CalvertHealth™
Medical Group

Consent to Care and Treatment

Patient Name: _____ DOB: _____

As a patient, you have the right to be informed about the state of your health and any recommended medical, diagnostic or surgical procedure that will be used in the course of your care at this practice so that you may make informed decisions as to whether or not to undergo any recommended treatment.

If you have been a patient of this practice prior to signing this consent, any medical conditions and/or treatment plans have already been discussed with you and you consent to the ongoing care and treatment that has been defined.

If you are a new patient with this practice, no specific treatment plan has yet been recommended.

This consent form gives us your permission to examine you and perform the evaluations necessary to evaluate your health and identify any conditions that may be affecting it. It also gives us your consent to recommend appropriate treatment for any conditions identified during the course of your care and treatment.

By signing this consent, you are giving us your permission to perform reasonable and necessary medical examinations and testing in order to assess your health and recommend treatment. You authorize this practice, your assigned physician and/or advanced practice clinician (Nurse Practitioner or Physician Assistant), and any employee working under the direction of the physician or other advanced practice clinician, to provide medical care to you. This medical care may include services and supplies related to your health and may include but not limited to preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the prescribing of drugs, devices, equipment or other items required to diagnose and treat a medical condition. This consent includes contact and discussion with other health care professionals who may be consulted regarding your care and treatment.

You are also indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain fully effective until it is revoked in writing.

You have the right at any time to discontinue services. You have the right to discuss the purpose, potential risks and benefits of any test ordered for you in the course of your treatment plan with your physician or health care provider. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

If additional testing, invasive or interventional procedures are recommended, you will be asked to read and sign additional consent forms specific to the test(s) or procedure(s) to be performed.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Name (please print) Date of Birth

_____ _____

Patient Signature (or Guardian if signing for another person) Date

_____ _____

Name of Guardian Relationship to Patient

_____ _____

Witness Witness Name (please print)

CalvertHealth™
Medical Group

Patient Privacy Policy
Effective Date: January 1, 2017

The Right to Obtain a Copy of this Notice. You have the right to a paper copy of this notice at any time. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please ask at registration or contact our Privacy Officer at the address or phone number located at the end of this document. You may obtain a copy of this notice at our website, www.CalvertHealthMedicalGroup.org.

Your Rights Regarding Your Protected Health Information. We are required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the Notice currently in effect. We reserve the right to change our privacy practices and this notice. We reserve the right to make the revised or changed notice effective for your PHI we already have as well as any information we receive in the future. We will post a copy of the current notice. The notice will always contain on the first page, the effective date of the Privacy Notice.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with us and the Secretary of the Department of Health and Human Services. All complaints must be in writing and sent to the address provided at the end of this notice. You will not be penalized for filing a complaint.

Contact Information
If you require further information about this Notice, have privacy issues or believe that your privacy rights have been violated, please contact:

CalvertHealth Medical Group
Attn: Privacy Officer
100 Hospital Road
Prince Frederick, MD 20678

Effective Date
This Notice is effective January 1, 2017.

By signing this document, I acknowledge that I have read and understood this Privacy Notice and that a copy of CalvertHealth Medical Group' Privacy Notice was offered to me.

Patient Signature	Date
Print Name	DOB

CalvertHealth™
Medical Group

Patient Financial Policy

Patient Name: _____ DOB: _____

Thank you for choosing CalvertHealth Medical Group (CHMG) as your health care provider. We are committed to building a successful provider-patient relationship with you and your family. Please understand that payment of your bill is part of your care. This Patient Financial Policy is intended to help avoid misunderstandings by detailing your financial obligations.

Insurance: Knowing your insurance benefit plan is your responsibility. It is your responsibility to make sure that our providers participate in your insurance company's plan and that the correct in-network facility is used for all test and hospital encounters. Please contact your insurance company with any questions you may have regarding your coverage.

We participate in most insurance plans, including Medicare. If you are not insured by a plan we accept, or if you choose to submit your claim yourself, payment in full is expected at each visit. We will provide you with appropriate documentation so that you can submit a claim to your insurance company.

If we do participate in your plan, but you do not have a **current insurance card** or the **designated primary care provider** is not a CHMG provider, payment is required in full for each visit until we verify coverage. Alternatively, if we do not participate in your insurance plan and you choose to see our providers, or if you do not have insurance and choose to see our providers, you will be considered 'self-pay' subject to the terms defined later in this document.

Proof of Insurance: If you have insurance and we submit claims on your behalf, we require a copy of your driver's license or other government issued photo ID and your current insurance card. This information must be provided prior to seeing a provider (physician, nurse practitioner or physician assistant).

Claims Submission: Your insurance benefit is a contract between you and your insurance company, and the charges for any services provided are your responsibility. We will submit claims to your insurance (primary and secondary or supplemental) company on your behalf. In order to submit claims we require the patient's name, address and date of birth, as well as the policyholder's name, address and date of birth. This information must match exactly what your insurance company has on file for you, including exact name, address and policy number. Any missing or incorrect information provided may result in claims being denied or reimbursement being delayed, in which case you will become responsible for the full amount of the services provided.

Coverage Changes: Please notify us before your scheduled appointment if any of your insurance information has changed. This includes changes of employer, insurance provider, address, policy number, covered dependents, etc. Not having up-to-date information may result in claims being denied or delays in reimbursement in which case you will become responsible for the full amount of the services provided.

Co-Payments: If your insurance company requires co-payments, those co-payments must be paid at the time of service. We collect co-pays at the point of appointment check in, not when you check out.

Deductibles and Out-Of-Pocket Expenses: We will bill you for any outstanding balance once your insurance company has processed your claim and made payment to us. This balance may include your contracted deductible or other out-of-pocket expense as determined by your insurance policy. Payment for outstanding balances is expected within 30 days of the statement date.

Referrals: It is your responsibility to obtain any necessary referrals from your primary care provider prior to receiving treatment. Patients who elect to receive service without a proper referral will be required to sign a waiver and will be expected to pay for the service prior to treatment.

Payment: We accept payment by cash, debit card, check, VISA, MasterCard, Discover and American Express. All outstanding balances must be paid at time of service unless prior arrangement has been made with the CHMG billing office As a convenience to our patients, all CHMG practices are able to collect payments for all other CHMG practices.

Returned Check Fee: We charge a $25.00 fee for returned checks. If a second check is returned, in addition to the returned check fee, you will be asked to pay by cash, money order, cashiers' check or credit card for future visits.

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Patient Financial Policy

Patient Name: _____ DOB: _____

Self-Pay: A Self-Pay patient is any patient who: does not have health insurance; chooses to submit their own claims, see a CHMG provider who does not participate in their health insurance plan, receive a service that requires a referral from their insurance company or primary care provider when they do not have the referral with them or receive a treatment they know is not covered by their insurance company. Self-pay patients will be charged a discounted fee for the services provided (please see comments and exceptions regarding physicals in the section below). Additional discounts may apply, and the patient may qualify for special consideration such as sliding scale; please see the receptionist for information regarding any available discount programs.

Sliding Scale: If you do not have insurance, you may be eligible for a reduction in fees for healthcare services based on your income. Please ask the receptionist for an application for Sliding Scale or contact our billing office to discuss eligibility requirements.

Non-Payment: If your account becomes delinquent, you agree to pay any charges that CHMG incurs to collect your unpaid bills, including but not limited to reasonable court costs and collection agency fees. Your account will be considered delinquent when it is 60 days past due. If your account becomes delinquent, you will receive a letter stating that you have 14 days to bring it current by paying the entire outstanding amount unless you contact us to make other payment arrangements. Other payment arrangements may include establishing a payment plan with us that results in full payment of the outstanding balance being made within six (6) months from the time when the account becomes delinquent.

Please be aware that if a balance remains unpaid, we may refer your account to a collection agency or a collection attorney. You understand and agree that, should your account be forwarded to a collection agency or attorney, you will pay a collection fee of 35% of the balance plus a processing fee of $25.00 in addition to the outstanding balance being collected. If the filing of a lawsuit is required to collect your outstanding balance, the collection fee will be 50% of the cost to collect the debt in addition to the amount of the outstanding balance plus any other applicable fees.

In the event of non-payment, CalvertHealth Medical Group may use an outside agency to verify yours and/or your spouse's employment and credit history in order to assess your ability to pay and offer you other payment solutions such as sliding scale

Minor Patients: Any adult (parent or guardian) accompanying a minor child to their appointment is responsible for payment for all services rendered to the minor child at the time of the appointment.

Physicals: Department of Transportation (DOT), 500, sports, camp and work physicals are not covered by many insurance companies. Payment for these services is expected at the time of service.

Form Completion: Your provider (physician, nurse practitioner or physician assistant) is available to complete medical forms or certifications that you may require. If you require a form to be completed during a visit that is not related to the stated purpose for the visit, a separate fee of $25.00 will be charged. For example, if you come in for a well-child visit and request a sports physical certificate to be completed, completion of the certificate is subject to the $25.00 fee.

Missed Appointments/Missed Procedures: Our policy is to charge patients for missed appointments and procedures that are not cancelled at least 24 hours prior to the scheduled appointment or procedure. Please refer to the No-Show/Late Cancellation Fee Policy that is included in our New Patient Packet and is required to be reviewed and agreed by all patients at least annually for details of the fees that will be charged.

Personal Injury Claims: CHMG does not respond to or accept Letters of Protection from attorneys for automobile accident injuries. CHMG does not have contractual agreements with auto insurance companies or Personal Injury Protection companies and therefore cannot submit claims to such companies for reimbursement or take co-pays. Patients who seek treatment for an injury resulting from an automobile accident are considered 'self-pay' and payment is expected at the time of service, subject to any self-pay discounts that may be available. If the patient has health insurance and plans to have their treatment covered by that insurance company, we will submit claims to their health insurance and collect co-pays as required by that company.

Account Consultation: Providers (physicians, nurse practitioners, physician assistants) are not trained to discuss financial issues with patients. Only CHMGs billing staff is trained to discuss your account, including charges, fees, payments and payment arrangements. If you have questions about any of the financial issues related to your account, please contact the **billing office at 410-414-4555**.

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Patient Financial Policy

Patient Name: _____ DOB: _____

Refunds: Occasionally, an insurance payment results in overpayment on your account. Any overpayment from an insurance claim will be refunded by check to the insurance company as soon as it is identified. Overpayments that are owed to the patient (i.e. from an overpayment of a co-pay) will be refunded to the patient by check provided there is no other outstanding balance on the patient's account. Over payments to an insurance company will not be refunded to the patient.

Worker's Compensation: It is your responsibility to file a Worker's Compensation report with your employer and to provide our office with verification that the report has been filed with the Worker's Compensation carrier and a claim number assigned. In order to file a claim on your behalf with your Worker's Compensation carrier, we require the following information for each claim submitted on each date of service: state where injury occurred (i.e. Maryland); date of injury; exact location on the body where the injury occurred and that is covered by the claim (i.e. left wrist); name, address and phone number of insurance carrier; insurance carrier's claim number; claim adjuster name and contact information.

It is your responsibility to obtain proper authorization from your Worker's Compensation insurance carrier prior to each visit. If we are unable to verify authorization prior to your visit, you will be required to reschedule your appointment until such time as authorization is verified. Any visit related to a Worker's Compensation claim will be limited to treatment of the body part for which the claim is filed.

We will file insurance claims on your behalf with your Worker's Compensation insurance carrier for services provided for the treatment of the related injury until such time as we receive confirmation from the carrier that the case is closed. If your Worker's Compensation claim is denied and you have health insurance, we will collect co-pays and submit claims to your health insurance company. If the claim is denied and you do not have health insurance, the charges will become your responsibility.

CHMG Billing Contact Information:

Physical Address
CHMG Billing Office
100 Harrow Lane, Suite 101
Prince Frederick, MD 20678
Billing Phone Number: 410-414-4555

Mailing Address
CHMG Billing Department
P.O. Box 405962
Atlanta, GA 30384-5692

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our financial and payment policy.

My signature below certifies that I have read, understand and agree to the terms of this Patient Financial Policy.

Patient Signature: _____ Today's Date: _____

CalvertHealth™
Medical Group

No-Show and Late Cancellation/Reschedule Policy

Patient Name: _____ DOB: _____

Thank you for choosing CHMG as your health care provider. We are committed to building a successful provider-patient relationship with you and your family. We understand there are times when you must miss a scheduled appointment or cannot cancel or reschedule in a timely manner; however, when you do not call to cancel a scheduled appointment at least 24 hour prior to the appointment or miss a scheduled appointment without notice, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise when another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

To help avoid misunderstandings, we are providing you with our No Show and Late Cancellation/Reschedule Policy. For purposes of this policy, a late cancellation is when a patient cancels or reschedules a scheduled appointment but provides less than 24 hours' notice. Late cancellations will be treated as a 'no-show' per CHMG policy.

The following policies will apply to 'no-shows' and late cancellations/reschedules, combined, on a rolling 12 month period.

'No-Shows' and late cancellations/reschedules for Office Visits:

- First offense will prompt a warning letter to the patient regarding their no-show or late cancellation/ reschedule occurrence and a notation will be made in the patient's chart.
- Second offense will prompt a phone call from the practice manager to the patient, a 2nd warning letter will be sent to the patient, and the patient will be charged a $25 'no-show' or late cancellation/reschedule fee. The practice manager will print a copy of the signed No-Show and Late Cancellation/Reschedule Policy along with the $25 fee ticket and warning letter, and mail all 3 documents to the patient.
- Third offense will prompt the patient to be discharged from the practice.

'No-Shows' or late cancellations/reschedules for Procedure:

- Patient will automatically be charged a $50 'no-show' or late cancellation/reschedule fee. The practice manager will print a copy of the signed No-Show and Late Cancellation/Reschedule Policy along with the fee ticket, and mail to the patient.

Additional Information:

The No-Show and Late Cancellation/Reschedule Policy is not provider specific but applies across all CHMG practices, such that a no-show or late cancellation/reschedule at one provider will affect the patient's ability to schedule appointments with another CHMG provider. **For a listing of affected providers and practices, please go to CalvertHealthMedicalGroup.org.**

All applicable no-show and late cancellation/reschedule fees must be paid prior to scheduling future appointments with any CHMG provider.

My signature below certifies that I have read, understand and agree to the terms of the No Show and Late Cancellation/Reschedule Policy.

Patient Signature: _____ Today's Date:_____

CalvertHealth™
Medical Group

Patient Portal Access

The CalvertHealth Medical Group Patient Portal is a key component of managing your health. The Patient Portal is a secure, online tool that lets you communicate with your healthcare team and manage your health information.

Using the Portal, you can:

- Review lab results;
- Review your medical history;
- Request medication refills;
- Request appointments;
- Request Referrals;
- Pay your CHMG bill;
- Send your provider or practice questions.

THE PATIENT PORTAL IS THE PRIMARY METHOD CHMG AND YOUR PROVIDER USE TO SHARE IMPORTANT INFORMATION WITH YOU!

We will send you secure communications through the portal to:

- Remind you of upcoming appointments
- Notify you of new providers
- Notify you of departing providers
- Notify you of changes to office opening and closing times (i.e. for inclement weather)

We no longer send notifications by regular mail. All communications will be by portal message, text message or telephone.

Patients who do not sign up for and activate their Patient Portal access will miss out on key communications and not be able to take advantage of this secure, online, 24/7 access to your medical records, medication refills, lab results, and provider communications.

When you check in for your appointment, we will ask for your email address and give you a token that you will use to activate your access. You will have 30 days from the date you receive it to go online to nextmd.com to enter the token and activate your access.

WE ENCOURAGE YOU TO ACTIVATE YOUR PORTAL ACCESS AS SOON AS YOU GET HOME.

Once you have activated your portal access, you can click on 'My Chart' then 'Request Health Records' to start downloading your medical records into your portal.

The Patient Portal is a convenient, secure way to communicate with your provider, manage your medications and monitor your health records. Please sign up and activate your portal access today.

CalvertHealth™
Medical Group

Medical Information Release Authorization – Person(s)

Date: _____

Patient Name: _____ DOB: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Preferred Phone: Home Work Cell

Primary Care Provider: _____ Phone: _____

Referring Provider: _____ Phone: _____

I give the following person/people permission to have access to all of my medical information that pertains to the following provider: _____.

	Name	DOB	Relationship to Patient	Phone Number
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

This form does not authorize the release of Medical Records to the individuals listed; please complete the Authorization for the Release of Health Information (Medical Records) form for the release of records.

This authorization to release will expire one (1) year from the date signed unless an earlier date is specified:

_____

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

_____
Witness Name (Please Print)

Please give this form to the Provider's office or FAX it to the office at: _____.

CalvertHealth™
Medical Group

Patient Ethnicity and Race Form

Patients Name: _____ Date of Birth: _____ MRN: _____

The State of Maryland is requesting CalvertHealth Medical Group inquire about the ethnicity and race for each patient in order to be in compliance with the Patient Centered Medical Home. **Patient is not required to complete this form. If this form is not complete, the staff will input "Not Specified".**

Question 1. Ethnicity
Are you Hispanic or Latino?
(A patient of Cuban, Mexican, Puerto Rican, South or Central America, or other Spanish culture of origin, regardless of race.)

☐ Yes ☐ No ☐ Unknown/Not Specifying

Question 2. Please select the racial category with which you most closely identify by placing an 'X' in the appropriate box.

RACIAL CATEGORY	DEFINITION OF CATEGORY
☐ American Indian or Alaska Native	A patient having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
☐ Asian	A patient having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
☐ Black or African American	A patient having origins in any of the black racial groups of Africa.
☐ Native Hawaiian or Other Pacific Islander	A patient having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
☐ White	A patient having origins in any of the original peoples of Europe, the Middle East or North Africa.
☐ Multi-Racial	A patient having origins of more than one Racial Category identified above.
☐ Unknown/Not Specifying	A patient whose race is unknown OR a patient who does not wish to supply race information.

Information obtained from the Office of Management and Budget.

CalvertHealth™
Medical Group

Hematology & Oncology
Adult Health Questionnaire

Name: _____ DOB: _____ Age: _____ Sex: ☐ M ☐ F

Thank you for taking the time to complete this form. Having a thorough medical history is an important step in our being able to provide you good service and help you achieve good health.

Today's Date: _____

Preferred Pharmacy: _____

Reason for today's visit: _____

CURRENT MEDICATIONS (You may bring your own list to your appointment if you prefer.)

Name of Medication	Strength of Medication	Dosing Instructions
Example: Tylenol	Example: 500Mg	Example: 1 pill three times a day

* Note: this information may be taken directly from the pharmacy label on prescription products.

ALLERGIES

☐ No known allergies	☐ Medication Allergies	☐ Environmental/Seasonal Allergies	☐ Latex Allergy

List Allergies	Reaction

PAST MEDICAL HISTORY (Check all that apply)

☐ Acid Reflux/GERD	☐ Asthma	☐ Epilepsy/Seizure Disorder	☐ Irritable Bowel
☐ ADHD	☐ Bleeding Disorders	☐ Glaucoma/Cataracts	☐ Kidney Disease
☐ Alcoholism	☐ Cancer	☐ Headaches	☐ Liver Disease
☐ Allergies	☐ Chronic Pain	☐ Hearing Loss	☐ Memory Loss
☐ Anemia	☐ Depression	☐ Heart Disease	☐ Osteoporosis
☐ Anxiety	☐ Diabetes	☐ High Blood Pressure	☐ Stroke
☐ Arthritis	☐ Emphysema/COPD	☐ High Cholesterol	☐ Thyroid Disease

☐ Other (Please list):_____

PAST SURGICAL HISTORY

Type of Surgery (operation)	Date

CalvertHealth™
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Hematology & Oncology
Adult Health Questionnaire

Patient Name: _____ Date of Birth: _____

FAMILY HISTORY (Check all that apply and indicate which family member)

☐ Asthma _____ ☐ Heart Disease _____
☐ Cancer (specify) _____ ☐ High Blood Pressure _____
☐ Dementia/Alzheimer's _____ ☐ High Cholesterol _____
☐ Depression _____ ☐ Stroke _____
☐ Diabetes _____ ☐ Thyroid Disease _____
☐ Emphysema/COPD _____

SOCIAL HISTORY

Tobacco

Have you ever smoked? ☐ Yes ☐ No If yes, what do you (did you) smoke? _____

Are you still smoking? ☐ Yes ☐ No

If no: How many years ago did you quit? _____ If yes: How many years have you smoked? _____
For how many years did you smoke? _____ How many packs per day do you smoke? _____
How many packs per day did you smoke? _____ Have you ever tried to quit? _____

Alcohol

☐ Do you drink alcohol, including beer, wine or hard liquor? ☐ Yes ☐ No

If yes: ☐ Daily ☐ Almost Daily (4-6 times per week) ☐ 1 – 3 times per week ☐ Less than one time per week

Do you drink caffeine? ☐ Yes ☐ No ☐ If yes, how many cups per day? _____

Illicit Drugs

Do you use any drugs or prescription medications not prescribed to you? ☐ Yes ☐ No
(Including marijuana, cocaine, amphetamines, pain or anxiety medications, etc.)

If yes, please specify type of drug and frequency of use: _____

Health Planning

Do you have Advanced Directives in place? ☐ Yes ☐ No

If no, would you like your healthcare Provider to discuss one with you? ☐ Yes ☐ No

If yes, would you like us to include it in your electronic health record? ☐ Yes ☐ No

CalvertHealth™
Medical Group

Hematology & Oncology
Adult Health Questionnaire

Patient Name: _____ Date of Birth: _____

HEALTH MAINTENANCE

All Patients:

Last Tetanus Booster	☐ Within past 10 years	☐ More than 10 years ago		☐ Unknown
Last Eye Examination	Date: _____	☐ Normal	☐ Abnormal	☐ Unknown
Last Hearing Test	Date: _____	☐ Normal	☐ Abnormal	☐ Unknown
Last sigmoidoscopy/colonoscopy or stool test	Date: _____	☐ Normal	☐ Abnormal	☐ Unknown
Last DEXA Bone Scan	Date: _____	☐ Normal	☐ Abnormal	☐ Unknown
Last pneumonia vaccine	Date: _____			
Flu shot this season?	☐ Yes ☐ No	Date: _____		

Women:

Last Pap Smear	Date: _____	☐ Normal	☐ Abnormal	☐ Unknown
Last Mammogram	Date: _____	☐ Normal	☐ Abnormal	☐ Unknown
Perform regular breast exam?	☐ Yes ☐ No			
Last Menstrual Period	Date: _____			
Menopausal	☐ Yes ☐ No	If yes, at what age? _____		

Men:

Last Prostate Specific Antigen – PSA	Date: _____	☐ Normal	☐ Abnormal	☐ Unknown
Last Prostate Exam	Date: _____	☐ Normal	☐ Abnormal	☐ Unknown
Perform regular testicular exams?	☐ Yes ☐ No			

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship: _____ Phone: _____

CONCERNS: Please indicate any concerns regarding your health in the space provided:

_____

_____

_