SAVING LIVES CENTER FAMILY CLINIC & URGENT CARE
4235 Southern Avenue
Capitol Heights, MD 20743
OFFICE (240)-618-3104 FAX (240)-618-3110

Patient Information Sheet

Date: _____

NAME: Last_____ First _____ Middle Initial _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP:_____

Billing Address (If different from above): _____

Guardian (If Patient under the age of 18) Name: _____

DATE OF BIRTH _____ **Gender**: □ F □ M

RACE: (Please circle one) CAUCASIAN AFRICAN AMERICAN HISPANIC OTHER _____
INDIAN NATIVE AMERICAN ASIAN

SOCIAL SECURITY Number (Adult Patient or Guarantor's SSN#) _____ (**MANDATORY**)

Email Address: _____

PHONE: Home (_____) _____ - _____ Cell (_____) _____ - _____
Work (_____) _____ - _____ EXT. _____

MARITAL STATUS: □ Married (Spouse _____) □ Widowed □ UNKNOWN
□ Single □ Divorced □ Legally Separated □ Partner

Pharmacy Information (telephone number/location): _____

Primary Care Physician: Name: _____ Phone: _____

Referring Physician: _____

Employer: _____ **Occupation**: _____

Employment Status: □ Full Time □ Not Employed □ Retired
□ Part Time □ Self Employed □ Active Military

Student Status: □ Full Time □ Part Time □ Not a Student

Emergency Contact NAME: First: _____ Last: _____Relationship: _____

Emergency Contact PHONE NUMBER: _____

How did you hear about us?
_____

I acknowledge that all information supplied by myself to Saving Lives Center Family Clinic & Urgent Care is true and correct: _____ (**Patient Initials**)

Signature of Patient or Personal Representative: _____ **DATE**: _____

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Patient Name: _____ DOB: _____ Date: _____

HIPAA – Privacy Policy

It is the policy of our practice that all physicians and staff members preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our entire practice have the necessary medical and PHI to provide our patients the highest quality medical care possible patients should not be afraid to provide information to our practice, physicians, staff members for purposes of treatment, payment, and healthcare procedures. Our HIPAA policy in its entirety can be obtained through our office at any time. Let us know if you would like to receive a copy prior to signing this consent.

Authorization: **Please initials each line**

_____ I understand HIPAA and its policies.

_____ I authorize the release of medical information necessary to process insurance claims and to health care professionals for treatment of care.

PRESCIPTION HISTORY AUTHORIZATION

I, _____, authorize the review of my prescription history for reasons of evaluation and treatments.

PATIENT CONFIDENTIALITY

Patient confidentiality is a top priority at Saving Lives Center Family Clinic & Urgent Care. Therefore, it is important that you provide us with the following information to ensure there is not violation of your privacy.

In the event that I, _____, am unable to be reached, Saving Lives Center Family Clinic & Urgent Care may leave my test results or lab results with the following: (**please check all that apply**)

_____ I may be reached at work. Telephone #: _____

_____ May leave normal results on answering machine/voice mail at work.

_____ May leave normal results on answering machine/voice mail at home.

_____ May leave normal results on answering machine/voice mail on cell phone.

_____ May leave all results on answering machine/voice mail at home/cell/work.

_____ Other; Describe: _____

_____

Release Authorization of Medical Information

Also, it is our experience that some patients may or may not wish for our staff to discuss medical conditions/information with family members. Please specify any family members who may obtain or call and discuss your medical information.

Name _____

Name _____

Signature of Patient or Personal Representative: _____ **DATE**: _____

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Insurance Information

* YOU ARE RESPONSIBLE FOR SUPPLYING ALL CURRENT ACTIVE INSURANCE INFORMATION AND NOTIFYING OFFICE OF ANY CHANGES TO YOUR INSURANCE. YOUR ACCOUNT AT SAVING LIVES FAMILY CLINIC & URGENT CARE IS YOUR RESPONSIBILITY.

Name of ***PRIMARY*** Insurance Company:	
Insurance ID:	
Insurance Group:	
Name of Insured:	Insured Date of Birth:
Relation to Insured:	

Name of ***SECONDARY*** Insurance Company:	
Insurance ID:	
Insurance Group:	
Name of Insured:	Insured Date of Birth:
Relation to Insured:	

Name of ***TERTIARY*** Insurance Company:	
Insurance ID:	
Insurance Group:	
Name of Insured:	Insured Date of Birth:
Relation to Insured:	

RESPONSIBLE PARTY: □ SELF □ GUARANTOR RELATIONSHIP_____

NAME_____

ADDRESS _____

CITY_____ STATE _____ ZIP_____

DOB_____/_____/_____

Signature of Patient or Personal Representative: _____ **DATE**: _____

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FINANCIAL POLICY

Patient Name: _____ DOB: _____ Date: _____

Welcome to our office. We are pleased to have you as a patient. We are committed to meeting your health care needs. It is our goal to provide you with the best possible health care and to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines:

1. You are ultimately responsible for payment of services you rendered from our office. Please contact your insurance company to confirm coverage and benefits. We can never guarantee coverage for any service provided by our office. You are responsible for any services that the insurance does not cover, such as but not limited to well visits, procedures, injections and immunizations, balance left after all insurance payments and contracted adjustments.

2. It is your responsibility to provide us with your current address, telephone number, and insurance information at each visit. If you do not have proof of current insurance at your visit, you will be considered a self-pay patient for that visit and payment in full will be due at the time of service.

3. It is your responsibility to contact your insurance carrier to confirm that our physicians participate in your plan and that we are your primary care provider. If your insurance is a managed care plan, our Doctor must be listed as the PCP. If our Doctor is not listed as the PCP, your visit will be considered a self-pay patient for the visit and payment in full will be due at the time of service.

4. All co-payments and deductibles are collected at the time of service.

5. If you miss your appointment without notification, you will be charged a fee as below.

APPLIED FEES:

1. Appointment cancelled less than 24 hours' notice for appointments	$25.00
2. Appointment cancelled less than 48 hours' notice for **echocardiograms**	$25.00
2. Patient "NO SHOW" for an appointment/Physical/Procedures	$25.00
3. Returned payment for Non-Sufficient Funds	$30.00
4. If patient account(s) is unpaid 90 days + interest charge will be applied	$5% applied
5. Collection Agency administrative charge	$25.00
6. To request medical records	$25.00+
7. Completion of all forms (to include by not limited to)	$25.00+

Adoption forms, Camp forms, FMLA, Disability, life insurance forms, school or camp physicals if not given at time of physical, other miscellaneous administrative forms required by third parties other than your insurance company.

All of these activities add to our cost of caring for patients. Still, we are committed to providing you the best possible care. With you, our patient, we look forward to a lasting and healthy relationship and we thank you for your understanding and cooperation.

PLEASE NOTE: You must be familiar with your insurance benefits. You are responsible for any balance on your account after 90 days of submission of claim to insurance company, whether your insurance has paid or not.

PLEASE UNDERSTAND: We file insurance claim as a courtesy to our patients. You have a contract with your insurance company of choice. We are not responsible for how your insurance company handles its claims or for the benefits they pay. We do not guarantee what your insurance company will or will not do with each claim. This is performed as a courtesy to you.

I have read and understand the financial policy stated above and agree to accept responsibility as described.

Signature of Patient or Personal Representative: _____ **DATE**: _____

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ADMINISTRATIVE POLICY

Patient Name: _____ DOB: _____ Date: _____

REFERRAL/PRIOR AUTHORIZATION/PRIOR CERTIFICATION

If your plan requires a referral, it is your responsibility to obtain this prior to being seen by a specialist. If we are required to obtain the referral or prior authorization/certification for you, please notify our office 5 days prior to the specialist's visit or procedure so that we have ample time to acquire this information from your insurance company. Per office policy, we do not back date referrals or prior authorization/certification.

MEDICAL RECORD REQUEST

All medical record requests must be on received in our office 7-10 business days prior to the date needed. Our fee for copies of medical records is based on the number of pages. Medical records requested by physicians treating the patient are free of charge.

REFILL REQUEST and NURSE CALLS

Please allow 3 business days for your refill request to be filled. Although we will try to return patient telephone request within 48 hrs., we ask that you kindly give our staff 72 hrs. to return any requests. Please have the pharmacy fax the request to us at (240)-575-9481. Most medication refills may require a follow-up visit with the physician. Antibiotics and pain medication will not be called in after hours. An appointment with the physician will be required to replace lost or misplace prescriptions.

COMPLETION OF ALL FORMS (to include by not limited to)

Please notify our office 7-10 business days prior the forms needing to be completed. The forms may be completed earlier than that stated but please allow ample time for the completion of the forms. Our fee for completion of form is in our financial policy.

1. Adoption forms
2. Camp forms
3. FMLA, disability, life insurance forms
4. Travel letters
5. School forms
6. Sports Physical forms
7. Other miscellaneous administrative forms required by third parties other than your health insurance company

OFFICE POLICY ON MANAGED CARE INSURERS

We are pleased to meet the needs of our patients by enrolling with various managed care insurance programs. While we are able to provide you with this service, it is extremely difficult to keep track of all the individual insurance requirements of each plan. Even with the same insurance company, plans often may differ. Providing quality medical care for our patients is our primary concern, and we are more than willing to provide that care based on your insurance contract guidelines. We request at each visit that you advise us of your guidelines. Unfortunately, if you do not inform us of any special requirements in your contract and subsequently provide services, or order services such as label work or procedures that are not covered, the office will have no choice but to bill you directly for all said charges. All fees submitted and denied by your insurance carrier will become your responsibility.

With your cooperation, you should be able to receive all benefits offered by your insurance plan, and we will be able to concentrate on caring for your medical needs.

I have read and understand the administrative policy stated above and agree to accept responsibility as described.

Signature of Patient or Personal Representative: _____ **DATE**: _____

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PATIENT CONSENT FORM

During the course of my care and treatment, I understand that various types of tests, diagnostic or treatment procedures ("Procedures") may be necessary. These Procedures may be performed by physicians, nurses, technicians, physician assistants or other healthcare professionals ("Healthcare Professionals") at Saving Lives Center Family Clinic & Urgent Care.

While routinely performed without incident, there may be material risks associated with each of these Procedures. I understand that it is not possible to list every risk for every Procedure and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the Procedures. I also understand that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative Procedures.

The Procedures may include, but are not limited to the following:

(1) **Needle Sticks**, such as shots, injections, intravenous lines, or intravenous injections (IVs). *The material risks associated with these types of Procedures include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue).*

(2) **Physical tests, assessments and treatments** such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, and other similar procedures. *The material risks associated with these types of Procedures include, but are not limited to allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition and death.* Apart from using modified Procedure and/or refusal of treatment, no practical alternatives exist.

(3) **Administration of Medications** whether orally, rectally, topically or through my eye, ear or nose. *The material risks associated with these types of Procedures include, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death.* Apart from varying the method of administration and/or refusal of treatment, no practical alternative exists.

(4) **Drawing Blood, Bodily Fluids or Tissue Samples** such as that done for laboratory testing and analysis. *The material risks associated with this type of Procedure include but are not limited to, paralysis of partial paralysis, nerve damage, infection, bleeding and loss of limb function.* Apart from long-term observation and/or refusal of treatment, no practical alternative exists.

(5) **Insertion of Internal Tubes** such as bladder catheterizations, nasogastric tubes, rectal tubes, drainage tubes, enemas, etc. *The material risks associated with these types of Procedure include, but are not limited to, internal injuries, bleeding, infection, allergic reaction, loss of bladder control and/or difficulty urinating after catheter removal.* Apart from external collection devices or refusal of treatment, no practical alternatives exist.

I understand that:

- The practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the outcome and/or result of any Procedures;
- The Healthcare Professional participating in my care will relay on my documented medical history, as well as other information obtained from me, family or others having knowledge about me, in determining whether to perform or recommend the Procedures' therefore, I agree to provide accurate and complete information about my medical history and conditions; and
- By signing this form:
- I consent to healthcare Professionals performing Procedures as they may deem reasonably necessary or desirable in the exercise of their professional judgment, **including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained;** and
- I acknowledge that I have been informed in general terms of the nature and purpose of the Procedures; the material risks of the Procedures; and practical alternatives to the Procedures.

If I have any questions or concerns regarding these Procedures, I will ask my physician to provide me with additional information. I also understand that my physician may ask me to sign additional informed Consent documents.

Signature of Patient or Personal Representative: _____**DATE**: _____

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HEALTH HISTORY

NAME _____ **AGE** _____ **BIRTHDATE** _____ **TODAY'S DATE** _____

Currently Live: ☐ Alone ☐ With Friends ☐ With Family ☐ With Significant Other

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Never Married ☐ Widowed

Check all items either YES or NO & give approximate date if past	NO	Yes NOW	Yes PAST	DATE	Check all items either YES or NO & give approximate date if past	NO	Yes NOW	Yes PAST	DATE
Abnormal Electrocardiogram (EKG)					Heart murmur as an adult				
Alcoholism					Hemorrhoids, rectal problems				
Anemia (Type)					Hepatitis (Type)				
Angina / chest pain					Hernia				
Arteriosclerosis					High blood pressure				
Arthritis					High cholesterol				
Asthma / Hay Fever					HIV / AIDS				
Blood disease					Jaundice				
Broken bones					Kidney or bladder disease				
Cataracts					Kidney stones				
Chemical dependency					Low blood pressure				
Chemotherapy					Migraine headaches				
Chronic bronchitis / emphysema					Mitral valve prolapsed				
Chronic liver disease					Night sweats				
Colon, bowel trouble – diverticulitis/colitis					Phlebitis				
Convulsions, seizures					Poor blood clotting				
Deafness or ringing ears					Psychiatric care				
Diabetes					Rheumatic fever				
Ear infections					Sexually transmitted / venereal disease				
Enlarged heart					Shortness of breath				
Epilepsy / seizures					Sinus trouble				
Forgetfulness					Skin disease / psoriasis / eczema				
Glaucoma					Stroke				
Gall Stones					Thyroid problem				
Gout					Tuberculosis or positive TB test				
Head injury					Wakefulness, difficulty sleeping				
Heart attack					Weight loss or weight gain				

HABITS

Do You	Yes	No	Daily Consumption	
Smoke	☐	☐	_____	Pkgs
Drink Coffee	☐	☐	_____	Cups
Drink Alcohol	☐	☐	_____	oz
Drink Beer	☐	☐	_____	oz
Chew Tobacco	☐	☐	_____	
Use Drugs	☐	☐	_____	

Type _____

Frequency _____

MEDICATIONS

Please list all medication you are now taking, **with DOSAGE** including all over the counter medications also.

_____

_____

_____

ALLERGIES

List anything that you are allergic to, such as medications, foods, etc., and indicate how each affects you.

_____

_____

_____

Immunizations: ☐ Tetanus-date: _____ ☐ Flu-date: _____ ☐ German Measles-date: _____ ☐ Pneumonia-date: _____

Hospitalizations (Not including normal pregnancies)

Operation or Illness	Year

Serious Illness not requiring hospitalization

Illness	Year

Have you had?	Yes	No	When or since when?
Burning when urinating? ……	☐	☐	
Blood in urine? ……	☐	☐	
Loss of bladder control? ……	☐	☐	
Blood in the stool? ……	☐	☐	
Alternating diarrhea/constipation? ...	☐	☐	
Pain during/after bowel movements?	☐	☐	
Black stools? ……	☐	☐	
Ribbon-like stools? ……	☐	☐	
Require laxatives or enemas? ……..	☐	☐	
Pain in calves of legs when walking?	☐	☐	
Pain in the big toe? ……	☐	☐	

Have you had pain or tightness in the chest which begins?

	Yes	No		Yes	No
When exerting yourself?	☐	☐	When walking against a wind?	☐	☐
After a heavy meal?	☐	☐	When walking up a hill?	☐	☐
When upset or excited?	☐	☐	Radiates down the arm?	☐	☐
When walking fast?	☐	☐	Disappears if you rest?	☐	☐
Palpitations?	☐	☐	When walking in cold weather?	☐	☐
If you have chest pain or tightness	☐	☐	Do you sleep on more than		
Please explain: _____			One pillow? ……	☐	☐

Do you wear artificial devices? (dentures, hearing aid)
☐ Yes ☐ No List:

MEN ONLY: ☐ Discharge from penis ☐ Pain in testicles ☐ Sexual difficulties ☐ Prostate trouble

Are You?
☐ Excessively cold ☐ Excessively hot ☐ Always hungry ☐ Always thirsty

WOMEN ONLY: Last Pap smear _____ Last Menstrual period _____ Method of contraception _____
Pregnancy # _____ Live births # _____ Miscarriages or abortions # _____ Last mammogram _____ Age periods started _____

☐ Vaginal itching or burning ☐ Vaginal discharge ☐ Problems with menstrual periods ☐ O her gynecological problems ☐ Other breast disease
☐ Sexual difficulties ☐ Breast cancer ☐ Discharge from nipple(s) ☐ Problems during pregnancy ☐ Ovarian cysts

FAMILY HISTORY

Check conditions(s) and relationship of any blood relative that has or has had any of the conditions listed.	Alive	Deceased	Father	Mother	Brother	Sister	Son	Daughter	Check conditions(s) and relationship of any blood relative that has or has had any of the conditions listed.	Alive	Deceased	Father	Mother	Brother	Sister	Son	Daughter
Alcoholism									High blood pressure								
Allergies									Kidney disease								
Anemia									Leukemia								
Arthritis									Liver disease								
Asthma / hay fever									Mental illness								
Birth defects									Migraines								
Cancer									Nervous breakdown								
Colon / bowel trouble									Obesity								
Congenital heart defects									Rheumatic fever								
Diabetes									Sickle-cell anemia								
Emphysema									Stomach ulcer								
Epilepsy									Stroke								

I certify that the above information is correct to the best of my knowledge. I will not hold Saving Lives Center Family Clinic & Urgent Care or members of its staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____