

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!

Ever Ponciano, MD

Christine Feathers, CRNP

Kimberly Longo, CRNP

Kristen Black, CRPN

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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

For all Billing inquiries, please call the office at 301-797-0210 Option 3. You are now able to pay your bill online at www.pcaofhagerstown.com or <https://pay.balancecollect.com/m/pcaofht>

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 be 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 Option 2 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 _____ 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 AFFILIATED COMPANIES. WE, UNDER CURRENT HIPAA OMNIBUS RULE, PROVIDE YOU THIS INFORMATION WITH YOUR KNOWLEDGE AND CONSENT.

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date _____ Patient Name: _____ Date of Birth: _____

**Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.**

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all
Somewhat difficult
Very Difficult
Extremely Difficult

**Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.**

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____


If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all
Somewhat difficult
Very Difficult
Extremely Difficult

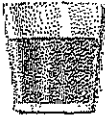
Maryland Primary Care Program - SBIRT Screening

Question	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4 + times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 to 2	3 to 4	5 to 6	7 to 9	10 or more	
How often have you had <ul style="list-style-type: none"> • 6 or more units if female • 8 or more units if male on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Total Score*						


12 fl oz of regular beer = 8-9 fl oz of malt liquor (shown in a 12-oz glass) = 5 fl oz of table wine = 3-4 oz of fortified wine (such as sherry or port; 3.5 oz shown) = 2-3 oz of cordial, liqueur, or aperitif (2.5 oz shown) = 1.5 oz of brandy (a single jigger or shot) = 1.5 fl oz shot of 80-proof spirits ("hard liquor")




about 5% alcohol




about 7% alcohol




about 12% alcohol




about 17% alcohol



about 24% alcohol



about 40% alcohol



about 40% alcohol

Drug Screening:

- In the last 12 months, did you use any illicit drugs? Yes No
- In the last 12 months, did you misuse any prescription medication? Yes No
- If yes to either of the previous questions, what drugs did you use in the last 12 months (circle all that apply)

Amphetamines	Fentanyl	Methamphetamines	Anti-psychotic medication
Barbiturates	Hallucinogens/ LSD	Opiate pills	Sleeping pills
Benzodiazepines	Heroin	Methadone	Other prescription medication
Cocaine	Inhalation/Glues/Solvents	Suboxone	Other: Note below
Ecstasy	K2/Synthetic marijuana	Other prescription medications	

History and Physical
Primary Care Associates of Hagerstown, LLC

Today's 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:	<input type="checkbox"/> Pneumovax 23 <input type="checkbox"/> Prevnar 13		
Date:	Hepatitis B Series		
Date:	Hepatitis A Series		
Date:	Last Flu vaccine		
Date:	<input type="checkbox"/> Shingrix <input type="checkbox"/> Zostavax		
Date:	COVID Vaccine- Manufacturer _____	LATEX ALLERGY: <input type="checkbox"/> YES <input type="checkbox"/> NO	

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

REVIEW OF SYSTEMS – Please identify which of the following 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 Dysfunction	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				
<input type="checkbox"/> 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	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Live with significant other <input type="checkbox"/> Other _____
How many of the following do you have	_____ Children _____ Grandchildren _____ Great-Grandchildren
Current Occupation	
Prior Occupation if Retired	
Interests / Hobbies	

