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

Kristen Black, CRNP

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<u>Cancellations and missed appointments</u>
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.

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

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

<u>Insurance Cards</u>
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.*

<u>Insurance Denials</u>
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.

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

<u>Office Visit Charges and Annual Wellness Examinations</u>
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.

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

<u>Billing / insurance payment inquiries</u>
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 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

_____ 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.

Patient Name ______________________________

DEPRESSION SCREENING: PHQ-9				
Over the last <u>2 weeks</u>, how often have you been bothered by any of the following: *(Check the appropriate box to the right)*	(0) Not at all	(1) Several Days	(2) More than half the days	(3) Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless.				
3. Trouble falling/staying asleep, sleep too much.				
4. Feeling tired or having little energy.				
5. Poor appetite or overeating.				
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.				
7. Trouble concentrating on things, such as reading the newspaper or watching television.				
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.				
9.Thoughts that you would be better off dead or of hurting yourself in some way.				

Anxiety Screening GAD 7				
Over the last <u>2 weeks</u>, how often have you been bothered by any of the following: *(Check the appropriate box to the right)*	(0) Not at all	(1) Several Days	(2) More than half the days	(3) Nearly every day
1. Feeling nervous anxious or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that is is hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid as if something awful may happen				

Maryland Primary Care Program - SBIRT Screening

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*		

Alcohol: One drink =

12 oz. beer

5 oz. wine

1.5 oz. liquor (one shot)

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

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

Please list all other providers that you see; please include therapists, chiropractors, acupuncturists, nutritionists, etc.:

Provider Name	Condition(s) Treating	Phone Number

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354 Mill Street
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Phone: (301) 797-0210
Fax: (301) 791-0210
Alt Fax: (877) 679-4651

Patient Name: ______________________________ DOB: ______________

Address: ______________________________ City: ______________

State: ______________ Zip: ______________ Phone: ______________

I request that my Protected Health Information (PHI) be released from / to the following company / agency:

Name of Practice / agency / company: ______________________________

Address: ______________________________ City: ______________

State: __________ Zip: __________ Phone: __________ Fax: __________

I authorize the following PHI to be released: ____ Discharge Summary ____ Consult Report (s) ____ History & Physical ____ Office Notes
____ Radiology Report (s) ____ Operative Report (s) ____ Lab Result (s) ____ Test Result (s) type: ______________
____ EKG Result (s) ____ Emergency Room Record (s) ____ Other ______________

I understand that the information in my health record may include information containing disclosure of sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), behavioral / mental health services, and/or treatment of alcohol or drug abuse. State and Federal Law protects the following. If this information applies to you, please indicate if you would like any of the information released:

____ Alcohol, drug or substance abuse record (s) ____ HIV testing / results ____ Mental Health / Psychotherapy record (s)
____ Other ______________________________

Covering the period from ____ specific dates ______________ to ______________ or ____ All past, present, future visits

Information should be released via secure fax or mail to the above-named organization.

I understand that this request for release of information is effective for 90 days and that once disclosed the information released is subject to redisclosure by the recipient and possibly no longer protected by Federal Privacy Laws. This request may be revoked at any time by a written request to Primary Care Associates of Hagerstown at 354 Mill St.: Hagerstown, MD 21740. This request will not apply to any PHI requests initiated prior to the date of revocation. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and Primary Care Associates will not condition my treatment on whether I decline to sign it. I understand that I may inspect a copy of the information to be used or disclosed. I agree to all charges for the above-mentioned PHI.

Signature of Patient: ______________________________ Date: ______________

If you are signing as a Personal Representative of the patient, please complete and sign below:

Your Name (print): ______________________________ Relationship: ______________

Your Signature: ______________________________ Date: ______________