Potomac Physician Associates, P.C.
10400 Connecticut Ave. Suite 606, Kensington, MD 20895 (301) 942-2212

Name:__________________________ ( ) Male ( ) Female Date:_________________
Birth Date:____________Work #___________Home# ____________ Cell#__________
Occupation: ______________________ Marital Status: ___________________________
Reason for today's visit: ____
Emergency Contact: _________________ Phone number: _____________________

PERSONAL HISTORY

Check if you have chronic medical problems for which you are currently being treated:

asthma _________________	diabetes ______________	mental retardation ____________
birth defects _____________	heart attack____________	anxiety _____________________
bleeding problem__________	heart disease___________	seizures ____________________
cancer __________________	high blood pressure_____	stroke ______________________
cystic fibrosis ____________	high cholesterol________	thyroid problems____________
depression_______________	other ___________________	

MEDICAL / SOCIAL Hx

MEDICATIONS	HABITS (please circle yes or no)
1. Non-Prescription (x any taken regularly) vitamins aspirin laxatives antacids decongestants Tylenol or Motrin Other:______________________________ 2. Prescriptions –(including birth control) Medication Dosage # times daily ___________________________________ ___________________________________ ___________________________________ ___________________________________ ___________________________________	Do You use Tobacco? YES NO What kind and how much? ___________ Do you drink alcohol? YES NO How much? _____________________ Do you use drugs? YES NO What types? ____________________________ Do you drink caffeinated beverages? YES NO Do you wear seat belts? YES NO Do you sleep well? YES NO Do you exercise regularly? YES NO Who else lives at home? ________________
IMMUNATIONS (X ANY RECEIVED) MMR HPV Hep B Meningitis Flu shot Pneumonia ___________ TB Skin test: Year: _____Pos: ___Neg:___ Tetanus Dates:_______________ ☐ Chicken Pox : Date: _______________	Have you ever experienced any of the following? marriage difficulties job difficulties sexual difficulties sexual abuse depression sleep difficulties emotional problems sexually transmitted disease_____________ ____________________________________
ALLERGIES (x any you are allergic to) No Known Allergies ☐ Aspirin ☐ Penicillin Codeine ☐ Sulfa Insect Bites ☐ Other Of the following check ones you are allergic to: Specify types (s)_____________________________	**WOMEN ONLY:** Date of last Pap smear:________________ Last Mammogram:__________ Pregnancies: ____________Deliveries:_______ Last menstrual cycle : ___________________ Last bone density test : _______________

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

List any hospital stays, including surgeries, starting with most recent.

DATE	REASON	HOSPITAL
1.		
2.		
3.		

Have you ever received any blood transfusions? O Yes O No

CONDITIONS

CHECK if you have NOW, or have EVER HAD any of the following conditions

unexpected weight changes, more than 10 lbs in the past year
serious problems with eyes or ears
persistent swollen glands/unusual lumps
breast lump (s) or unusual discharge
irregular or fast heartbeat
chest pain or tightness
frequent swelling of ankles or legs
unusual or severe shortness of breath
unusual skin problems or persistent sores
redness, severe pain or swelling of joints
frequent or severe back pain
other:______________________________
____
____

changes in appetite
difficulty swallowing
frequent or severe abdominal pain
frequent nausea or vomiting
blood in bowel movement
pain or burning with urination
loss of control of urination
genital problems
problems with pregnancy

FAMILY HISTORY

Check if there is anyone in your immediate family with a history of:
(Indicate relationship i.e., Mother, Father, Grandparent, Aunt, Sibling)

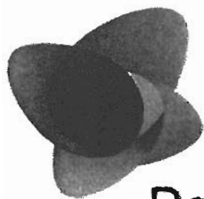
asthma ______________	diabetes ______________	mental retardation ______________
birth defects ______________	heart attack______________	anxiety ______________
bleeding problem______________	heart disease______________	seizures ______________
cancer ______________	high blood pressure______	stroke ______________
cystic fibrosis ______________	high cholesterol__________	thyroid problems______________
depression______________	other ______________	

Pharmacy Name: ______________________**Telephone #**________________________
Address:
____

What questions do you wish to ask the doctor? ______________________________
Do you wish to be an organ donor? YES NO
Do you have a living will? YES NO

____
Patient Signature Date

____
Physician Signature Date



Potomac
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KENSINGTON

PATIENT ACKNOWLEDGEMENT & CONSENT FORM

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.**

Patient's 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.

Patient's Signature Date

Print Full Name DOB

Joanna M. Delaney, D.O.
Rebecca M. Gross, M.D.
Bradley J. Hunter, D.O.
Uma Jayaraman, M.D.
Richard H. Pollen, M.D.
Steven M. Schwartz, M.D.
Asha Subramanian, M.D.
Janine Griffith PA-C
Nicole Koch, P.A.-C
Renee LaPointe, P.A.-C
Amanda V. Sultani, P.A.-C

Internal Medicine
Family Medicine
Endocrinology

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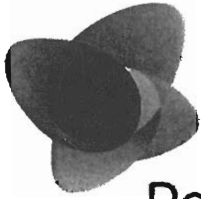

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PERSONAL REPRESENTATIVE, FAMILY OR OTHER ENTITIES AUTHORIZED ACCESS TO PROTECTED INFORMATION TO BE USED AND/OR DISCLOSE (OPTIONAL)

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 USPS MAIL, ANSWERING MACHINE AND/OR VOICEMAIL as well as Patient Portal

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, mobile phone, patient portal account, 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 **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 ______mobile number _____ Patient Portal____USPS Mail

____(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

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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:__________

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AUTHORIZATION FOR RELEASE OF INFORMATION

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 HEALTH CARE FINANCING ADMINISTRATION). A COPY OF THE AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

THIS AUTHORIZATION MAY BE REVOKED BY EITHER MY INSURANCE CARRIER OR ME AT ANY TIME IN WRITING.

X____ ____________________

SIGNATURE OF PATIENT, INSURED, OR BENEFICIARY DATE

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE PAYMENT OF ALL MEDICAL INSURANCE BENEFITS WHICH ARE PAYABLE TO ME UNDER THE TERMS OF MY INSURANCE POLICY TO BE PAID DIRECTLY TO THIS PHYSICIAN FOR SERVICES RENDERED. I FURTHER AUTHORIZE THE RELEASE OF ANY INFORMATION NEEDED FOR PROCESSING MY INSURANCE CLAIMS. A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT PAID BY MY INSURANCE COMPANY.

X____ ____________________

SIGNATURE OF PATIENT, INSURED, OR BENEFICIARY DATE

FINANCIAL AGREEMENT

I HEREBY ASSUME FINANCIAL RESPONSIBILITY FOR AND AGREE TO MAKE PAYMENT IN FULL TO **POTOMAC PHYSICIAN ASSOCIATES** FOR ALL CHARGES FOR SERVICES OR MEDICAL SUPPLIES FURNISHED THE ABOVE-NAMED PATIENT NOT OTHERWISE AUTHORIZED OR PAID BY MY INSURANCE CARRIER. PAYMENT IS TO BE MADE WITHIN 30 DAYS AS STATEMENTS ARE PRESENTED WITH SETTLEMENT IN FULL, OR PAYMENT ARRANGEMENTS TO BE MADE COMPLETE TO THE BEST OF MY KNOWLEDGE, AND FURTHER AUTHORIZE **POTOMAC PHYSICIAN ASSOCIATES** TO INVESTIGATE ANY AND ALL FINANCIAL INFORMATION GIVEN CONCERNING THIS OR RELATED CLAIMS.

X____ ____________________

SIGNATURE OF PATIENT, INSURED, OR BENEFICIARY DATE

COLLECTION FEES

SHOULD THE TREATING PHYSICIAN, REFER MY ACCOUNT TO A COLLECTION AGENCY AND/OR ATTORNEY FOR COLLECTION, I AGREE TO PAY ALL COLLECTION COSTS, INCLUDING BUT NOT LIMITED TO COURT COSTS AND ATTORNEY FEES OF 25 PERCENT OF MY BILL. I UNDERSTAND THAT ALL DELINQUENT ACCOUNTS SHALL BEAR INTEREST AT THE RATE OF 12 PERCENT PER ANNUM.

X____ ____________________

SIGNATURE OF PATIENT, INSURED, OR BENEFICIARY DATE

FOR MEDICARE PART B PATIENTS ONLY

I UNDERSTAND THAT IN CERTAIN CIRCUMSTANCES MEDICARE MAY DECIDE THAT APPROPRIATE MEDICAL SERVICES ARE NOT MEDICALLY REASONABLE OR NECESSARY UNDER THE MEDICARE LAW. SINCE MEDICARE MAY DENY PAYMENT FOR THESE SERVICES, I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT OF THESE CHARGES.

X____ ____________________

SIGNATURE OF PATIENT, INSURED, OR BENEFICIARY DATE

Patient name (print)________________________________ **Date of Birth:**____________________