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

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

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.

Patient Signature: _____ Today's Date: _____

CalvertHealth™
Medical Group

Patient Financial Policy

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 Billing Office
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: _____

Patient Name: _____ DOB: _____

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 hours 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 to the patient and 2nd warning letter will be sent to the patient.
- Third offense will prompt the patient to be discharged from the practice. The patient will receive a letter of discharge by certified mail and the patient portal.

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

- Patient will automatically be charged a $100 'no-show' or late cancellation/reschedule fee. The practice staff 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 for one provider could impact the patient's ability to schedule appointments with another CHMG provider. **For a listing of all CalvertHealth Medical Group 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

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

Medical Information Release

Patient Name: _____DOB: _____Date:_____

Address: _____

Phone: **HOME**: _____**WORK**: _____**CELL**:_____

Preferred Phone Contact, please circle: HOME WORK CELL

Do you authorize for a detailed message to be left on your above Preferred Phone? ____YES ____NO

Primary Care Provider: _____Phone:_____

Referring Provider: _____Phone: _____

Pharmacy: _____Pharmacy Phone: _____

I give the following person/people permission to have access to all of my medical information that pertains to the following provider: **CalvertHealth Medical Group Obstetrics & Gynecology**
I give permission for a detailed message to be left on the following designees telephones: ___YES ___NO

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

This form does not authorize the release of printed copies of your 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 in one (1) year from the date signed unless an earlier date is specified:
Please expire on: _____

_____ _____
Patient Signature Date

_____ _____
Witness Date

_____ _____
Witness Name (Please Print)

Please return this form to the Provider's office or FAX it to the office at: **410-414-4741**

CalvertHealth Medical Group

Health History

Today's Date: _____

Patient Name: _____ DOB: _____

Preferred Pharmacy: _____ Referred by: _____

Reason for Visit: _____

MEDICAL HISTORY

Height: _____ Weight: _____

Do you have any allergies to Latex or medications? No Yes

Allergic to:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____

Do you have or have you ever had any of the following: (check all that apply)

___ Anemia
___ Arthritis
___ Asthma
___ Blood clots in lung
___ Blood clot in legs
___ Blood transfusion
___ Breast Soreness
___ Chicken Pox
___ Chlamydia
___ Chronic Bronchitis
___ Colitis/Ulcers
___ Depression/Anxiety
___ Diabetes
___ Eating Disorder
___ Endometriosis
___ Epilepsy
___ Fibroids
___ Gallbladder problems
___ Glaucoma
___ Gonorrhea
___ Heart Disease/Attack
___ Hepatitis
___ Herpes
___ Hirsutism (excessive hair growth)
___ High blood pressure
___ High cholesterol
___ HIV/AIDS
___ Infertility
___ Kidney infections
___ Lung disease
___ Liver problems
___ Migraines
___ Osteoporosis/Osteopenia
___ Ovarian cysts
___ Pelvic infection
___ Phlebitis
___ Pneumonia
___ Recurrent vaginitis
___ Reflux
___ Rheumatic fever
___ Scarlet fever
___ Seizures
___ Stroke
___ Syphilis
___ Thyroid problems
___ Tuberculosis
___ Cancer (type, date, current status): _____
_____
___ Other illness or injury: _____
_____

MEDICATIONS: (include prescriptions, hormones, vitamins, herbs, and over-the-counter medications)

Name	Dosage	Frequency	Reason	Name	Dosage	Frequency	Reason

SURGICAL/INJURY HISTORY

Disease/Diagnosis/Injury	Procedure/Surgery	Date	Physician	Hospital

CalvertHealth Medical Group

Health History

Patient Name: _____ DOB: _____

OBSTETRICAL HISTORY

Total Pregnancies ____ Full Term ____ Preterm ____ Abortions ____ Miscarriages ____ Ectopic ____ Living Children ____

Date Born	Wks pregnant	Sex	Weight	Delivery Type	Physician/Hospital	Complications/Problems

GYNECOLOGIC HISTORY

Age period started _____ Periods come every _____ days They last _____ days Flow is Light Moderate Heavy
Last menstrual period _____ Are you menopausal Yes No At what age did you become menopausal _____
Type of menopause: Natural Surgical Premature Chemo Other: _____
Sexually Active Yes No Sexual Orientation _____ # of partners _____ Type of birth control _____
Last pap smear _____ History of abnormal pap Yes No Occupation _____
Marital Status: Single Married Separated Divorced Widowed Domestic Partner

SOCIAL HISTORY

Do you smoke? Yes No How much do you smoke? _____ How many years did you smoke? _____
Do you drink alcohol? Yes No Amount and frequency _____
Do you drink caffeine? Yes No Amount and frequency _____
Do you use illegal drugs? Yes No When? Past Present Date Stopped: _____
Type: _____ Frequency: _____

LIFESTYLE

Level of activity: Above Average Average Sedentary Do you use seatbelts? Yes No
Type of exercise _____ Frequency of exercise _____
Special diet and type: _____
Advanced directives: (circle one) None DNR Living Will Medical Power of Attorney

FAMILY HISTORY

Family Member	Alive/Deceased	Cause of death	Age at death	Other diseases (if cancer list type)
Mother				
Father				
Brother (s)				
Sister (s)				

LIST BLOOD RELATIVES WHO HAVE/HAVE HAD THE FOLLOWING MEDICAL CONDITIONS

DISEASE	RELATIVE	DISEASE	RELATIVE	DISEASE	RELATIVE
Diabetes		Mental Illness		Colon Cancer	
Stroke		Depression		Ovarian Cancer	
Heart Disease		Sickle Cell		Uterine Cancer	
Blood Clots		HIV/AIDS		Prostate Cancer	
High Blood Pressure		Tuberculosis		Lung Disease	
Osteoporosis		Thyroid Disease		High Cholesterol	
Hepatitis		Birth Defects		Other	
Addiction		Breast Cancer		Other	

Patient Signature: _____ Date: _____