CalvertHealth™
Medical Group

Plastic & Reconstructive Surgery
New Patient Information

As of ________________
Today's Date

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

Patient Name ________________________________ SSN # ________________

Address ____

DOB ____________ Age: __________ ☐ Male ☐ Female Marital Status: ____________

Home Phone ________________ Referring Doctor/Person ____________________

Work Phone ________________ Primary Doctor ____________________

Cell Phone ________________ Email Address ____________________

Emergency Contact ____________________ Relationship to Patient ____________

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Patient's Employer/School ____________________ Occupation ________________

Address ____

Primary Health Insurance Company ________________________________

Insured's Name ________________ DOB __________ Employer ____________

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other ________________

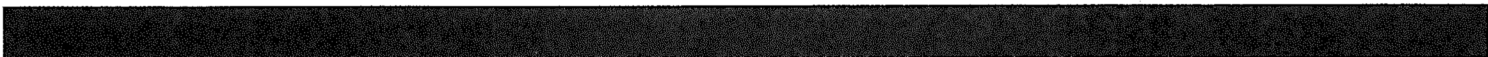
Secondary Health Insurance Company ________________________________

Insured's Name ________________ DOB __________ Employer ____________

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other ________________

Photography Policy: I hereby authorize the doctor and his associates to take pre-operative, intra-operative and post-operative photographs of the area being treated, if needed for use in my treatment. I authorize the photographs to be sent to my health insurance company to approve treatment and/or payment for rendered services as necessary. I understand and agree that my photographs may be shown to future patients in order to illustrate surgical results. If the photographs include any distinguishing marks as indicated by me the photographs will not be shown to future patients without my written approval. I authorize the doctor and his associates to send the photographs to my primary and other physicians involved in my treatment. I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of the photographs or my interview. I further understand that neither I nor anyone accompanying me, may record, video tape or take any photographs during my visit and/or procedure. I understand I may get a copy of the photographs upon signing a medical release and paying a fee for each copy. I understand photographs will not be loaded to the internet or used in any advertising unless I provide my written approval.

________________________ ________________ ____________
Signature of Patient or Responsible Party | Relation to Patient | Date



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 Signature (or Guardian if signing for another person) Date

________________________ ________________________
Name of Guardian Relationship to Patient

________________________ ________________________
Witness Witness Name (please print)

CalvertHealth™
Medical Group

Plastic & Reconstructive Surgery
Medical History Information

As of ________________
Today's Date

Patient Name ______________________________ Height ____________ Weight ____________

What is the reason for your visit today ____
Is the reason related to an accident? ☐ No ☐ Yes If yes, please explain and provide date of accident
____

Please list all medications you are taking, including dosage and any vitamins, herbals, non-prescriptions

Medication Name	Dosage	Times per day

Are you allergic to any drugs? ☐ No ☐ Yes If yes, please list all drugs you are allergic to __________
____

Do you drink alcohol? ☐ Daily ☐ Socially ☐ Never
Do you currently use illegal drugs? ☐ No ☐ Yes
Do you currently use any type of tobacco/nicotine? ☐ No ☐ Yes ☐ In the Past-Quit Date __________
If Yes, what type ☐ cigarettes ☐ e-cigarettes ☐ Chewing Tobacco ☐ Gum ☐ Vape ☐ Juul ☐ Patch

Please list any surgeries you have had and the date

Surgery	Date	Notes

Have you ever experienced bleeding problems after surgery? ☐ No ☐ Yes Explain ______________
Have you ever experienced problems with anesthesia? ☐ No ☐ Yes Explain ______________

Check any condition below that you have ever been diagnosed with

- ☐ AIDS or HIV+
- ☐ Abdominal Bleeding
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Artificial Joints
- ☐ Arthritis
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Breast Cancer
- ☐ Bronchitis
- ☐ Cataracts
- ☐ Chest Pain
- ☐ Convulsions
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Gastric Reflux
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Valve Prolapse
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Herpes
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Melanoma
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Pacemaker
- ☐ Paralysis
- ☐ Pneumonia
- ☐ Prostate Problem
- ☐ Psychiatric Disorder
- ☐ Pulmonary Embolism
- ☐ Rheumatic Fever
- ☐ Seizures/Epilepsy
- ☐ Skin Cancer
- ☐ Skin Disease
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Other

Have any of your blood relatives ever had any of the following?

	Relation to Patient		Relation to Patient
☐ Anesthesia Problems		☐ High Blood Pressure	
☐ Autoimmune Disorder		☐ Hemophilia	
☐ Bleeding Disorder		☐ Kidney Disease	
☐ Blood Clots/PE/DVT		☐ Liver Disease	
☐ Breast Cancer		☐ Lung Disease	
☐ Cancer		☐ Malignant Hyperthermia	
☐ Depression		☐ Melanoma	
☐ Diabetes		☐ Skin Cancer	
☐ Heart Disease		☐ Stroke	

Do you exercise? ☐ No ☐ Yes Amount per week? ____________________

Do you have any of the following now or have you had any of the following in the past year?

	Yes	No		Yes	No
Chest Pain			Currently Pregnant		
Fainting			Burning During Urination		
Fever or Chills			Yeast Infection		
Nausea, Vomiting, Diarrhea			Bleed Easily		
Unexpected Weight Loss or Gain			Blood Clots		
Cold Sores			Blood Transfusion		
Chronic Chough			Breast Mass/Discharge		
Ear Pain			Swollen Lymph Gland		
Hearing Loss			Changing Skin Lesion		
Runny Nose/Sore Throat			Back Pain		
Sinus Disorder			Joint/Muscle Pain		
Excessive Thirst/Hunger			Limited Motion in Joints		
Frequent Urination			Muscle Weakness		
Abdominal Pain			Numbness or Tingling		
Gastro-Intestinal Problems			Headache		
Bladder Problems			Shortness of Breath		
Currently Breast Feeding			Wheezing		

INFORMED RISK OF TOBACCO/NICOTINE AND WOUND HEALING

This informed risk statement is to ensure that you understand that the use of tobacco/nicotine can inhibit wound healing, contribute to scars, skin necrosis (wound break down), cancer and is not limited to just these complications and risks. Please inform Dr. Ehrmantraut if you use and/or have used tobacco/nicotine. You are advised to discontinue the use of tobacco/nicotine. If you are scheduled for a surgery, you **MUST** stop all forms of tobacco/nicotine four (4) weeks prior to your surgery, and not use it for at least four (4) weeks after your surgery. This means complete abstinence from all forms of tobacco/nicotine, including gum, the patch, e-cigarettes, etc. If you need assistance, you are advised to contact your family physician, CalvertHealth Medical Center or the Calvert County Health Department for a smoking cessation program. If you currently use tobacco/nicotine, you will be given an order to undergo urine nicotine testing which you must perform two weeks prior to your scheduled surgery date. If the results of your urine nicotine test show an unacceptable level of nicotine in your system, your surgery will be canceled. If you need emergency surgery please discuss this with Dr. Ehrmantraut.

I have read the above information and understand the risks associated with tobacco/nicotine use, that there are many complications that can result due to the use tobacco/nicotine. I understand that I am responsible to seek a smoking cessation program. If I am schedule for surgery, I agree to stop the use of tobacco/nicotine four (4) weeks prior to my surgery and not use tobacco/nicotine for at least (4) weeks after my surgery. I agree to undergo an urine nicotine test before my surgery. Furthermore, I verify that the information provided on this form is true and accurate to the best of my knowledge.

X ____ ____________

Signature of Patient or Responsible Party Date

CalvertHealth™
Medical Group

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 receives a treatment they know is not covered by their insurance company.

Financial Assistance: The Practice has payment plans, financial assistance, and sliding fee scale, to uninsured and others with self-pay balances. Please ask the office assistant for further information.

Non-Payment: If a balance remains unpaid past 90 days your account will be transferred to a collection agency or collection attorney. In the event your accounts remain in delinquent standing with the collection agency, you may be terminated from the medical group.

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 usually covered by any insurance companies. Payment for these services are expected at the time of service.

Personal Injury Claims: CHMG will bill the current health insurance for treatment covered by the insurance company. All applicable co-pays will be collected at time of service.

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**.

Worker's Compensation: Prior authorization is required from your employer before service can be provided. 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. 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 Plastic & Reconstructive Surgery Billing Office
Prince Frederick, MD 20678
Billing Phone Number: 410-414-9844

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

Patient Financial Policy

Patient Name: ______________________ DOB: ______________________

Thank you for choosing CalvertHealth Medical Group (CMHG) 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: Please confirm your provider is enrolled with your insurance carrier prior to scheduling your visit.
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 at each visit. 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 may 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 during appointment check in.

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 and/or at your next appointment.

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 arrangements/payment plans have been set up. 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. In the event a check has been returned the patient must pay by credit card or cash. 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 all future visits.

CalvertHealth™
Medical Group

Patient Privacy Policy

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, 2020.

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

Optional: If you would like the office to discuss or release* ANY *medical information with a spouse, child, relative or any other person, please fill out the below information.

Patient Authorization for Use or Discloser of Protected Health Information

I hereby authorize the release of my protected health information as indicated below, to the following individual(s):

______________ Person Name	______________ Relation to Patient	Check One: O-Entire Medical Record O-Specific Information ______________
______________ Person Name	______________ Relation to Patient	Check One: O-Entire Medical Record O-Specific Information ______________
______________ Person Name	______________ Relation to Patient	Check One: O-Entire Medical Record O-Specific Information ______________

I understand that information released by this authorization may be disclosed by the recipient and may no longer be protected by federal and state law. I understand this authorization ends **7 years** from the date indicated below. I understand that I have the right to revoke this authorization, ***in writing***, as described in the Notice of Privacy Policy. I understand that a revocation is not effective to the extent that my physician has already disclosed the health information. I agree to pay a reasonable, per page cost, to cover the cost to copy my medical record, when requested.

______________________________ ______________
Patient/Patient Representative Signature Date

Patient Representative:
O-Parent/Guardian
O-Medical Power of Attorney (Documentation Required)

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 circle 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.