐ Heartburn	☐ Incontinence	☐ Loss of Consciousness
☐ Trouble Breathing with Exercise	☐ Diarrhea	☐ Increased Nighttime Urination	☐ Increased Arm / Leg Weakness
☐ Heart Murmur	☐ Constipation	☐ Blood in Urine	☐ Numbness of Arm / Leg
☐	☐ Change in Bowels	☐ Sexual Disfunction	☐ Memory Problems
☐	☐ Abdominal Pain / Bloating	☐ Change in Menstrual Pattern	☐ Increased Headaches
☐	☐ Blood in Stool	☐	☐

PSYCHIATRIC	NEW COMPLAINTS
☐ Depression	
☐ Anxiety	
☐ Panic Attacks	
☐ Increased Mood Swings	
☐ Loss of Concentration	
☐ Trouble Sleeping	

FAMILY HISTORY – Please identify the appropriate information in the space provided

☐ Adopted

MEMBER	CURRENT MEDICAL CONDITION(S) OR CAUSE OF DEATH	AGE	LIVING	DECEASED
MOTHER				
Maternal Grandmother				
Maternal Grandfather				
FATHER				
Paternal Grandmother				
Paternal Grandfather				
SIBLING Brother / Sister				
SIBLING Brother / Sister				
SIBLING Brother / Sister				
SIBLING Brother / Sister				

FAMILY HISTORY OF ANY OF THE FOLLOWING:

	WHO	AGE AT DIAGNOSIS
BREAST CANCER		
COLON CANCER		
PROSTATE CANCER		

PERSONAL INFORMATION

Current Relationship Status	☐Single ☐Married ☐Widowed ☐Separated ☐Divorced ☐Live with significant other ☐Other _____
How many of the following do you have	_____ Children _____ Grandchildren _____ Great-Grandchildren
Current Occupation	
Prior Occupation if Retired	
Interests / Hobbies	

Todays Date: _____ Name: _____ DOB: _____

MEDICATION NAME Include vitamins, inhalers, injectables	DOSAGE (mg, mL, etc)	FREQUENCY