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, 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 Inauirles

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 use 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 the 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 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 Name: First

DOB: Sex: o M O F 00ther Marital Status: C]Single C]Married ODivorced OWidowed DSeparated t]Life Partner

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



Race: DWhite OBIack/African American OAsian üAmerican Indian/Alaska Native ONative Hawaiian/Pacific Islander ODeclined

Ethnicity: DNot Hispanic/Latino OHispanic/Latino ODeclined

Preferred Language: OEnglish OSpanish LIOther

Address: City State Zip

Phone: Home Cell Work

Email:

Best Contact Method: QHome ocell OWork OEmail QMaiI

Employment Status: OFuII-Time OPart-Time C)Unemployed OStudent [Disabled ORetired Employer / School:

# FINANCIALLY RESPONSIBLE PARTY

Cl Same as patient (If different please complete this section)

Name: First Ml Last

Relationship to patient: oSpouse OParent [Guardian CIOther

Address: City State Zip

Phone: Home Cell Work

Email:

Employer:



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:

3/2021 HIE

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:

J 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 THE 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:



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|  | | | | |  | | MEDICAL HISTORY please identify any problems you have been diagnosed with | | | | | | | | | | | |  | | |
|  | Aller ies | | | |  | |  | Blood Transfusions | | | | |  | GERD reflux | | |  | | Lu us | | |
|  | Anemia | | | |  | |  | Cancer: t | e | | | |  | Gout | | |  | | Mi raine Headaches | | |
|  | An ina | | | |  | |  | CVA / Stroke | | | | |  | Glaucoma | | |  | | M ocardial Infarction | | |
|  | Anxiet | | | |  | |  | Corona Arte Disease | | | | |  | He atitis | | |  | | Osteo orosis | | |
|  | Arthritis | | | |  | |  | COPD Em h sema | | | | |  | Hives | | |  | | Panic Attacks | | |
|  | Asthma | | | |  | |  | Crohn's Disease | | | | |  | H | erli idemia | |  | | Pe tic Ulcer Disease | | |
|  | A-Fib | | | |  | |  | De ression | | | | |  | H | ertension | |  | | Renal Disease | | |
|  | Beni n Prostatic H | | | | ertro h | |  | Diabetes: t e | | | | |  | Irritable Bowel Disease | | |  | | Seizure Disorder | | |
|  | Bi-PoIar Disorder | | | |  | |  | Diverticulosis | | | | |  | IV Dru Use | | |  | | Slee A nea | | |
|  | Blood Clots | | | |  | |  | CHF con estive heart failure | | | | |  | Liver Disease | | |  | | Th roid Disease | | |
|  | | | SURGICAL HISTORY | | | | | | | | | List all surgeries, including inpatient and outpatient | | | | | | |  | | |
| YEAR | | | PROCEDURE / SURGERY | | | | | | | | |  | LOCATION CITY / STATE | | | | | | ANY COMPLICATIONS | | |
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|  | | | OTHER HOSPITALIZATIONS - including pregnancy, illness, other procedures, accidents, etc. | | | | | | | | | | | | | | | | | |  |
| YEAR | | | REASON FOR HOSPITALIZATION | | | | | | | | | | LOCATION CITY / STATE | | | | | |  | | ANY COMPLICATIONS |
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|  | | | | | IMMUNIZATION HISTORY | | | | | | | | | DRUG 1 FOOD ALLERGIES | | | | | | | | |
| Date: | | | | |  | | | Tetanus / Di htheria / Pertussis Booster | | | | | | DRUG OR FOOD ITEM | | | | | | REACTION | | |
| Date: | | | | |  | | | c] Pneumovax 23 c] Prevnar 13 | | | | | |  | | | | | |  | | |
| Date: | | | | |  | | | He atitis B Series | | | | | |  | | | | | |  | | |
| Date: | | | | |  | | | He atitis A Series | | | | | |  | | | | | |  | | |
| Date: | | | | |  | | | Last Flu vaccine | | | | | |  | | | | | |  | | |
| Date: | | | | |  | | | Shingrix o Zostavax | | | | | |  | | | | | |  | | |
| Date: | | | | |  | | | COVID Vaccine- Manufacturer | | | | | | LATEX ALLERGY: YES NO | | | | | | | | |
| SOCIAL HISTORY | | | | | | | | | | | | | | | | | | |  | | | | |
| Tobacco Use o NO | | | | | | | How much daily? o % Pack C] 1 Pack other  How many years? O Former-year Quit | | | | | | | | | | | | o Cigarettes Smokeless E] Pipe C] Vaping Cigars | | | | |
| Alcohol Use  o NO | | | | | | | c] Daily C] Weekly c] Occasionally How many drinks?  Cl Former- Year Quit | | | | | | | | | | | | c] Beer Wine  Liquor | | | | |
| How often do you get 30 — 60 minutes of aerobic exercise? | | | | | | | | | | | | | D Daily Weekly | | | | | | Monthly | | | | |
| Drug Use o NO | | | | | | | Marijuana IV drugs C] Prescription Drug Abuse other | | | | | | | | | | | |  | | | | |

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| REVIEW OF SYSTEMS — Please identify which of the flowing medical symptoms you have recently experienced | | | | | | | | | | | | | | | | | | | | | | | |
| CONSTITUTIONAL | | | | | | | EARS NOSE, THROAT MOUTH | | | | EYES | | | | | SKIN | | | | | | | |
|  | Unintentional Wei ht Loss | | | | | |  | Hearin Chan e | | |  | Vision Loss | | | |  | Rashes | | | | | | |
|  | Wei htGain | | | | | |  | Ear Pain / Rin in |  | |  | Vision Chan e | | | |  | Chan e in Moles | | | | | | |
|  |  | | | | | |  | Worsenin Nasal Con estion | | |  | Pain with the E es | | | |  | New Lum s | | | | | | |
|  | Chills | | | | | |  | Sore Throat | | |  | Double Vision | | | |  | Chan e in Color | | | | | | |
|  | Increased Fati ue | | | | | |  | Mouth Ulcers / Dental Problems | | |  | Increased Itchin | |  | |  | Increased Bruisin | | | | | | |
|  | Loss of A | etite | | | | |  | Nose Bleeds | | |  |  | | | |  |  | | | | | | |
|  | Ni ht Sweats | | | | | |  | Trouble Swallowin |  | |  |  | | | |  |  | | | | | | |
| ENDOCRINE | | | | | | | HEMATOLOGIC I LYMPHATIC | | | | MUSCULOSKELETAL | | | | | RESPIRATORY | | | | | | | |
|  | Increased Thirst | | | | | |  | Increased Bleedin |  | |  | Increased Joint Tenderness | | | |  | Cou h | | | | | | |
|  | Increased Urination | | | | | |  | Swollen L m h Nodes | | |  | Joint Swellin |  | | |  | Shod of Breath | | | | | | |
|  | Chan e in Heat / Cold Tolerance | | | | | |  | Fre uent Infections | | |  | Increased Muscle Aches | | | |  | Wheezin | |  | | | | |
|  | Increased Sweatin | |  | | | |  | Anemia | | |  | Increased Foot / Ankle swellin | | |  |  | Chest Pain with Breathin | | | |  | | |
|  | Hot Flashes | | | | | |  |  | | |  |  | | | |  | Slee in on more Pillows | | | | | | |
|  |  | | | | | |  |  | | |  |  | | | |  | Cou hin u Blood | | | | | | |
| CARDIOVASCULAR | | | | | | | GASTROINTESTINAL | | | | GENITOURINARY | | | | | NEUROLOGIC | | | | | | | |
|  | Chest Pain / Pressure | | | | | |  | Nausea / Vomitin |  | |  | Increased Urination / Fre uenc | | | |  | Increased Dizziness | | | | | | |
|  | Heart Racin / Ski | | in |  | | |  | Heartburn | | |  | Incontinence | | | |  | Loss of Consciousness | | | | | | |
|  | Trouble Breathin with Exercise | | | | | |  | Diarrhea | | |  | Increased Ni httime Urination | | | |  | Increased Arm / Le Weakness | | | | | | |
|  | Head Murmur | | | | | |  | Consti ation | | |  | Blood in Urine | | | |  | Numbness of Arm / Le | | | |  | | |
|  |  | | | | | |  | Chan e in Bowels | | |  | Sexual Disfunction | | | |  | Memo Problems | | | | | | |
|  |  | | | | | |  | Abdominal Pain / Bloatin | |  |  | Chan e in Menstrual Pattern | | | |  | Increased Headaches | | | | | | |
|  |  | | | | | |  | Blood in Stool | | |  |  | | | |  |  | | | | | | |
| PSYCHIATRIC | | | | | | | NEW COMPLAINTS | | | | | | | | | | | | | | | | |
|  | De ression | | | | | |  | | | | | | | | | | | | | | | | |
|  | Anxiet | | | | | |  | | | | | | | | | | | | | | | | |
|  | Panic Attacks | | | | | |  | | | | | | | | | | | | | | | | |
|  | Increased Mood Swin s | | | | | |  | | | | | | | | | | | | | | | | |
|  | Loss of Concentration | | | | | |  | | | | | | | | | | | | | | | | |
|  | Trouble Slee in | |  | | | |  | | | | | | | | | | | | | | | | |
| FAMILY HISTORY — Please identify the appropriate information in the space provided | | | | | | | | | | | | | | | | | | |  | | | | | | |
| o 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 / Sister | | | | | | |  | | | | | | | | | | | |  | |  | |  | | |
| FAMILY HISTORY OF ANY OF THE FOLLOWING: | | | | | | | | | | | | | | | | | | |  | | | | | | |
|  | | | | | | | WHO | | | | | | | | | | | | AGE AT DIAGNOSIS | | | | | | |
| BREAST CANCER | | | | | | |  | | | | | | | | | | | |  | | | | | | |
| COLON CANCER | | | | | | |  | | | | | | | | | | | |  | | | | | | |
| PROSTATE CANCER | | | | | | |  | | | | | | | | | | | |  | | | | | | |
|  | | | | | | | PERSONAL INFORMATION | | | | | | | | | | | | | | | | | |
| Current Relationship Status | | | | | | | DSingle üMarried nWidowed OSeparated üDivorced olive with significant other 00ther | | | | | | | | | | | | | | | | | |
| How many of the following do ou have | | | | | | | Children Grandchildren Great-Grandchildren | | | | | | | | | | | | | | | | | |
| Current Occupation | | | | | | |  | | | | | | | | | | | | | | | | | |
| Prior Occupation if Retired | | | | | | |  | | | | | | | | | | | | | | | | | |
| Interests I Hobbies | | | | | | |  | | | | | | | | | | | | | | | | | |

Todays Date: Name: DOB:



|  |  |  |
| --- | --- | --- |
| MEDICATION NAME  Include vitamins, inhalers, injectables | DOSAGE mg, mL etg | FREQUENCY |
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Maryland Primary Care Program - SBIRT Screening

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| --- | --- | --- | --- | --- | --- | --- |
| Question |  |  | Scoring System | | | Your  Score |
|  | 1 | 2 | 3 | 4 |
|  | Never | Monthly of less | 2-4 times per month | 2-3 times per week | 4+ times per week |  |
| How often do you have a drink containing alcohol? |  |  |  |  |  |  |
| How many units of alcohol do you drink on a typical day when you are drinking? |  |  |  |  |  |  |
| How often have you had 6 or more units if female, for male 8 or more units on a single occasion in the last year? |  |  |  |  |  |  |
|  | |  |  | Total Score\* | |  |

A close-up of a beer

Description automatically generated

|  |  |  |
| --- | --- | --- |
| 1. In the last 12 months, did you use any illicit drugs? | Yes | No |
| 2. In the last 12 months, did you misuse any prescription medication? | Yes | No |

3. 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 |
| Benzo diazepines | Heroin | Methadone | ()Other prescription medication |
| Cocaine | Inhalation/Glues/Solvents | Suboxone | Other: Note below |

# 