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

Child's Name: _____Today's Date: _____
DOB: _____ Age: _____ Date of Last Physical Exam: _____
Current Medication: _____
Who else lives at home? _____
Reason for Today's Visit: _____

Allergies:

○ No Known Allergies ○ Animals ○ Insect Bites ○ Aspirin ○ Penicillin
○ Grass ○ Pollen ○ Codeine ○ Antibiotics ○ Sulfa
○ Foods
If you are allergic to foods or antibiotics please specify:
_____

Does your child have a history of severe allergies, wheezing, or eczema? Yes or No
If yes, what type of reaction does your child get? _____

Family History

X if there is anyone in your immediate family with a history of:
(Indicate relationship, i.e., Mother, Father, Grandparent, Aunt, Uncle, Sibling)
□ asthma _____ □ diabetes _____ □ mental retardation _____
□ birth defects _____ □ heart attack _____ □ psychiatric disorders ____
□ bleeding problem _____ □ heart disease _____ □ seizures _____
□ cancer _____ □ high blood pressure _____ □ thyroid problems _____
□ depression _____ □ kidney disease _____ □ hearing disorder _____
□ eczema _____ □ other: _____
□ inherited or genetic disease _____ □ high cholesterol _____ □ stroke _____

Pregnancy and Birth

Is this child yours by: Birth___ Adoption___ Stepchild___ Other___
Were their any problems with the pregnancy? Yes or No
If so, explain: _____
Was the pregnancy normal and full term? Yes or No
Was the baby delivered vaginally or by C-Section? _____
If C-Section, please explain why? _____
What was the baby's birth Weight? _____ Length: _____
Did the baby have any trouble in the hospital that necessitated an extended hospital stay?
If yes, please explain: _____

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

Infections, Illnesses, Miscellaneous Problems and Development:

Does you child have any medical conditions or history of frequent problems or infections? Yes or No

If so, what? _____

Has your child ever been hospitalized? Yes or No

If so, for what condition and when? _____

Has your child had any surgeries? Yes or No

If so, what procedure and when? _____

Has your child ever had a seizure, or loss of consciousness? Yes or No

List any major accidents: _____

Does your child speak in sentences? Yes or No

What age did your child: Sit alone: _____ Walk alone: _____ Start speaking: _____

Is your child toilet trained? Yes or No

Feeding and Digestive

Has your child had any unusual feeding problems? Yes or No

If yes, explain what and for how long? _____

Was your child breastfed? Yes or No

If so, for how long? _____

Is your child's appetite usually good? Yes or No

Does his or her diet exclude any foods? Yes or No

If so what foods? _____

Has constipation or diarrhea been a problem? Yes or No

Behavior

Does your child have any problems in school? Yes or No

Have behavior problems caused any concerns? Yes or No

If so, please explain: _____

Does your child get along well with other: Children___ Teachers ___ Adults ___

Immunizations, Medications, and Tests

To your knowledge, are your child's shots up to date? Yes or No

Do you have his/her shot record? Yes or No

Has your child had a skin test for Tuberculosis Yes or No

Date: _____ Results: positive or negative

Has your child had the chicken pox? Yes or No

If so, when? _____

Is you child currently on any medications? Yes or No

If so, please list: _____

Any other important information you would want the Doctor to know?

_____

_____

Signature Patient/Guardian _____ **Date:** _____

Potomac
Physician Associates

KENSINGTON

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Internal Medicine
Family Medicine
Endocrinology

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

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KENSINGTON

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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

10400
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Potomac
Physician Associates

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

Potomac Physician Associates must receive permission, from a child's parent or legal guardian, prior to Providing treatment(s) for preventative care, 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 Potomac Physician Associates, P.A. permission to assess and treat the aforementioned minor without an adult present. I also agree to be financially responsible for payment of all charges in connection with the care and treatment Rendered.

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 Potomac Physician Associates, P.A. permission to assess and treat the aforementioned minor in the presence of Either of the following adults (you may choose more than one), who is authorized to approve treatment:

Name: _____ Relation to minor _____

Name: _____ Relation to minor _____

I also agree to be 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 Potomac Physician Associates.

This authorization is valid for:

- ☐ This visit only (date of appointment): _____
- ☐ Until otherwise revoked

Please Note: Insurance card(s) and co-pay amounts (if applicable) must be presented at each visit.

Authorized by: _____ Date: _____

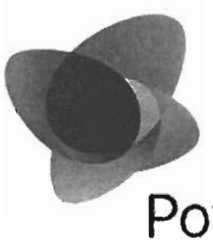
Parent or Legal Guardian

Emergency Contact Phone #1 _____

Emergency Contact Phone #2 _____

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.



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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:**_____