PLUMTREE FAMILY HEALTH

Your demographic information is crucial to our ability to notify you concerning your medical care.
Please complete this form in its entirety.

Office Policies:

1. *Any Co-pay not collected at the time of service will be assessed a $10.00 service fee.*
2. *Patients who no show for scheduled appointments will be assessed a $25.00 service fee (History & Physicals are $50.00)*

PATIENT INFORMATION

Name:
Last First MI

Address: City: St: Zip:

Phone Numbers:
Home: Work: Cell:

Birthdate (mm/dd/yyyy) | **Social Security Number**

Marital Status: ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Other

Sex: ❒ Male ❒ Female
*Certain tests are adjusted for this information.
Race: **Ethnicity:**

E-MAIL ADDRESS:

Preferred form of contact:

❒ Home # ❒ Cell # ❒ Text Cell # ❒ E-Mail

INSURANCE INFORMATION

PRIMARY INSURANCE NAME/TYPE (example: Blue Cross, Coventry, etc.):

Subscriber Name:
Last First MI

Insurance ID #	**Subscriber's Birthdate:**	**Relationship to Patient :**	Sex of Subscriber: ❒ Male ❒ Female

SECONDARY INSURANCE NAME:

Subscriber Name:
Last First MI

Insurance ID #	Subscriber's Birthdate:	Relationship to Patient :	Sex of Subscriber: ❒ Male ❒ Female

Name of Pharmacy:	**Location:**	**Phone#:**

PATIENT EMPLOYMENT OR SCHOOL INFORMATION

Employer Name:	Occupation::

Student: ❒ Yes ❒ No	School Name:	

EMERGENCY INFORMATION- You may list more then one. Please add additional information on the back of the form.

Name:	Relationship to Patient:

Home: ( )	Alternate Phone: Please specify (cell, work, etc.) ( )

RELEASE OF BENEFITS AND INFORMATION

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I certify that the above information is true and correct to the best of my knowledge. I will notify your office of any and all changes to the above information. I authorize Plumtree Family Health Center to release any information required to process my claims with my insurance company.

Signature:	Date:

Parent (if minor):	Date:

Plumtree Family Health Center

Patient Name: _____Date of Birth: _____

FINANCIAL AGREEMENT

I acknowledge and agree that co-payments are due at the time of treatment. I acknowledge that I need to bring my insurance card for every visit. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges. Plumtree Family Health Center, LLC reserves the right to review, change and/or modify the terms of the financial policy at its discretion. I have received a copy of the financial policy and I agree to all terms including fees for missed appointments.

Please acknowledge receipt and review of this notice by signing initials. **X** _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s) have insurance coverage and assign directly to Plumtree Family Health Center, LLC all insurance benefits, if any, otherwise payable to me for services rendered by these physicians in person or under their supervision. I understand that I am financially responsible for all charges whether or not paid by insurance. It is the patient's responsibility to question their insurance carrier regarding benefits and coverage or lack thereof for specific services. Plumtree Family Health Center, LLC may use my health care information and may disclose such information to my insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. A photocopy of these assignments shall be valid as the original.

Please acknowledge receipt and review of this section by signing initials. **X** _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE TO PATIENTS

Plumtree Family Center, LLC is required by law to maintain the privacy of protected health information, and to provide patients with this notice of its duties and practices as well as changes to those practices. The Privacy Notice to Patients describes how medical information about you may be used and disclosed and how you can get access to this information. I understand that I have the right to refuse to sign this acknowledgement and that I have the right to revoke, in writing, and consent that I provide for access to my and/or my minor/child's record or to the patient for whom I have legal responsibility of.

Also, we have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

Please acknowledge receipt and review of this section by signing initials. **X** _____

CONSENT FOR TREATMENT

I AUTHORIZE Plumtree Family Health Center, LLC to provide me with medical care and treatment.

Please acknowledge receipt and review of this section by signing initials. **X** _____

CONSENT FOR PDMP SEARCH

I AUTHORIZE Plumtree Family Health Center, LLC to access my prescription history to provide medical care and treatment.

Please acknowledge receipt and review of this section by signing initials. **X** _____

By Signing below I have read and agree to the term of this entire agreement.

Patient Signature\Guardian: _____

Relationship to Patient: _____

Date: _____

104 Plumtree Road, Suite 102, Bel Air, Maryland 21015 Phone 410-569-4224 Fax 410-569-4368
www.PlumtreeFamily.com

Plumtree Family Health Center

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

Protected Health Information (PHI) Release

Please read carefully and print legibly.

****Complete all THREE sections and sign the bottom.****

Please select how you authorize Plumtree Family Health Center to share important PHI with you.

Home Telephone _____

☐ I give PFHC permission to leave a message on my home phone with detailed PHI

Work Telephone _____

☐ I give PFHC permission to leave a message on my work phone with detailed PHI

Cell Phone _____

☐ I give PFHC permission to leave a message on my cell phone with detailed PHI

Written\Electronic Communication

☐ I give PFHC permission to mail detailed PHI to my home address.

☐ I give PFHC permission to send detailed PHI through my e-mail address; provided below.

_____

I authorize Plumtree Family Health Center to release my Protected Health Information to the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

OR ☐ I do not want any information released regarding my healthcare at PFHC.

Emergency Contacts:

1) Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

2) Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Patient Signature: _____ **Date:** _____

This form should be updated on an annual basis. Please contact our office with changes prior to annual review.

104 Plumtree Road, Suite 102, Bel Air, Maryland 21015 Phone 410-569-4224 Fax 410-569-4368
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