



# POTOMAC PHYSICIAN ASSOCIATES

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www.ppa.md

## Patient Responsibilities

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

The doctors of PPA want to keep healthcare accessible and affordable to our patients. You can help by taking responsibility for the following:

1. Notify us of any changes in your address or insurance information at the time of the change.
2. Know your insurance policy. Every policy has its own rules and regulations. It is in your best interest to know what your policies are, and if referrals are required. If you are seeing a specialist and arrive without getting proper referrals you understand that this means you become responsible for this service.
3. We order tests that are medically necessary. It is your responsibility to know what tests your insurance policy covers and does not cover. (This includes all lab and radiology tests.)
4. All appointments must be scheduled in advance. A \$50.00 No Show or Late Cancellation fee will apply if you do not cancel your annual appointments 24 hours in advance or do not show for your annual appointment.
5. Co-payments must be made at the time services are rendered. (This is a health insurance requirement.)
6. Pay your bill promptly. If there is financial hardship, please contact the billing department at (301)917- 6513 in advance of appointment.
7. If your check is dishonored or returned for any reason, we may electronically debit your account for the amount of the check plus a processing fee of \$35.00.
8. When needing a prescription refill or referral request of any kind, we will require 48 hours from the time of your call to process your request.

I \_\_\_\_\_ have read and understand the above policies.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PPA Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**Potomac Physician Associates, PC**

Name: \_\_\_\_\_ ( ) Male ( ) Female Date: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ Work # \_\_\_\_\_ Home# \_\_\_\_\_ Cell# \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Marital Status: S M D W (please circle)  
 Emergency Contact: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Phone number: \_\_\_\_\_ Other #: \_\_\_\_\_  
 Reason for today's visit: \_\_\_\_\_

**PAST MEDICAL HISTORY**

**Check which condition(s) you are currently being treated for or have been in the past :**

Arthritis       Depression/ Anxiety       High cholesterol       Stroke  
 Asthma       Diabetes  
 Headaches       Hypertension       Thyroid Problems  
 Birth defects       Heart Attack       IBS/ Digestive problems       Other \_\_\_\_\_  
 Bleeding disorder/  
 Anemia       Seasonal allergies  
 Cancer       Heart Disease       Seizure Disorder  
 Heartburn/ Ulcer       Sexually Transmitted Disease  
 Type \_\_\_\_\_  
 What is the year of your last colonoscopy? \_\_\_\_\_

**CURRENT MEDICATIONS**

**MEDICATION ALLERGIES**

Medication Name	Dosage	# Times daily	Please list any drug allergies with reactions:
List any medications you are currently taking, please include any over the counter medications, vitamins, supplements etc...			
1.			1.
2.			2.
3.			3.
4.			4.
5.			5.

**SOCIAL HISTORY** (please circle Yes or No)

Do you use tobacco? YES NO Formerly (year quit \_\_\_\_\_)  
 If yes what kind and how much per day? \_\_\_\_\_ # years \_\_\_\_\_

Do you drink alcohol? YES NO Formerly (year quit \_\_\_\_\_)  
 How many drinks per week? \_\_\_\_\_

Do you use drugs? YES NO Formerly (year quit \_\_\_\_\_)  
 If yes what types? \_\_\_\_\_ How many times per week? \_\_\_\_\_

Do you drink caffeinated beverages? YES NO  
 If yes how many per day? \_\_\_\_\_

Do you Exercise? YES NO  
 If yes how many times per week? \_\_\_\_\_

Do you wear a seatbelt? YES NO

Who else lives at home? \_\_\_\_\_  
 Do you feel safe at home? YES NO

\*\*\*\*\*PLEASE TURN OVER AND COMPLETE\*\*\*\*\*

**SURGICAL HISTORY**

List any in or out patient surgical procedures you have had, starting with the most recent.

Date	Surgery
1.	
2.	
3.	
4.	
5.	

Have you ever received a blood transfusion?       Yes       No

***Gynecological History (for Women Only)***

Date of last Pap smear \_\_\_\_\_ # pregnancies \_\_\_\_\_  
 Date of last mammogram \_\_\_\_\_ # deliveries \_\_\_\_\_  
 Date of last bone density \_\_\_\_\_

**FAMILY HISTORY**

**Has any member of you family had any of the following illnesses:  
 (Indicate relationship i.e., Mother, Father, Grandparent, Sibling)**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Asthma _____                      | <input type="checkbox"/> Diabetes _____               | <input type="checkbox"/> Mental retardation _____ |
| <input type="checkbox"/> Birth defects _____               | <input type="checkbox"/> Heart attack _____           | <input type="checkbox"/> Osteoporosis _____       |
|  | o Age diagnosed _____                                 |   |
| <input type="checkbox"/> Bleeding problem/<br>Anemia _____ | <input type="checkbox"/> Heart disease _____          | <input type="checkbox"/> Seizures _____           |
|  | o Age diagnosed _____                                 |   |
| <input type="checkbox"/> Cancer _____                      | <input type="checkbox"/> High blood pressure _____    | <input type="checkbox"/> Stroke _____             |
| <input type="checkbox"/> Cystic fibrosis _____             | <input type="checkbox"/> High cholesterol _____       | <input type="checkbox"/> Thyroid problems _____   |
| <input type="checkbox"/> Depression/anxiety _____          | <input type="checkbox"/> IBS/Digestive problems _____ | <input type="checkbox"/> Other _____              |

Living	Yes	No	Current Age or Age at death	Cause of Death
Mother	Yes	No	_____	_____
Father	Yes	No	_____	_____
Sister	Yes	No	_____	_____
Brother	Yes	No	_____	_____

Pharmacy Name: \_\_\_\_\_ Telephone # \_\_\_\_\_

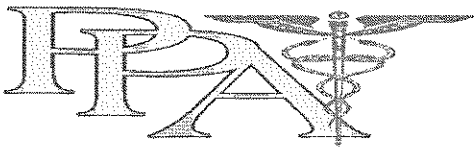
Address: \_\_\_\_\_

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Physician Signature

\_\_\_\_\_  
 Date



# omac Physician Associates

19735 Germantown Rd  
 Germantown, MD 20874  
 (301) 917-6513

## PATIENT INFORMATION

NAME (Last, First Middle)			MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		CITY, STATE ZIP		REFERRING PHYSICIAN		SECONDARY/BILLING ADDRESS (if Applicable)	
HOME PHONE	DAY PHONE	EMAIL ADDRESS		PRIMARY CARE PROVIDER		CITY, STATE ZIP	
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME		CONTACT PHONE	HOME PHONE
PRIMARY EMPLOYER				SECONDARY EMPLOYER (if Applicable)			
ADDRESS				ADDRESS			
CITY, STATE ZIP				CITY, STATE ZIP			
WORK PHONE				WORK PHONE			

## RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)			SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)		
HOME PHONE	DAY PHONE	EMAIL ADDRESS		CITY, STATE ZIP		
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE	
RELATIONSHIP TO PATIENT						

## PRIMARY INSURANCE

NAME OF INSURANCE COMPANY			POLICY#			
NAME OF INSURED			GROUP#			
ADDRESS OF INSURANCE COMPANY			COPAY AMT \$			
CITY, STATE ZIP		PHONE	DEDUCTIBLE \$			
RELATIONSHIP TO PATIENT			EFFECTIVE DATE	EXPIRATION DATE		

## SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#			
NAME OF INSURED			GROUP#			
ADDRESS OF INSURANCE COMPANY			COPAY AMT \$			
CITY, STATE ZIP		PHONE	DEDUCTIBLE \$			
RELATIONSHIP TO PATIENT			EFFECTIVE DATE	EXPIRATION DATE		

I hereby authorize this physician to apply for benefits on my behalf for covered services rendered.  
 I certify that the information I have reported with regard to my insurance coverage is correct.  
 I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier,  
 (or, in the case of Medicare Part B benefits to the social security administration and healthcare administration).  
 A copy maybe used in place of the original.  
 This authorization maybe revoked by either me or my insurance carrier at any time in writing.

SIGNATURE OF PATIENT/GUARDIAN

DATE



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## PATIENT ACKNOWLEDGEMENT & CONSENT FORM

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### Acknowledgement of Notification

The educational pamphlet entitled "Notice of Privacy Practices" provides information about how Potomac Physician Associates 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 all of the offices.

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**.

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**Patient 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 **Potomac Physician Associates** 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/Medicaid 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.

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**Patient Signature**

**Date**

---

**Print Full Name**



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## 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 #
-------------------------------------	--------------	---------

Name of Authorized Person or Entity	Relationship	Phone #
-------------------------------------	--------------	---------

### AUTHORIZATION FOR USE OF ANSWERING MACHINE AND/OR VOICE MAIL

**Potomac Physician Associates** physicians and healthcare staff routinely are unable to contact patients directly during normal business hours. On these occasions our offices leave messages on communication devices provided by our patients. Due to the new federally mandated HIPAA Privacy Rule we must obtain your authorization to continue this mode of communication. Protected Healthcare Information that we may possibly disclose on your home, work, or cell phone would include, but is not limited to: test/lab results, prescription/pharmacy information, appointment instructions for visits and procedures, and surgical posting/scheduling information.

\_\_\_\_\_(Initial) I agree to allow **Potomac Physician Associates** 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 or \_\_\_\_\_ cell number

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

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

For PPA Internal Use Only

### UNABLE TO OBTAIN NOTICE RECEIPT ACKNOWLEDGEMENT

**Option 1:** I could not obtain a signed Notice Receipt Acknowledgement from the patient for the following reason:  
\_\_\_\_\_

**Option 2:** I attempted to obtain a signed Notice Receipt Acknowledgement from the patient on \_\_\_\_/\_\_\_\_/\_\_\_\_, but was unable for the following reason:  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
PPA Employee Signature

\_\_\_\_\_  
Date



# Privacy Practices

**UNDERSTANDING YOUR HEALTH RECORD & INFORMATION:** Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

**YOUR HEALTH INFORMATION RIGHTS:** Unless otherwise required by law your health record is the physical property of the healthcare practitioner or facility that compiled it; the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information, and request amendments to your health record. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect, and obtain a copy of your health record. You may obtain an accounting of disclosures of your health information, request communications of your health information by alternative means or at alternative locations, revoke your authorization to use or disclose health information except to the extent that action has already been taken.

**OUR RESPONSIBILITIES:** This organization is required to maintain the privacy of your health information, and in addition, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. This organization must abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have provided. If we maintain a Web site that provides information about our customer services or benefits we will post our new notice on that Web site. We will not use or disclose your health information without your authorization, except as described in this notice.

## EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS

**We will use your health information for treatment.** For example: Information obtained by a healthcare practitioner will be recorded in your record and used to determine the course of treatment that should work best for you. By way of example, your physician will document in your record their expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations (example varies by practitioner type). We will also provide your other practitioners with copies of various reports that should assist them in treating you.

**We will use your health information for payment.** For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

**We will use your health information for regular health operations.** For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

**Business Associates:** There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we've asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

**Directory (inpatient settings):** Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

**Notification:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

**Communication with family:** Health professionals, using their best judgment, may disclose to a family member, other relatives, close personal friends or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

**Research (inpatient):** We may disclose information to researchers when an institutional review board, that has reviewed the research proposal and established protocols to ensure the privacy of your health information, has approved their research.

**Funeral directors:** We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

**Organ procurement organizations:** Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

**Marketing:** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Fund raising:** We may contact you as part of a fundraising effort.

**Food and Drug Administration (FDA):** As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

**Workers compensation:** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

**Public health:** As required by law, we may disclose your health information to public health or legal authorities charged with tracking births and deaths, as well as with preventing or controlling disease, injury, or disability.

**Correctional institution:** Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals. An inmate does not have the right to the Notice of Privacy Practices.

**Law enforcement:** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

**Notice of Privacy Practices availability:** This notice will be prominently posted in the office where registration occurs and patients will be provided with a hard copy.

**Effective Date:** This notice will be effective from April 14, 2003.

**Modification & Amendment:** This notice may be modified or amended by other documents, upon notification from your healthcare provider.

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

We believe that your health information is private to you. We make every effort to protect your information from unnecessary disclosure. Some of the characteristics of our practice include the following procedures:

We may use a sign-in sheet to facilitate patient visits.

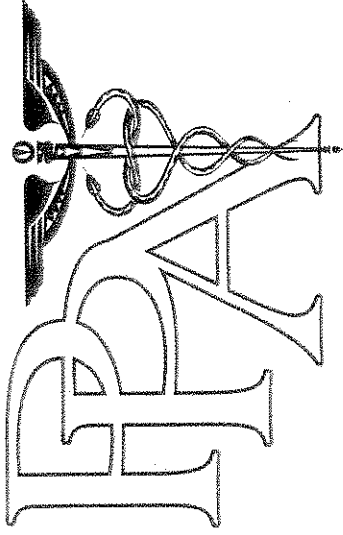
When legally appropriate, we shred information that may contain protected healthcare information.

We employ firewalls and passwords to protect your information from unauthorized individuals.

We educate our staff as to the importance of protecting health care information.

We require your written authorization prior to disclosing information to sources not defined in this document.

You may revoke your written authorization at any time by sending us a written request.



**FOR MORE INFORMATION OR TO REPORT A PROBLEM:** If you have questions or would like additional information, please contact the HIPAA Policy Officer for this practice. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

# Notice of Our Privacy Practices



## Potomac Physician Associates

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This educational publication is licensed and authorized by the Montgomery County Medical Society (Montgomery County, MD, <http://www.mcmesoc.org>) and is certified to be HIPAA compliant at the time of printing (March 2003).

**MCMES**  
Montgomery County Medical Society

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