**Welcome to Our Practice**

**Thank you for choosing us for your care. To help us serve you efficiently, please read the following guidelines carefully. Feel free to call with any questions.**

**Office Entry Instructions. Please use the Suite 350 entrance when arriving for your appointment.**

**Before Your Appointment**

* **Arrival: Arrive 20–30 minutes early to complete paperwork and insurance verification.**
* **What to Bring:**
	+ **Insurance card and photo ID (required at each visit)**
	+ **List of current medications, supplements, and eye drops**
	+ **Legal documents: MOLST, Living Will, or Power of Attorney (if applicable)**

**Insurance & Billing**

* **Your insurance is a contract between you and your insurance provider.**
* **Primary Care Provider (PCP): If your insurance requires our office/provider to be listed, update it prior to the visit or bring proof of the change.**
* **Copays: Due at time of service.**
* **Coverage: It is your responsibility to verify we are in-network. If out-of-network, full payment is expected.**
* **Billing Questions: Call (301) 797-0210, Option 3 or pay online at** [**www.pcaofhagerstown.com**](http://www.pcaofhagerstown.com)

**Office Policies**

* **Cancellations: 24-hour notice required. There is a charge for no-shows and late cancelations. Three no-shows may result in dismissal.**
* **Medication Refills: Call Option 2, allow 48–72 hours (5 business days for controlled substances).**
* **After-Hours Advice: Our after-hours line is for *urgent medical concerns only*. For life-threatening emergencies, please call 911 or go to the nearest emergency room.
Please note: Medication refills will not be processed through the after-hours line.**
* **Forms/Letters: 5 business day turnaround; charges apply.**
* **Test Results: You will be contacted within 2 weeks.**
* **Medicare Wellness: Annual, no-cost visit; not a physical exam or sick visit.**

**Specialty Services & Guidelines**

* **Blood Pressure Checks: Insurance may be billed.**
* **Referrals: Require 5 business days.**

**Office Hours**

* **Open: Monday–Friday, 8:00 AM–4:30 PM**
* **Phones Answered: 8:00–12:30 & 1:30–4:00 PM**

****

**New Patient Registration Form**

**PATIENT INFORMATION**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_\_  Gender at Birth: ☐ M ☐ F Gender Identity: ☐ Man ☐ Woman ☐ Non-binary / Third gender
☐ Transgender Man ☐ Transgender Woman ☐ Prefer not to answer Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Race: ☐ White ☐ Black ☐ Asian ☐ American Indian/Alaska Native ☐ Pacific Islander ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONTACT INFORMATION** Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Contact: ☐ Phone ☐ Email ☐ Mail

**EMPLOYMENT** ☐ Employed ☐ Part-Time ☐ Retired ☐ Student ☐ Disabled ☐ Unemployed Employer/School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hobbies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE & BILLING AGREEMENT**

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policyholder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ I understand that I am responsible for knowing my insurance coverage.
☐ I authorize the release of medical records to my insurance company and referring physicians.
☐ I accept financial responsibility for services not covered by insurance.
☐ I authorize payment of medical benefits directly to Primary Care Associates of Hagerstown.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_\_

**HIPAA Authorization for the Release of Health Information:**

**Patient Information**
Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization to Disclose Health Information**
I hereby authorize the use or disclosure of my protected health information as described below:

**Personal Contact Preference**

☐ Phone ☐ Okay to Leave Voicemail ☐ Text (when applicable) ☐ Email ☐ Mail

**Who may receive the information:**
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who may receive the information:**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information to Be Disclosed**
☐ All health information related to treatment, billing, and medical records
☐ Specific records only (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Rights and Acknowledgment**

* I understand that I have the right to revoke this authorization at any time by providing written notice.
* I understand that revocation will not affect any actions taken before the revocation is received.
* I understand that information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA.

**Signature**

Patient or Legal Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PCA of Hagerstown Phone:** (301) 797-0210 **Fax:** (301) 797-6514 alt (877)679-4651

**Patient Information**

**Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_
**Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose of Request (Check all that apply)**

☐ Continuity of Care   ☐ Legal   ☐ Personal Use   ☐ Insurance    ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Type of Request**

☐ I authorize **PCA of Hagerstown** to **release** my records to the entity listed below.
☐ I authorize **PCA of Hagerstown** to **obtain** records from the entity listed below.
**Receiving/Sending Party**

**Facility/Provider Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information to Be Released (Check all that apply)**

☐ Medical records from the past \_\_\_ years ☐ Office Visit Notes ☐ Labs/Diagnostic Tests
☐ Imaging/X-ray Reports ☐ Immunization Records☐ Behavioral/Mental Health Notes
☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that:

* This authorization is voluntary, and I may revoke it at any time by submitting a written request, except where information has already been disclosed.
* Information disclosed under this authorization may be subject to re-disclosure and may no longer be protected by HIPAA.

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_

**If signed by legal representative, print name and relationship to patient:**
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT HEALTH ASSESMENT**

**CURRENT MEDICATIONS**

(Include prescriptions, over the counter, supplements, vitamins, eye drops)

**SPECIALTY PROVIDERS**

Please list any specialists you see regularly:

| **Specialty**  | **Name & Practice** | City/State |
| --- | --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**SURGICAL HISTORY**

Please list any past surgeries and dates:

**PAST MEDICAL HISTORY (Check all that apply)**

☐ Asthma      ☐ COPD      ☐ Hypertension
☐ Diabetes Type 1  ☐ Diabetes Type 2 ☐ Thyroid Disease
☐ High Cholesterol  ☐ Heart Disease  ☐ Stroke/TIA
☐ Seizures     ☐ Anxiety     ☐ Depression
☐ Kidney Disease  ☐ Liver Disease  ☐ Cancer (Type:\_\_\_\_\_\_\_\_\_\_\_)
☐ GERD/Reflux    ☐ Anemia    ☐ Blood Clots
☐ Osteoporosis   ☐ Migraines   ☐ Arthritis
☐ Sleep Apnea    ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY *(Check if applicable)***

| **Condition** | **Mother** | **Father** | **Sibling(s)** | **Grandparent(s)** |
| --- | --- | --- | --- | --- |
| Heart Disease | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ | ☐ |
| Cancer (type: \_\_\_\_\_\_\_\_) | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ |
| Depression/Anxiety | ☐ | ☐ | ☐ | ☐ |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ☐ | ☐ | ☐ | ☐ |



Maryland Primary Care Program - SBIRT Screening

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **0** | **1** | **2** | **3** | **4** | **Your score** |
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2-4 times per months | 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? | 1-2 | 3-4 | 5-6 | 7-9 | 10+ |  |
| 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? | Never | Less than monthly  | Monthly  | Weekly | Daily or almost daily |  |
|   |  |  |  |  | **Total** |  |
|  |  |  |  |  | A close-up of a beer  Description automatically generated |  |

|  |  |  |
| --- | --- | --- |
| 1. In the last 12 months, did you use any illicit drugs? \_\_\_\_\_ |  |  |
| 2. In the last 12 months, did you misuse any prescription medication? \_\_\_\_  |  |  |

3. If yes to either of the previous questions, what drugs did you use in the last 12 months

|  |  |  |  |
| --- | --- | --- | --- |
| 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 |

**STAFF USE:**

**POSITIVE NEGATITVE**

|  |
| --- |
| **DEPRESSION SCREENING: PHQ-9**  |
| **Over the last 2 weeks, 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.**  |  |  |  |  |

**PATIENT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **Anxiety Screening GAD 7**  |
| **Over the last 2 weeks, 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**  |  |  |  |  |