**New Minor Patient Information**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_

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

Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information:**

Primary Insurance Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group/Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Name and DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Information:**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office Policies and Procedures:**

We are an appointment-based practice. All patients must make an appointment to be medically evaluated and diagnosed in person. All telecommunications from our Nurse Practitioners are limited to INTERPRETATIVE services only.

**Operating Hours:**

Monday – 9:00 AM - 4:00PM

Tuesday - CLOSED

Wednesday - 9:00 AM - 4:00PM

Thursday - 7:30 AM - 3:30 PM

Friday - 9:00 AM - 4:00PM

Saturday- CLOSED

Sunday - CLOSED

1. **After Hours:** If it is a Medical Emergency, call 911 immediately. For all non-emergency medical issues, please call our office and follow the phone instructions, or visit an after-hours clinic approved by your insurer. Please save other inquiries for business hours.
2. **Patient Responsibilities:** By signing this form, you agree to the following:
	1. Notify us of any changes in your address or insurance at the time of change.
	2. Know your insurance policy. Every policy has its own rules and regulations. It is your best interest to know what those policies are.
	3. Act in a professional and cordial manner with all our office staff. Rude, aggressive, or other offensive behavior towards any member of our office staff will result in immediate patient dismissal.
3. **Patient Portal:** All patients under the age of 65 **must** register for a portal account. The portal enables patients to receive their lab results, view reports, request refills, schedule appointments, pay invoices and communicate with the providers through a secure, HIPAA compliant website. Patients require an email address to use this system and will receive an email notification when they receive a new health update.
4. **Service Expectations:** Please allow *1-2 business days* for our staff to complete prior-authorization requests, records requests, prescription refill requests, and form completions. This does not include the time needed for non-practice entities to complete requests.
5. **Health Insurance:** We currently accept most United Healthcare, Cigna, Aetna, Tricare, Blue Cross Blue Shield, and Medicare. We ***do not*** accept any form of Medicaid, even if it is within one of the accepted plans.
6. **Financial Responsibility:** By signing this form, the patient agrees to pay all co-pays, co-insurances, deductibles, outstanding balances, or other fees at the time of their visit. Payment must be received before the appointment or we reserve the option to reschedule it. Our practice accepts credit/debit cards and personal checks as forms of payment. An outstanding balance that is not paid within 30 days of the patient receiving notice is considered PAST DUE and will be forwarded to a collection agency.
7. **Late Policy, Cancellations, and No Show**: We have the right to cancel or reschedule your appointment if you are 15 minutes late or later. Please cancel an appointment NO LESS than 24 hours before the scheduled time. Repeated offenses to this policy will be tracked and could be subject for patient dismissal. Patients who do not show up to their scheduled appointment and do not call to cancel or reschedule will be charged a **$100.00-$150.00** no show fee.
8. **Prescription Refills:**
	1. It is illegal to alter and/or tamper with any prescriptions written by a medical provider. Any prescription thought to be tampered with after leaving our facility will result in **IMMEDIATE dismissal** from our practice. Our office will also be required to notify the DEA as well as local law enforcement.
	2. All chronic (regularly taken) medications require regular follow-up visits at our office. Our Providers will let you know the appropriate interval between visits and schedule your next follow up appointment accordingly. If you are overdue for your visit, your provider may choose to provide you enough medication until your scheduled appointment (maximum 1 week) as a courtesy.
	3. Medications for acute problems (cough, fever, etc.) **will require** an office visit to ensure a correct diagnosis and appropriate medication is prescribed.
	4. If a patient needs a refill between office visits, please have your pharmacy send us an electronic refill request or send a request through the portal.
9. **Controlled Substances:**
	1. Any patient who is prescribed controlled substances will be subject to random urine drug screening at the providers discretion. Refusal to comply with random urine drug screening will result in immediate dismissal from our practice.
	2. All patients who receive controlled substance prescriptions from our office must be receiving them from our office ONLY. If it is brought to our attention that patients are having controlled substance prescriptions filled by more than one provider, the patient will be dismissed from our practice and the other provider(s) filling the prescriptions will be notified.
10. **Referrals:** Many insurance companies now require referrals for a patient’s visit to specialists. An office visit is required for referrals.
11. **Administrative Fee:** It is required to be part of the practice and must be collected before being seen by a Provider, requesting prescription refills, or requesting phone consults with providers.
12. **Saturday Walk-In Clinic:** On Saturdays, our Bethesda office sees patients from 9:00 AM to 3:00 PM. Saturday hours are walk-in only. Saturday services include prescription refills, cold/flu/sinus symptoms, UTI’s, immunizations/vaccinations, sprains, and minor laceration repair. Services we do not provide on Saturdays include adult physicals, wellness exams, hypertension, chest pain, lab work, and issues best addressed by an Emergency Room.

**I HEREBY CONSENT TO ALL OFFICE POLICIES AND PROCEDURES LISTED IN THIS FORM BY SIGNING BELOW.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­­­Patient Name (Printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/ Guardian Signature Date

**PATIENT ACKNOWLEDGEMENT & CONSENT FORM**

**Acknowledgement of Notification**

The educational pamphlet entitled “Notice of Privacy Practices” provides information about how Kelly Care may use and disclose protected health information about you and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our **Notice of Privacy Practices** states that we reserve the right to change the terms described. Should this happen, we will post the changes in the office.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions; but if we do, we are bound by our agreement with you.

By signing below, you acknowledge receipt of our **Notice of Privacy Practices.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­­­Patient Name (Printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/ Guardian Signature Date

**Consent for Use and Disclosure of Information**

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Kelly Care for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare Services and its’ agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­­­Patient Name (Printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/ Guardian Signature Date

**AUTHORIZATION FOR USE OF USPS MAIL, ANSWERING MACHINE AND/OR VOICEMAIL as well**

**as ELECTRONIC ACCESS (Patient Portal and Email)**

Protected Healthcare Information that we may possibly disclose on your home, work, mobile phone, patient portal account, email and current home address on file would include, but is not limited to: test/lab results, prescription/pharmacy information, patient plans, future orders, appointment instructions for visits and procedures, and clinical information.

 (Initial) I agree to allow **Kelly Care** physicians and healthcare staff to leave messages that include Protected Healthcare Information of the following:

Please initial next to the applicable communication devices:

\_\_\_Home Number \_\_\_Work Number \_\_\_Mobile Number \_\_\_Patient Portal \_\_\_Email \_\_\_USPS Mail

 (Initial) No, I do not agree to allow **Kelly Care** physicians and healthcare staff to leave messages that include Protected Healthcare Information on my home, work and cell phone.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­­Patient Name (Printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/ Guardian Signature Date

**PERSONAL REPRESENTATIVE, FAMILY OR OTHER ENTITIES AUTHORIZED ACCESS TO PROTECTED INFORMATION TO BE USED AND/OR DISCLOSE (OPTIONAL)**

Name or specifically identify these persons and/or entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment and other healthcare operations.

|  |  |  |
| --- | --- | --- |
| Name of Authorized Person or Entity |  | Relationship  |
| Phone |  |  Email |
| Name of Authorized Person or Entity |  | Relationship |
| Phone |  | Email |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­­­Patient Name (Printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/ Guardian Signature Date

**HIPAA Privacy Authorization Form for Medical Office**

1. **Authorization:**

\_\_\_\_\_\_\_\_ I authorize **Kelly Care** to send, receive, use, and disclose the protected health information described below for:

Physician/Office Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Office Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. **Effective period and types of records to be disclosed:**

This authorization for release of information covers all past, present, and future medical records

(or until informed otherwise in writing) including:

* Visit Notes
* Test Results
* Insurance information
* Lab results
* Reports of other health care providers
* Medications
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. **Extent of Authorization:**

I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. This authorization shall be effective until revoked in writing.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date

Permission to Treat Minor Patient (Without Parent/Legal Guardian Present)

Kelly Care must receive permission from a child’s parent or legal guardian prior to providing preventative care for treatment including examination, diagnosis, immunization, injection, injury, or illness that is non-life threatening. This form provides the legal permission to (depending on the minor’s age) either treat without any adult present (Section A), or with a designated adult present (Section B).

Patient’s Name:

Patient’s Date of Birth: Today’s Date: \_\_\_

# Section A (ONLY for child at least 16, but not 18 years old)

*Authorization to treat your minor child in case you or your designated representative are unable to accompany your child to one of his/her visits:*

I, (print your name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , grant Kelly Care permission to assess and treat the aforementioned minor without an adult present.

# Section B (for child under 18 years old)

*Delegation of authority for medical treatment of a minor child to the designated representative indicated below*:

 I, (print your name) , grant Kelly Care permission to assess and treat the aforementioned minor in the presence of either of the following adults (18 years or older) who is authorized to approve treatment:

Name: Relation to minor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: Relation to minor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that, despite this consent, Kelly Care, in its sole discretion, may decide not to act on this consent, and instead require my presence during my child’s treatment or care. I also understand that I am financially responsible for payment of all charges in connection with the care and treatment rendered.

# NOTE: A parent / legal guardian MUST be present for a minor patient’s first visit with Kelly Care.

# Authorized by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTE: Article 20-102 of the Annotated Code of Maryland (State Law) allows for the following exceptions, where a minor has the same capacity as an adult to consent to medical treatment:

1. Treatment for and/or advice about drug abuse, alcoholism, venereal disease, or pregnancy other than sterilization.
2. Physical exam for and treatment of injuries and/or collection of evidence from an alleged rape or sexual offense.
3. Consultation, diagnosis and treatment of a mental or emotional disorder.