

PLEASE PRINT CLEARLY

Today's Date: _____

Appointment Location: _____

PATIENT DEMOGRAPHICS

Patient's Last Name: _____ First: _____ M.I. _____

Alias/Nickname: _____ Birthdate: _____ Age: _____

Sex: [] M [] F Social Security # _____ Marital Status (Circle One): S M D

Religion: _____ Language: _____ Interpreter Needed: [] Yes [] No

Ethnicity: [] Hispanic or Latino [] Not Hispanic or Latino [] Unknown [] Declined to Answer

Check all Race Categories the patient self-identifies as:

- American Indian / Alaskan Native
 Native Hawaiian or Other Pacific Islander

- Asian
 White / Caucasian

- Black or African American
 Declined to Answer

Patient Physical Address: *If PO Box is used for mailing please list as Mailing Address*

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Please check the box below if the address is;

- Temporary from _____ to _____ Confidential

Patient Mailing Address: *Complete if different from Permanent Address*

Street Address: _____ P.O. Box: _____

City: _____ State: _____ Zip Code: _____ County: _____

Contact Phone Numbers: Home: _____ Work: _____

Cell / Mobile: _____ Email: _____

Preferred Communication Method(s): [] Mail [] Phone [] My Portfolio *(Please ask us about this new web based service)*

HOW DID YOU HEAR ABOUT US?

- [] Billboard [] Email [] Friend/Family [] Google/Search [] Health Fair [] Home Mailer [] Magazine/Newspaper
[] Movie Theater [] Seminar [] Social Media [] Transit Bus [] Other _____

EMERGENCY CONTACT INFORMATION

Name(s): _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SPOUSE INFORMATION (Complete If Applicable)

Name: _____ Cell / Mobile: _____
Employer: _____ Work Phone: _____

PARENT INFORMATION (Complete if Patient is a Minor)

Patient Lives With: Mother & Father Father Mother Other: _____

Is a Legal Custody Agreement in Place? Yes No

**If yes, you MUST provide our office with a copy of the custody agreement. In cases of divorce or separation where no custody agreement exists, both parents have equal rights regarding decisions and information concerning the patient's medical care.*

Father's Name: _____	Mother's Name: _____
SS# _____ Birthdate: _____	SS# _____ Birthdate: _____
Street Address: _____	Street Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Home Ph: _____ Cell: _____	Home Ph: _____ Cell: _____
Employer: _____	Employer: _____
Work Phone: _____	Work Phone: _____

PATIENT EMPLOYMENT or STUDENT STATUS

Employment: Full Time Part Time Retired Active Military Not Employed

Student - Full Time Student - Part Time Disabled: Date: _____

Occupation: _____ Employer: _____ Work Phone: _____

Employer Address: _____

COORDINATION OF MEDICAL CARE

Primary Care Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

Preferred Pharmacy: _____ Phone Number: _____

FINANCIALLY RESPONSIBLE PARTY

Patient Spouse Parent(s) Legal Guardian Other _____

Please complete this section if you checked Legal Guardian, Other, or if only one parent is the guarantor.

Last Name: _____ First Name: _____ Middle: _____

Social Security #: _____ Gender: _____ Date of Birth: _____ Age: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Phone Number(s): _____

INSURANCE

Please inform the Front Desk staff if this visit is related to an Auto Accident, Workers Compensation, or Disability Claim

Primary Insurance: _____

Policy#: _____ Grp#: _____ Ins Phone: _____

Insurance Address: _____

Policy Holder's Name: _____ Relationship To Patient: _____

Policy Holder's Birthdate: _____ Policy Holder's SS#: _____

** If there is No Secondary Insurance, please circle: NONE*

Secondary Insurance: _____

Policy#: _____ Grp#: _____ Ins Phone: _____

Insurance Address: _____

Policy Holder's Name: _____ Relationship To Patient: _____

Policy Holder's Birthdate: _____ Policy Holder's SS#: _____

AFFIRMATION

By signing below, I represent that the information given by me to UMCMG is accurate to the best of my knowledge.

Patient or Responsible Party Signature

Date

Patient / Responsible Party Name (PRINT)

Relationship to Patient

**UNIVERSITY OF MARYLAND COMMUNITY MEDICAL GROUP CONSENT FOR TREATMENT,
FINANCIAL RESPONSIBILITY AND HEALTHCARE OPERATIONS**

UNIVERSITY OF MARYLAND COMMUNITY MEDICAL GROUP, for the purposes of this consent, includes all hospitals, physician offices and other facilities providing healthcare services which are part of UNIVERSITY OF MARYLAND COMMUNITY MEDICAL GROUP.

REQUEST, AUTHORIZATION AND CONSENT FOR TREATMENT: I voluntarily request, authorize, and consent to hospital care including medical and/or surgical treatment and diagnostic, radiology, and laboratory examinations and procedures by physicians, residents, nurses and other technical staff of University of Maryland Community Medical Group. I understand and agree that healthcare professionals in training, which may include but are not limited to residents, fellows, medical/nursing/dental students may assist or participate in providing hospital and/or medical care to me. I understand that these professionals in training work under the direction or supervision of my physician or other healthcare professional and may perform or observe some of the health services I receive and specifically consent to.

I understand that the extent and severity of my injury or illness is not known at this time. I further understand and agree that the practice of medicine is not an exact science and that no guarantees have been made as to the results of either hospital care and medical and/or surgical treatment or examinations. If applicable, I give University of Maryland Community Medical Group permission to appropriately dispose of any specimens/tissue (such as blood samples, PAP smears, skin tags, etc.) taken from my body. Once disposed of, these specimens/tissues cannot be retrieved. I hereby authorize University of Maryland Community Medical Group to retain, preserve and use for scientific or teaching purposes or dispose of at their convenience, any specimens or tissues taken from my body during any hospital/clinic procedure(s).

EMERGENCY CARE: I acknowledge that the treatment rendered to me on an emergency basis is not intended to be comprehensive in scope and it may be necessary to select another physician for a further diagnosis and continuation of treatment after my discharge from University of Maryland Community Medical Group

INDEPENDENT CONTRACTORS: I acknowledge that not all healthcare providers are either employees, servants or agents of University of Maryland Community Medical Group. Some are independent contractors who have been granted the privilege of using the University of Maryland Community Medical Group facilities for the care and treatment of their patients. I understand that if the employment status of an individual is important to me in making treatment and other healthcare decisions, I may inquire as to that individual's employment status. I further understand that University of Maryland Community Medical Group is not liable for the care and treatment decisions of these independently contracted healthcare providers.

_____ (Patient/Responsible Party initials)

INSURANCE CERTIFICATION AND ASSIGNMENT: I hereby certify that the information given by me in applying for payment under titles XVIII and XIX of the Social Security Act and/or by any other third party payers is correct. I assign to University of Maryland Community Medical Group all benefits for hospital care due to me under the terms of said policies and programs but not to exceed the regular charges for similar services. I assign payment to the physician(s) rendering medical services and I assign payment for the unpaid charges of the physician(s) for whom the University of Maryland Community Medical Group is authorized to

bill in connection with its services. I understand that I am responsible for payment of any health insurance deductibles, coinsurance, or any other expenses incurred which are not paid by any insurers or other third party payers.

MEDICARE AUTHORIZATION: I request payment of authorized Medicare benefits be made on my behalf for any service furnished me by University of Maryland Community Medical Group, including physician services. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

PRIVACY OF INFORMATION: I acknowledge that I have received a copy of University of Maryland Community Medical Group Notice of Privacy Practices which explains how University of Maryland Community Medical Group may use and disclose protected health information. _____

(Patient/Responsible Party initials)

PERSONAL PROPERTY/VALUABLES: I understand that University of Maryland Community Medical Group recommends that all personal belongings shall be sent home with a family member or friend and that University of Maryland Community Medical Group will not be responsible for the theft, loss or damage of my personal property which includes but is not limited to money, jewelry, eyeglasses, dentures, hearing aids, garments or other articles of unusual value. I understand that there may be storage options available for my use. I assume full responsibility for all of my personal property and valuables and release UMMS from responsibility and liability for such items.

GUARANTEE OF ACCOUNT: I acknowledge responsibility for this account and assume and guarantee payment of all hospital and physician charges, including copayments and deductibles and non-covered charges rendered to me during this visit. Should this account be referred to an attorney for collection, I agree to pay attorney fees of twenty-five percent (25%), collection expenses, and interest at the highest rate authorized by law. I understand that I may be billed separately for services provided to me or on my behalf during this period of treatment by independent professional groups or hospital based physician services (radiology, anesthesiology, emergency, pathology etc.).

WIRELESS COMMUNICATION: I expressly consent and authorize University of Maryland Community Medical Group and its agents to:

- a. Contact me at any telephone number, including wireless numbers, email addresses, or unique electronic identifiers or modes that I provided to University of Maryland Community Medical Group at any time associated with me or my account;
- b. Communicate with me using any current or future means of communication, including but not limited to, automated telephone dialing systems, artificial or pre-recorded messages, SMS text messages, or other forms of electronic messages, in connection with any communication regarding my account;
- c. Leave answering machine and voicemail messages, in compliance with applicable laws, for any reason related to the services provided by University of Maryland Community Medical Group or services to be provided by University of Maryland Community Medical Group in the future, including collection of amounts owed on my account.

I further promise to immediately notify University of Maryland Community Medical Group if any telephone number, email address or other unique electronic identifiers or modes that I provided to University of Maryland Community Medical Group change or are no longer used by me.

I CERTIFY THAT I HAVE READ THIS CONSENT AND AM THE PATIENT OR THE PARENT OR GUARDIAN OF THE PATIENT OR AM DULY AUTHORIZED AS PATIENT'S AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS. BY SIGNING BELOW, I REPRESENT THAT THE INFORMATION GIVEN BY ME IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

PATIENT OR RESPONSIBLE PARTY SIGNATURE RELATIONSHIP TO PATIENT

PRINT NAME WITNESS (SIGNATURE)

DATE TIME

REASON IF UNABLE TO SIGN:

____ PHYSICAL CONDITION ____ MENTAL CONDITION

TO BE USED FOR VERBAL CONSENT:

ON _____ AT _____ O'CLOCK,

DATE TIME

NAME OF PERSON GIVING CONSENT

THE TERMS OF THIS CONSENT WERE REVIEWED WITH THE PATIENT, PARENT OR GUARDIAN OF THE PATIENT OR THE DULY AUTHORIZED AGENT OF THE PATIENT VERBALLY AND SUCH INDIVIDUAL PROVIDED VERBAL CONSENT TO THE TERMS SET FORTH HEREIN.

WITNESS (SIGNATURE)

University of Maryland Community Medical Group complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. University of Maryland Community Medical Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

University of Maryland Community Medical Group provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Reba White. If you believe that University of Maryland Community Medical Group has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Reba White, 920 Elkridge Landing Rd, Linthicum, Maryland 21090, (443) 462-5194. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Reba White is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



UNIVERSITY of MARYLAND
COMMUNITY MEDICAL GROUP

Authorization to Disclose Health Information
(Excluding Medical Records/PHI)

Patient Name: _____ Date of Birth: _____ Date: _____

Authorization to Disclose Health Information

I, _____, grant permission for the following person(s) to obtain information regarding medical care, and speak with the provider, and/or staff regarding the patient listed above.

Name

Relationship

Patient or Responsible Party Signature

Date

Patient / Responsible Party Name

Relationship to Patient