Maryland Healthy Kids Program
Medical/Family History Questionnaire

Patient Name:	Date of Birth:	Sex: (circle) Male Female
Form Completed By: / Today's Date	Relationship:	

PREGNANCY AND BIRTH HISTORY

Name of Hospital: _____
Illnesses during pregnancy? No ☐ Yes ☐
Medications during pregnancy? No ☐ Yes ☐
Alcohol/Drug Abuse? No ☐ Yes ☐
Problems at birth? No ☐ Yes ☐
Describe: _____
Type of delivery? ☐ Vaginal ☐ C-section
Birth Weight_____Discharge Weight_____
Did baby receive Hepatitis B vaccine? No ☐ Yes ☐
Date of Hepatitis B immunization:_____
Newborn Hearing Screen? No ☐ Yes ☐

PSYCHOSOCIAL HISTORY

Who lives in household?_____
_____
How many?_____
☐ Rent? ☐ Own? ☐ Shelter?
Who cares for child?_____
Date of Birth? Mother_____
Father_____
Are parents working? Mother No ☐ Yes ☐
Father No ☐ Yes ☐
Foster Care? _____Dates:_____
Other Languages?_____

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:

			Who?
Allergies (List) _____	No ☐	Yes ☐	_____
_____			
Asthma	No ☐	Yes ☐	_____
TB/Lung Disease	No ☐	Yes ☐	_____
HIV/AIDS	No ☐	Yes ☐	_____
Suicide Attempts	No ☐	Yes ☐	_____
Heart Disease	No ☐	Yes ☐	_____
High Blood Pressure/Stroke	No ☐	Yes ☐	_____
High Cholesterol	No ☐	Yes ☐	_____
Blood Disorders/Sickle Cell	No ☐	Yes ☐	_____
Diabetes	No ☐	Yes ☐	_____
Seizures	No ☐	Yes ☐	_____
Mental Illness	No ☐	Yes ☐	_____
Cancer	No ☐	Yes ☐	_____
Birth Defects	No ☐	Yes ☐	_____
Hearing Loss	No ☐	Yes ☐	_____
Speech Problems	No ☐	Yes ☐	_____
Kidney Disease	No ☐	Yes ☐	_____
Alcohol/Drug Abuse	No ☐	Yes ☐	_____
Hepatitis/Liver Disease			
Thyroid Disease	No ☐	Yes ☐	_____
Learning Problems/Attention	No ☐	Yes ☐	_____
Deficit Disorder	No ☐	Yes ☐	_____
Family Violence	No ☐	Yes ☐	_____

Other: _____
_____

MEDICAL HISTORY

Has your child ever had:

Allergies (List) _____	No ☐	Yes ☐
_____		
Asthma	No ☐	Yes ☐
Chicken Pox (Year) ___	No ☐	Yes ☐
Frequent Ear Infections	No ☐	Yes ☐
Vision/Hearing Problems	No ☐	Yes ☐
Skin Problems/Eczema	No ☐	Yes ☐
TB/Lung Disease	No ☐	Yes ☐
Seizures/Epilepsy	No ☐	Yes ☐
High Blood Pressure	No ☐	Yes ☐
Heart Defects/Disease	No ☐	Yes ☐
Liver Disease/Hepatitis	No ☐	Yes ☐
Diabetes	No ☐	Yes ☐
Kidney Disease/Bladder Infections	No ☐	Yes ☐
Physical or Learning Disabilities	No ☐	Yes ☐
Bleeding Disorders/Hemophilia	No ☐	Yes ☐
Sexually Transmitted Diseases	No ☐	Yes ☐
Emotional or Behavioral Problems	No ☐	Yes ☐
Depression/Suicidal Thoughts	No ☐	Yes ☐
Hospitalizations/Surgeries	No ☐	Yes ☐
Physical/Emotional/ Sexual Abuse	No ☐	Yes ☐
Bone or Joint Injuries	No ☐	Yes ☐
Obesity/Eating Disorders	No ☐	Yes ☐
Other: _____	No ☐	Yes ☐
_____		

Current Medication(s): (*List*) _____
_____

Reviewed by:	Date of Review:

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Assignment of Benefits Form

Patient: _____ DOB: _____
Address: _____ Practice Name: Dunkirk Family Practice, PA
City, State, Zip: _____ ID#: _____
Phone: _____ Group#: _____

I, _____, understand that services rendered to me by Dunkirk Family Practice, PA are my financial responsibility and that the provider will bill my insurance company _____, as a courtesy. I authorize my insurance company to pay my benefits directly to Dunkirk Family Practice, PA and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I haves agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and coinsurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by _____ (insurance company).

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Dunkirk Family Practice, PA within 48 hours. I agree that if I fail to send the payment to Dunkirk Family Practice, PA and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize Dunkirk Family Practice, PA to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.
I authorize Dunkirk Family Practice, PA to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

_____ _____
Dated Witness

_____ _____
Signature of policyholder Patient or Guardian

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Name: _____ **DOB:**_____

Authorization to Disclose Information

PURPOSE OF THIS FORM

In order for Dunkirk Family Practice, P.A. to use or disclose Protected Health Information to someone other than you, you must complete this Authorization Form and return it to Dunkirk Family Practice, P.A.

Protected Health Information (PHI) is information that is created, received, transmitted or stored by Dunkirk Family Practice, P. A. which relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies you or provides a reasonable basis for identifying you. Except as permitted by law, Dunkirk Family Practice, P. A. may not use or disclose PHI to persons other than those you specify on this form.

You may request that Dunkirk Family Practice, P. A. share information on your behalf by filling out this form. This form is not needed if you are requesting your own PHI. There is a separate Release Form for that type of request.

PART I: Authorized Person(s)
I authorize Dunkirk Family Practice, P. A. to disclose the PHI identified in Part II of this form to the following person(s): (Please designate at least one person and fill in their name and phone number)
( ) Spouse _____
( ) Parent _____
( ) Other (Please specify) _____

PART II: Description of the information to be used or disclosed
I authorize Dunkirk Family Practice, P.A. to disclose PHI (including written, electronic, or oral information) to the person identified in **PART** I of this form in connection with (mark all that apply): (If you want different people to have access to different information, you must fill out separate forms).
___All medical records pertaining to _____
___All medical records, including consultations, labs, billing and/or account information
___Lab reports only
___Immunizations only
___Other (Specify) _____

PART III: Validity of Form
___Dunkirk Family Practice, P.A. will provide a copy of this signed Authorization Form to me.
___This Authorization form is valid until the **earliest** of:
(1)_____(please provide date or event);
(2)The date Dunkirk Family Practice, P.A. receives my written request for change; or
(3)Twenty years from the date I sign this form.

PART IV: Acknowledgement and Signature
I understand that:

- I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION FORM.
- I HAVE THE RIGHT TO REVOKE THIS FORM AT ANY TIME BY SUBMITTING A CANCELLATION OF AUTHORIZATION FORM TO DUNKIRK FAMILY PRACTICE, P.A.
- CANCELLATION WILL TAKE EFFECT AS OF THE CANCELLATION DATE OR EVENT, OR ONCE DUNKIRK FAMILY PRACTICE, P.A. RECEIVES THE CANCELLATION OF AUTHORIZATION FORM.
- THE PERSON I AM AUTHORIZING TO RECEIVE MY PHI MAY NOT BE REQUIRED TO TREAT THIS INFORMATION AS CONFIDENTIAL.

_____ _____
Your Signature (or Signature of Personal Representative*) Date
*If you are acting as the Personal Representative of the individual whose PHI is to be disclosed, you must provide proof of your authority to act for that individual.

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ (Print patient's full name)
_____ Birthdate (MM/DD/YY)
_____ (Street Address)
_____ Social Security Number
_____ (City, State, Zip code)
_____ Phone (Home)

At the request of the individual, I _____ (Patient's Name), do hereby authorize _____ (Name of Releasing Company) to release:

Releasing Company's Phone & Fax Number: _____

DATES OF _____

_____DISCHARGE SUMMARY _____PATHOLOGY REPORTS _____HISTORY & PHYSICAL
_____EMERGENCY REPORTS _____LABORATORY REPORTS _____PROGRESS NOTES
_____RADIOLOGY REPORTS _____OPERATIVE NOTES _____ECG/EEG/CARDIC CATH
_____OTHER_____
_____
_____

_____I do _____I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Virus)

Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO:

Dunkirk Family Practice, PA
Name of Company/Agency/Facility/Person
2025 Chaneyville Rd Suite 200
Street Address
Owings, MD 20736
City, State, Zip

Phone #: 410-286-3865
Fax #: 410-286-8085

PURPOSE OF DISCLOSURE:

_____REFERRAL TO SPECIALIST _____INSURANCE _____WORKERS COMP
_____CHANGE OF DOCTOR _____LEGAL INVESTIGATION
_____DISABILITY DETERMINATION _____PERSONAL _____CONTINUING CARE
_____OTHER

*Please provide the current telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above-named company. This authorization is valid for twelve (12) months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ **Signature of individual or guardian or Personal Representative of patient's estate**

_____ **Date**

NOTE: There will be a charge for a personal copy or the permanent transfer of your records.

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NOTICE OF HEALTH INFORMATION PRACTICES / PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Privacy Notice is being provided to you as a requirement of the federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. Your "protected health information" means any written, oral or electronic information about you, including demographic data that can be used to identify you, created or received by your health care provider, which relates to your past, present, or future physical or mental health or condition.

Uses and Disclosures of Protected Health Information for Treatment, Payment, and Health Care Operations. We may use your protected health information for the purposes of providing treatment, obtaining payment for treatment, and conduction health care operations. Your protected health information may be used or disclosed only for these purposes unless we have obtained your authorization or the use or disclosure is permitted or required by the HIPAA regulations or other law. Disclosures of your protected health information for the purposes described in the Privacy Notice may be made in writing, orally, or by electronic means.

1. **Treatment**. We will use and disclose your protected health care information to provide, coordinate, or manage your health care and related services, including coordination and management with third parties for treatment purposes. Here are some examples of how we may use or disclose your protected health information for treatment:
    - **a.** We may disclose your protected health information to a laboratory to order tests.
    - **b.** We may disclose your protected health information to other physicians who may be treating you or consulting with us regarding your care.
    - **c.** We may disclose your protected health information to those who may be involved in your care after you leave here, such as family members or your personal representative.
2. **Payment.** We will use your protected health information to obtain payment for the services we provided to you. We may also disclose your protected health information to another provider involved in your care for their payment activities. Here are some examples of how we may use or disclose your protected health information for payment:
    - **a.** We may communicate with your health insurance company to get approval for the services we render, to verify your health insurance coverage, to verify that particular services are covered under your insurance plan, and to demonstrate medical necessity.
    - **b.** We may disclose your protected health information to anesthesia care providers involved in your care so they can obtain payment for their services.
3. **Health Care Operations.** We may use and disclose your protected health information to facilitate our own health care operations and to provide quality care to all of our patients. Health Care Operations include such activities as: quality assessment and improvement; employee review activities; conduction or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance reviews; business planning and development, and business management and general administrative

activities. In certain situations, we may also disclose your protected health information to another provider or health plan for their health care operations. Here are some examples of how we may use or disclose your protected health information for health care operations:

a. We may use your protected health information to review our treatment and services and to evaluate the performance of our staff in our caring for you.

b. We may combine protected health information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective.

c. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes.

d. We may also use or disclose your protected health information in the course of maintenance and management of our of our electronic health information systems.

4. **Fundraising Activities.** We may use your demographic information, including name and address, to contact you for fundraising purposes. Here are some examples of how we may use or disclose your protected health information for fundraising activities:

   a. We may use your demographic information to send mass mailings regarding information about certain Dunkirk Family Practice fundraising events and/or donations.

   You have the right to opt out of receiving fundraising communications at any time. If you wish to be removed from future DFP fundraising communications, please contact the office by telephone (410-286-3865) or e-mail us from your patient portal. We will honor your request not to receive any DFP fundraising communications from us after the date we receive your decision. You also have the opportunity to opt out on the Notice of Health Information Practices. Please note that a request to opt out will have no impact on health care services provided.

5. **Other Uses and Disclosures.** As part of the function above, we may use or disclose your protected health information to provide you with appointment reminders, to inform you of treatment alternatives, or to provide you with information about other health-related benefits and services which may be of interest to you.

Uses and Disclosures of Protected Health Information Permitted without Authorization Required or Opportunity for the Individual to Object

The Federal privacy rules allow us to use or disclose your protected health information without your authorization and without your having the opportunity to object to such use or disclosure in certain circumstances, including:

1. **When Required by Law.** We will disclose your protected health information when we are required to do so by federal, state or local law.
2. **For Public Health Reason.** We may disclose your protected health information as
   a. For the prevention, control, or reporting of disease, injury or disability;
   b. For the reporting of vital events such as birth or death;
   c. For public health surveillance, investigations, or interventions;
   d. For purposes related to the quality, safety, or effectiveness of FDA-regulated products or activities, including:

i. Collection and reporting of adverse events, product defects or problems, or biological product deviations
ii. Tracking of FDA-regulated products
iii. Product recalls, repairs, or look back,
iv. Post-marketing surveillance

e. To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease or condition;
f. Under certain limited circumstances, to report to an employer, information about an individual who is a member of the employer's workforce.
g. Wound or physical injury reporting, as required by law.
h. Incompliance with, and as limited by the relevant requirements of a court order or court-ordered warrant, a subpoena, summons, or similar process.
i. Identification or location of a suspect, fugitive, material witness, or missing person.
j. Under certain limited circumstances when you are the victim of a crime.
k. Alerting law enforcement of the death of an individual where there is suspicion that the death may have resulted from the criminal conduct.
l. Reporting criminal conduct that occurred on the premises of the provider.
m. In an emergency, to report a crime.

3. **To Report Abuse, Neglect, or Domestic Violence.** We may notify government authorities if we believe a patient is a victim of abuse, neglect, or domestic violence. We will make this disclosure only when specifically authorized or required by law, or when the patient agrees to the disclosure.
4. **CRISP Participation.** We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide health information exchange. 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 all 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.

Anti-Kickback Letter

Dear Patient:

Due to policy provisions in your contract with your insurance carrier, we are obliged to collect all patient responsibility balances.

If your insurance policy has provisions such as deductibles, coinsurances, or copayments please note that these are provisions that have been agreed to between you and your carrier. We cannot legally discount fees after their submission on your behalf to your carrier.
If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined by your carrier. Writing off patient responsibility balances could jeopardize our contract with your carrier.

If a portion of your fees are applied to an annual out of pocket maximum, and we do not collect that fee, your out of pocket maximum has not been correctly calculated.
Additionally, for those Medicare patients that may have any medical services that are eligible under Medicare, we are legally obliged to collect the patient responsibility coinsurance, copayment or deductible under the terms of the anti-kickback laws.

We sincerely regret if any of these regulatory provisions cause you any inconvenience, but we are bound by all provisions of insurance policy and federal law. If you have any issues or concerns with your insurance, we will be more than happy to assist in the resolution of those issues or concerns. Please feel free to contact us with any questions you may have or any assistance you may require to fully understand these provisions.

Sincerely,
Dunkirk Family Practice, PA

Effective 04/05/2017

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NOTICE OF HEALTH INFORMATION PRACTICES ACKNOWLEDGEMENT

This notice will expire in twenty (20) years.

DUNKIRK FAMILY PRACTICE, P.A. has provided me with the information concerning my health information and how it is or can be used. I have read the Notice of Health Information Practices and understand that a copy is available upon my request.

☐ By checking this box, I am opting out of receiving fundraising communications with Dunkirk Family Practice, PA. I am aware that by checking this box, Dunkirk Family Practice acknowledges my right to opt out and will not send fundraising communications to me as of this date.

_____
Print Name

_____
Patient Signature (Parent of Minor)

_____
Date of Birth

_____
Name of Minor Child

_____
Date

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GUIDELINES AND PATIENT FINANCIAL POLICIES
REVISED AS OF 04/201

Initials	Item #	Policy
	1.	**Emergencies:** Our providers will make every effort to receive your calls and respond promptly in an emergency If you do not receive an immediate response, you will call 911 receive paramedic intervention and seek the nearest emergency room.
	2.	**Prescription Refills:** It is our policy that you should be responsible to know when your medication must be refilled at least a week before you run out. Medications are refilled only at the patient visit or when requested in advance through your pharmacy. For weekend, walk-in, after hours, or phone call refill requests, please allow 72 hours for the physician to refill your request.
	3.	**Information:** You agree to provide your correct name, current and correct address, cellular or other phone number, e-mail address insurance information Social Security number, driver's license or picture identification at the time of registration or as requested by the practice at any time.
	4.	**Financial Responsibility:** By the initial and the signature signed on the financial policy, you accept financial responsibility for ALL charges for services rendered to you if a minor or under guardianship, the parent or guardian accompanying the patient assumes this liability.
	5.	**Payment Methods:** We accept cash, check, and several major credit cards. Reception staff may be contacted regarding credit cards accepted. Active participation with the insurance companies is the responsibility of the patient to obtain BEFORE time of appointment.
	6.	**Appointments:** Our office will schedule appointments as a common courtesy for patients and in consideration of your time. Minors must be accompanied by a parent or guardian to be seen *unless* special arrangements have been made with the office, which includes a signed written note from a parent or guardian. We require a minimum of 24 hours (or the Friday before a Monday appointment) notice of cancellation as a courtesy to other patients seeking services. A fee of $35 will be charged for non-cancelled and missed appointments. A pattern of non-cancelled/missed appointments may result in the discharge from the practice.
	7.	**Well Visits (Two-in-One Visit):** At the discretion of your care provider, you may be responsible for a co-payment after your visit if there are extra concerns that are not covered during our routine preventative care visit.
	8.	**Form Fees:** Our practice charges for additional paperwork outside of the medical records. The following fees apply are subject to change without notice: (a) single page forms- $25; (b) multi-page forms- $35. Additional forms may apply at the discretion of the practice and upon notification to you.
	9.	**Medical Records:** The medical chart is the property of the practice. However, copies of your pertinent medical information are available upon request. The practice charges a fee for a copy of the record according to the fees provided by Maryland State law.
	10.	**Insurance copayments, deductibles, and coinsurance:** Insurance companies do not pay all fees and may exclude certain services from coverage. It is your responsibility to understand your insurance plan. All copayments, deductibles, and coinsurance, or non-covered services are to be paid in a timely fashion according to office policies. If you are unable to pay your copayment at time of service, an extra processing fee of $10.50 will be added to the visit. If requested, and as a condition of the service you agree to sign an "insurance waiver" if we determine or question your insurance coverage. You accept responsibility for all such expenses even if your insurance company is billed as a courtesy.

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	11.	**Usual and Customary:** Some insurance plans may indicate that our fees are above "usual and customary". As a result, your plan may reduce our fee to an "allowed amount" before calculating payment. This practice does not recognize a specific carrier's use of terms. As such, unless we have specifically contracted with the carrier it is expected that you will be liable for our full fees.
	12.	**Slow Insurance Response:** You agree that if your insurance company takes more than 60 days to respond to your insurance claim that we shall consider your services your financial responsibility and it will be your responsibility to seek reimbursement from your insurance company.
	13.	**Accident:** Although our office is happy to treat your medical conditions, if the cause is related to an auto accident, you will be required to pay the full fee of $180 at the time of your visit.
	14.	**Statement Policy:** Our office sends patient statements each month. Payments are due upon receipt of the statement. You understand that if we participate with your insurance company the sending of a statement may be delayed until your insurance responds to a claim for services. Such a delay can take months. You understand that such a delay does not alter our policy of patient financial responsibility and you will be liable for all service fees.
	15.	**Collection and Bank Fees:** Accounts more than 90 days old are subject to transfer to an outside collection agency. These agencies charge fees. You agree to be liable for all such collection expense, legal fees and court costs. In addition banks charge for checks that do no clear cannot be cashed. You agree to be liable for all such fees with a minimum charge of $35.
	16.	**Patient Discharge:** The practice reserves the right to discharge a patient for any reason. Please note that discharges may occur for failure to meet your obligations under this document. In addition, because of care quality considerations, the practice may discharge you for failure to comply with treatment plan(s) as outlined by your physician.
	17.	**Insurance Claims:** If applicable, our office will submit insurance claims. You agree to allow our practice to "accept assignment" of benefits and receive payment directly from your insurance company. In the event your insurer sends payment for the claim from our office to your directly, you agree to endorse the payment to our practice in fulfillment of any amounts due within 10 days of postmark.

I HAVE READ AND UNDERSTAND ALL THE TERMS OF THIS POLICY AND MY INITIALS AND MY SIGNATURE BELOW ATTECT THAT I FULLY UNDERSTAND EACH ITEM AND AGREE TO THE TERMS ABOVE.

Signature_____Date_____

Patient Name_____DOB_____

Witness_____Date_____

Printed Name_____Date_____

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Patient Information Form

Reason for Today's Visit: _____

Name: _____ Sex: ____ M ____ F

Home Phone: _____Work Phone: _____Cell Phone: _____

Email Address: _____

Home Address: _____City: _____Zip Code: _____

Patient's Social Security #: _____Date of Birth: _____

Driver's License #: _____State: _____ Exp. Date: _____

Marital Status: Married Divorced Legally Separated Single

Full Time Student: Yes No Name of School: _____

Nearest relative not living with you: _____ Phone: _____

Nearest friend not living with you: _____ Phone: _____

Whom may we contact in the case of an emergency? _____ Phone: _____

Whom may we thank for referring you to us? _____ Phone: _____

Who is responsible for this bill? _____

Did you sustain an injury at work? □Yes □No

Are you covered under an employer or union policy? □Yes □No

Are your injuries accident related? □Yes □No

Is your spouse or other family member employed? □Yes □No

Are you currently employed? □Yes □No

Do you have a secondary or medical insurance policy? □Yes □No

Have you ever served in the military? □Yes □No

Are you covered under any other health care plan? □Yes □No

Accident or Injury Information

If this visit accident related? Yes No

If yes, please provide details of the accident: Date and Location: _____

Details of accident or injury: _____

_____

_____

Did you consult another physician regarding any other injuries resulting from this accident?

Name of physician: _____

Date first seen by other physician: _____

Could this injury be covered by Worker's Compensation? Yes No

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Medical Insurance

Name of Insured: _____

Relationship to Patient: _____

Policyholder Date of Birth: _____ Policyholder Social Security #: _____

Insurance Carrier Name, Address, Phone #: _____

_____

Identification card present upon encounter: Yes No

Eligibility date indicated on card as: _____

Is this plan HMO, PPO or EPO? Yes No (circle the correct response)

If this is for EHB; who administers the plan: _____

Secondary Medical Insurance

If information is same as the information above indicate with "Same as and indicate which policyholder is applicable" in the appropriate data fields.

Name of Insured: _____

Relationship to Patient: _____

Policyholder Date of Birth: _____ Policyholder Social Security #: _____

Insurance Carrier Name, Address, Phone #: _____

Identification card present upon encounter: Yes No

Eligibility date indicated on card as: _____

Is this plan HMO, PPO or EPO? Yes No (circle the correct response)

If this is for EHB; who administers the plan? _____

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 have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. This information will be kept confidential. I am aware that a copy of my insurance identification card will be made available and a copy kept in my records. I am responsible for updating this information if and when there are changes.

_____ _____

Signature Date

Dunkirk Family Practice
2025 Chaneyville Road, Suite 200, Owings, MD 20736 | Phone: 410-286-3865 | Fax: 410-286-8085 | www.DunkirkFamilyPractice.com

Red Flag System Letter

We, the staff of Dunkirk Family Practice, PA are committed to awareness and vigilance regarding any possible occurrences of identity theft. We are committed to training and implementation of the following compliance program.

1. Identify Relevant Red Flag Risk Factors

- Employees opening or managing accounts, those with access to personal information, billing customers, providing customer service, or collecting debts.
- Outsourced service providers and their access to patient and billing information.
- Patients seeking health care using someone else's name or insurance information.
- A patient providing altered or suspicious identification documents.

2. Detect Red Flags

- Is the photograph or physical description on the ID inconsistent with what the patient looks like?
- Are employees accessing information unrelated to their job description or unassigned task?
- Is mail returned as undeliverable, even though the patient still shows up for appointments?
- Do any patients complain about receiving a bill for a service that they did not receive?
- Are there inconsistencies between a physical examination or health care history reported by the patient and the treatment records?

3. Prevent and Mitigate If red flags are identified, we are prepared to respond appropriately to prevent and mitigate the harm done.

- We require picture identification of persons seeking services or paying for services. We train staff to carefully examine any questionable forms of identification and ask for secondary identification.
- We add provisions to our outsourced, contracted providers requiring that they have procedures in place to detect Red Flags and either report them or respond appropriately to prevent and mitigate the crime themselves.
- We are vigilant in heeding warnings from others that identity theft may be ongoing such as website or association newsletters and bulletins.

4. Update our Program

- Keep our program current.
- Provide ongoing education and training.
- Provide annual report of instances, and actions taken.

_____ _____

Patient Signature Date

_____ _____

Patient Name (Please Print) Patient's Date of Birth

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Wellness Visit (Physical Exam) and Office Visit

Dear Patient:

Our goal is to provide you, the patient, with the best medical care. Annual physical exams give us a chance to address your overall physical and emotional health. The ***preventative*** care we provide during a physical also include an assessment of *dietary and exercise habits, review of vaccinations, discussion of screening tests, lifestyle behaviors, etc.* We often look in on chronic stable problems or other ongoing medical conditions, though we don't always charge for that, depending on the degree of difficulty or amount of time spent.

Regular office visits differ from the ***preventative and wellness care*** provided at a physical. Regular office visits address *other new ongoing or poorly controlled medical problems*. These types of problems need to be addressed in an appointment separate from a ***preventative*** or physical exam. You OR your doctor may identify an issue that may need to be addressed during a physical, ***separate from preventative care.***

Our goal is to address as much as we can in a quality manner during visits. Please note that the insurance companies **do** allow providers to address additional complaints beyond a physical examination, **if** there is time. If additional problems are found or addressed, an additional office evaluation code will be generated in addition to a preventative physical examination code. We are required to submit billing in this fashion, if we address care beyond preventative care at the physical examination. *This essentially generates an extra charge to the insurance company for issues addressed beyond preventative care, which in turn may require you to pay additional copay, coinsurance or deductible charges.*

The coding rules set by the health care industry, specifically state, *"If an abnormality is encountered or a pre-existing problem is addressed in the process of performing this preventative medicine evaluation service, then the appropriate visit code should also be reported."* We can actually fail and audit if we violate these rules.

You have entrusted us with your medical care. Please also trust that we practice the highest integrity with our billing practices. Our goal is to provide excellent care and take appropriate time doing it. Please speak with your practitioner if you have any questions regarding the charges from your preventative care/physical today.

Sincerely,

Your practitioners at Dunkirk Family Practice, PA

I have read the Physical Exam and Office Visit letter and understand that I may be billed an additional charge from my insurance company. This charge may be a copay, coinsurance, or deductible and I will be responsible for payment of this additional charge.

_____

Patient Name **Date**

_____

Patient or Guardian Signature **Patient's Date of Birth**

LET US KNOW IF YOU WOULD LIKE A COPY OF THIS SIGNED FORM