

Patient Registration Form

Patient Information	Patient Information:					
	Last Name:		First Name:		M.I.:	Previous Name (if applicable)
	Mailing Address:			Apt #		
	City/State/Zip:					
	Home Phone:		Cell Phone:		Work Phone:	
	Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) <input type="checkbox"/> Voice <input type="checkbox"/> Text				If Voice, Please Select Preferred Number: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
	Family Physician or Pediatrician:			Date of Birth:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender
	Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other _____			Social Security #:		
	Employer Name:			Emergency Contact Name:		
	Emergency Contact Phone #:				Relationship to Patient:	
Additional Information and Responsible Party	Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor:					
	Last Name:			First Name:		
	Date of Birth:		Social Security #:		Phone:	
	Address of Person Responsible:					
	City/State/Zip:			Relationship to Patient:		
	Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):					
	Email Address:					
	Race (please select): <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Decline			Ethnicity (please select one): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline		
	Preferred Language (please select one):		<input type="checkbox"/> English	<input type="checkbox"/> Bosnian	<input type="checkbox"/> Indian (including Hindi & Tamil)	
			<input type="checkbox"/> Sign Language	<input type="checkbox"/> Spanish	<input type="checkbox"/> Russian	<input type="checkbox"/> Other
Preferred Pharmacy Name & Location:						
Insurance Information	Primary Medical Insurance		Secondary Medical Insurance			
	Ins. Co. Name		Ins. Co. Name			
	Policy Holder Name:		Policy Holder Name:			
	Policy Holder's Date of Birth:		Policy Holder's Date of Birth:			
	Policy Holder's Social Security #:		Policy Holder's Social Security #:			
	Patient Relationship to Policy Holder:		Patient Relationship to Policy Holder:			
<p>I certify that I have read and agree to the Maryland Concierge Primary Care (MCPC) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to MCPC all money to which I am entitled for medical expenses related to the services performed from time to time by MCPC, but not to exceed my indebtedness to MCPC. I authorize MCPC to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A \$20.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from MCPC by text or e-mail at the number or address stated above, including but not limited to communications about appointments, feedback, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party. Comments submitted on surveys may be anonymously shared on the MCPC Public Website.</p> <p>MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to MCPC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.</p>						
I have reviewed a copy of Maryland Concierge Primary Care's Privacy Notice. (Initials)						
Signature of Responsible Party:		X				Date:
Printed Name of Responsible Party:		X				Date:

NEW PATIENT MEDICAL HISTORY FORM



Full Name: _____ Date: _____

Birth Date: _____ Age: _____

ALLERGIES NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS <i>(Please list ALL)</i>	DOSE <i>(Mg., pill, etc.)</i>	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information

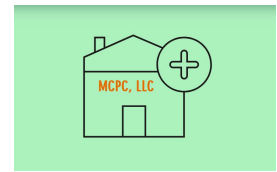
HEALTH MAINTENANCE SCREENING TEST HISTORY

Y / N

CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? Y N
COLONOSCOPY/SIGMOID	Date:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY	Date:	Facility/Provider:	Abnormal Result? Y N

VACCINATION HISTORY

Last Tetanus Booster or TdaP:	Last Pnuemovax (<i>Pneumonia</i>):
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine (<i>Shingles</i>):	



PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer (<i>type: _____</i>)			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes (<i>type: _____</i>)			
Emphysema (<i>COPD</i>)			
Heart Disease			
High Blood Pressure (<i>hypertension</i>)			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal (<i>kidney</i>) Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

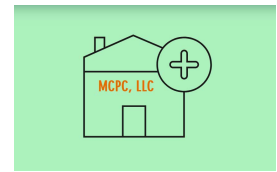
SURGERIES

TYPE (<i>specify left/right</i>)	DATE	LOCATION/FACILITY

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

Patient Name: _____ DOB: _____



FAMILY MEDICAL HISTORY NO SIGNIFICANT FAMILY HISTORY IS KNOWN

Mother :
Father :
Siblings :
Children :
Grandparents :

Other Family History:

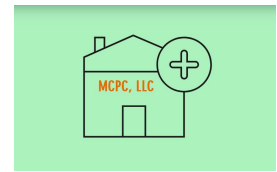
SOCIAL HISTORY

Occupation (or prior occupation):	<input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> LOA <input type="checkbox"/> Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift?	Y N N/A
Marital Status (check one):	Single Partner Married Divorced Widowed
Do you have children? Y N	If yes, how many?

OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? Y N (If you never smoked, please move to Alcohol /Drug Use)
Current: Packs/day _____ # of Years _____	Past: Quit Date: _____ Packs/day _____ # of Years _____
Other Tobacco (check one):	<input type="checkbox"/> Pipe <input type="checkbox"/> Cigar <input type="checkbox"/> Snuff <input type="checkbox"/> Chew
ALCOHOL/DRUG USE	Do you drink alcohol? Y N <input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor # of Drinks/week:
Do you use marijuana or recreational drugs? Y N	Have you ever used needles to inject drugs? Y N
Have you ever taken someone else's drugs? Y N	

Patient Name: _____ DOB: _____



OTHER HEALTH ISSUES *continued...*

SEXUAL ACTIVITY	Sexually involved currently? Y N <i>(If no sexual history, please continue to Exercise)</i>	
Sexual partner(s) is/are/have been: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Birth control method: <input type="checkbox"/> None <input type="checkbox"/> Condom <input type="checkbox"/> Pill/Ring/Patch/Inj/IUD <input type="checkbox"/> Vasectomy Tubal Ligation		
EXERCISE	Do you exercise regularly? Y N <i>(If you answered no, please move to Sleep)</i>	
What kind of exercise?		Duration: How long (min.): _____ How often: _____
SLEEP	How many hours, on average, do you sleep at night <i>(or during the day, if working night shift)</i> ?	
DIET	How would you rate your diet? <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Would you like advice on your diet? Y N
SAFETY	Do you use a bike helmet? Y N	Do you use seat belts consistently? Y N
Working smoke detector in home? Y N		If you have guns at home, are they locked up? Y N
Is violence at home a concern for you? Y N		Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N

OTHER PROVIDERS/SPECIALISTS

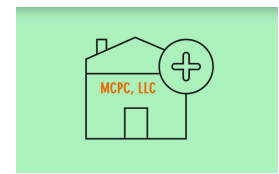
SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other: _____		
Other: _____		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military?	If yes, how long and what branch?
Were you deployed?	If yes, where?

Patient Name: _____

DOB: _____



REVIEW OF SYSTEMS ENTER X FOR ALL THAT APPLY

CONSTITUTION		CARDIOVASCULAR		SKIN	
	Activity change		Chest pain		Color change
	Appetite change		Leg swelling		Pallor
	Chills		Palpitations		Rash
	Diaphoresis	Gastrointestinal			Wound
	Fatigue		Abdominal distention	ALLERGY/IMMUNO	
	Fever		Abdominal pain		Environmental allergies
	Unexpected weight change		Anal bleeding		Food allergies
HEAD, EAR, NOSE & THROAT			Blood in stool		Immunocompromised
	Congestion		Constipation	NEUROLOGICAL	
	Dental problem		Diarrhea		Dizziness
	Drooling		Nausea		Facial asymmetry
	Ear discharge		Rectal pain		Headaches
	Ear pain		Vomiting		Light-headedness
	Facial swelling	ENDOCRINE			Numbness
	Hearing loss		Cold intolerance		Seizures
	Mouth sores		Heat intolerance		Speech difficulty
	Nosebleeds		Polydipsia		Syncope
	Postnasal drip		Polyphagia		Tremors
	Rhinorrhea		Polyuria		Weakness
	Sinus pressure	Genitourinary		HEMATOLOGIC	
	Sneezing		Difficulty urinating		Adenopathy
	Sore throat		Dysuria		Bruises/bleeds easily
	Tinnitus		Enuresis	PSYCHIATRIC	
	Trouble swallowing		Flank pain		Agitation
	Voice change		Frequency		Behavior problem
EYES			Genital sore		Confusion
	Eye discharge		Hematuria		Decreased concentration
	Eye itching		Penile discharge		Dysphoric mood
	Eye pain		Penile pain		Hallucinations
	Eye redness		Penile swelling		Hyperactive
	Photophobia		Scrotal swelling		Nervous/anxious
	Visual disturbance		Testicular pain		Self-injury
RESPIRATORY			Urgency		Sleep disturbance
	Apnea		Urine decreased		Suicidal ideas
	Chest tightness	MUSCULAR			
	Choking		Arthralgias		
	Cough		Back pain		
	Shortness of breath		Gait problems		
	Stridor		Joint swelling		
	Wheezing		Myalgias		
			Neck pain		
			Neck stiffness		

Patient Name: _____

DOB: _____



Maryland Concierge Primary Care, LLC

Services and Fee Schedule

Contract- Direct Primary Care Services

\$150.....Individual

\$300.....Family up to 4 (\$50 per additional family member)

Contract includes 24/7 access to medical provider 365 day per year; 1 in person visit per contract member per month; unlimited telehealth visits; \$75 per fee for in-person visit beyond allotted visit

Non-Contract- Direct Primary Care Services (In-Person)

\$125.....Initial Visit

\$75.....Established visit

Non-Contract- Direct Primary Care Services (Telehealth Visits)

\$55.....Initial Visit

\$35.....Established Visit

Medical Weight Management (In-Person)

\$125.....Initial Visit

\$75.....Established Visit

DOT Physical (In-Person)

\$175

Medical Marijuana (In-Person; Maryland Only)

\$150.....Initial Certification

\$100.....Re-Certification

The following visit types will require in-person visits:

- *Physical (employment, travel, sports, DOT)
- *Pre-op exams
- *Medical marijuana (initial & re-cert)
- *Medical weight management
- *Medical management for controlled medications

Maryland Concierge Primary Care, LLC does not accept direct payment from Medicare, Commercial or Third Party payers. All fees are due at the time of service. A superbill and receipt will be provided for patients who wish to seek out-of-network or FSA/HSA. There is a \$35 returned check and disputed item fee. Accounts that are more than 30 days past due will be forwarded to collections.

My signature acknowledges receipt of the above fee schedule and payment policy.

Signature of Patient/Guardian: _____ Date: _____

Printed Name of Patient/Guardian: _____ Date: _____



**MARYLAND CONCIERGE PRIMARY CARE, LLC
HIPAA NOTICE OF PRIVACY PRACTICES**

Effective Date: 01/01/2019

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices ("Notice") apply to Maryland Concierge Primary Care, LLC (MCPC), its affiliates and its employees. MCPC will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by MCPC. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act ("HIPAA"). A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer at the address below.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

Authorization and Consent: Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Uses and Disclosures for Treatment: We will make uses and disclosures of your protected health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

Uses and Disclosures for Payment: We will make uses and disclosures of your protected health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations: We will make uses and disclosures of your protected health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your protected health information for purposes of improving clinical treatment and patient care.

Individuals Involved In Your Care: We may from time to time disclose your protected health information to designated family, friends and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. With such request, you must provide an appropriate alternative address or method of contact. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You must make such requests in writing, including your name and address, and send such writing to the Privacy Officer at the address below.

Research: In limited circumstances, we may use and disclose your protected health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board which oversees the research or by representations of the researchers that limit their use and disclosure of your information.

Fundraising: We may use your information to contact you for fundraising purposes. We may disclose this contact information to a related foundation so that the foundation may contact you for similar purposes. If you do not want us or the foundation to contact you for fundraising efforts, you must send such request in writing to the Privacy Officer at the address below.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

- Any purpose required by law;
- Public health activities such as required reporting of immunizations, disease, injury, birth and death, or in connection with public health investigations;
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect or domestic violence;
- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls;
- To your employer when we have provided health care to you at the request of your employer;

- To a government oversight agency conducting audits, investigations, civil or criminal proceedings;
- Court or administrative ordered subpoena or discovery request;
- To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
- To coroners and/or funeral directors consistent with law;
- If necessary to arrange an organ or tissue donation from you or a transplant for you;
- If you are a member of the military, we may also release your protected health information for national security or intelligence activities; and
- To workers' compensation agencies for workers' compensation benefit determination.

DISCLOSURES REQUIRING AUTHORIZATION:

Psychotherapy Notes: We must obtain your specific written authorization prior to disclosing any psychotherapy notes unless otherwise permitted by law. However, there are certain purposes for which we may disclose psychotherapy notes, without obtaining your written authorization, including the following: (1) to carry out certain treatment, payment or healthcare operations (e.g., use for the purposes of your treatment, for our own training, and to defend ourselves in a legal action or other proceeding brought by you), (2) to the Secretary of the Department of Health and Human Services to determine our compliance with the law, (3) as required by law, (4) for health oversight activities authorized by law, (5) to medical examiners or coroners as permitted by state law, or (6) for the purposes of preventing or lessening a serious or imminent threat to the health or safety of a person or the public.

Genetic Information: We must obtain your specific written authorization prior to using or disclosing your genetic information for treatment, payment or health care operations purposes. We may use or disclose your genetic information, or the genetic information of your child, without your written authorization only where it would be permitted by law.

Marketing: We must obtain your authorization for any use or disclosure of your protected health information for marketing, except if the communication is in the form of (1) a face-to-face communication with you, or (2) a promotional gift of nominal value.

Sale of Protected Information: We must obtain your authorization prior to receiving direct or indirect remuneration in exchange for your health information; however, such authorization is not required where the purpose of the exchange is for:

- Public health activities;
- Research purposes, provided that we receive only a reasonable, cost-based fee to cover the cost to prepare and transmit the information for research purposes;
- Treatment and payment purposes;
- Health care operations involving the sale, transfer, merger or consolidation of all or part of our business and for related due diligence;
- Payment we provide to a business associate for activities involving the exchange of protected health information that the business associate undertakes on our behalf (or the subcontractor undertakes on behalf of a business associate) and the only remuneration provided is for the performance of such activities;

- Providing you with a copy of your health information or an accounting of disclosures;
- Disclosures required by law;
- Disclosures of your health information for any other purpose permitted by and in accordance with the Privacy Rule of HIPAA, as long as the only remuneration we receive is a reasonable, cost-based fee to cover the cost to prepare and transmit your health information for such purpose or is a fee otherwise expressly permitted by other law; or
- Any other exceptions allowed by the Department of Health and Human Services.

RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION:

Access to Your Protected Health Information: You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable electronic format, if readily producible. Requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person. You will be charged a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies you will be charged a fee for copying and postage.

Amendments to Your Protected Health Information: You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make requested amendments, but we will give each request careful consideration. All amendment requests, must be in writing, signed by you or legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.

Accounting for Disclosures of Your Protected Health Information: You have the right to receive an accounting of certain disclosures made by us of your protected health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Protected Health Information: You have the right to request restrictions on uses and disclosures of your protected health information for treatment, payment, or health care operations. We are not required to agree to most restriction requests, but will attempt to accommodate reasonable requests when appropriate. You do, however, have the right to restrict disclosure of your protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the protected health information pertains solely to a health care item or service for which you, or someone other than the health plan on your behalf, has paid MCPC in full. If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as we appropriate. We will notify you if we remove a restriction imposed in accordance with this paragraph. You also have the right to withdraw, in writing or orally, any restriction by communicating your desire to do so to the individual responsible for medical records.

Right to Notice of Breach: We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself.

Paper Copy of this Notice: You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice. To do so, please submit a request to the Privacy Officer at the address below.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at the below address. There will be no retaliation for filing a complaint.

Office for Civil Rights by sending a letter to:
200 Independence Avenue, S.W
Washington, D.C. 20201
calling 1-877-696-6775
or on-line at: www.hhs.gov/ocr/privacy/hipaa/complaints/

For Further Information: If you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice, you may contact the MCPC Privacy Officer by phone at (240) 416-7431 or at info@mcpchealth.com.

This Notice of Privacy Practices is also available on our web page at www.mcpchealth.com.

My signature below acknowledges receipt of the HIPPA Notice and Privacy Practices.

Signature of Patient/Guardian: _____ Date: _____

Printed Name of Patient/Guardian: _____ Date: _____