Laurel Medical Associates, LLC
13635 Baltimore Avenue
Laurel, Maryland 20707
PHONE 301-497-0401
FAX 301-497-0402
www.laurelmedicine.com

NEW PATIENT INFORMATION

PATIENT'S NAME (First, Middle, Last)	MARTIAL STATUS SEX S M W D SEP M F	DOB	ETHINICITY	RACE
STREET ADDRESS	CITY AND STATE	ZIP CODE	TELEPHONE #1 (HOME)	
PATIENT'S EMPLOYER ADDRESS/CITY/STATE /ZIP	OCCUPATION HOW LONG EMPLOYED?	LANGUAGE SPOKEN	TELEPHONE #2 (CELLULAR)	
PREFERRED PHARMACY NAME/PHONE/CITY/ZIP	NO PREFERRED PHARMACY ☐ NO INFORMATION AVAILABLE ☐	CALL BACK WITH THE PHARMACY INFORMATION OR EMAIL INFO TO homecaredoctor@laurelmedicine.com ☐		
DRUGS ALLERGIES, IF ANY		PERSONAL E-MAIL ADDRESS		
Preferred Method of Contact ☐ text ☐ e-mail ☐ phone				
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION	HOW LONG EMPLOYED?	BUSINESS TELEPHONE #	
EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE		
DO YOU HAVE A LIVING WILL ?				
HOW DID YOU HEAR ABOUT US? (i.e. NEWSPAPER, POST CARD, REFERRAL OR INSURANCE CARRIER WEBSITE)				

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE		
INSURANCE CARRIER (PRIMARY)	ID #	GROUP #
INSURANCE CARRIER (SECONDARY)	ID #	GROUP #
MEDICARE ID #	RAILROAD RETIREMENT ID #	

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please check the following and sign)

___I authorize use of this form on all my insurance submissions.
___I authorize disclosure of protected health information for treatment, payment and health operation.
___I authorize release of information to all my insurance Companies.
___I understand that I am responsible for non-covered services, missed appointments, remaining deductibles, co-pay's and co-insurances.
___I authorize my doctor to act as my agent in helping me obtain payment from the insurance Companies.
___I authorize payment directly to my doctor.
___I permit a copy of this authorization to be used in place of the original.
___I acknowledge that I have received Notice of Privacy Practices information.
___I authorize Laurel Medical Associates to communicate with me via em: the patient Portal.

Sign Name:_____ Date:_____

Updated 01/23/2020

New Patient Medical Information (circle/list all that apply)

Patient Name: **DOB:** **Date:**

Past Medical History

1. Diabetes
2. High Blood Pressure
3. Heart Attack
4. Kidney Disease or Failure
5. Asthma
6. Gastroesophageal Disease (GERD)
7. Other

_____

_____

Family History

1. Diabetes
2. Hypertension
3. Heart Attack
4. Other

_____

_____

Past Surgical History

1. Gall Bladder
2. Appendix
3. Tonsils

ALLERGIES

1. Penicillin
2. Sulfa
3. Other

_____

_____

Social History:

1. Smoking: packs per day_____ How many years?_____
2. Alcohol: Y/N. If yes explain:_____

Thank you for you time.
Updated 01/23/2020

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NEW PATIENT INFORMATION

PATIENT'S NAME (First, Middle, Last)	MARTIAL STATUS S M W D SEP	SEX M F	DOB

STREET ADDRESS	CITY AND STATE	ZIP CODE	TELEPHONE #1 (HOME) CELL #

PREFERRED PHARMACY NAME/PHONE/CITY/ZIP

NO PREFERRED PHARMACY ☐

NO INFORMATION AVAILABLE ☐

CALL BACK WITH THE PHARMACY INFORMATION OR EMAIL TO

info@laurelmedicine.com

Sign Name:_____ Date:_____

Tear along perforated line for contact number and email address

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Phone Number

301-497-0401

Email Address

info@laurelmedicine.com

Updated 01/23/2020

LAUREL MEDICAL ASSOCIATES
PATIENT ACKNOWLEDGEMENT/CONSENT FORM

Laurel Medical Associates "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. Please acknowledge reading this office's "Notice of Privacy Practices" by initialing below.

_____
Initials

Our "Notice of Privacy Practices" states that we reserve the right to change the terms described. Should this happen, you will receive a copy by mail.

_____
Initials

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

_____
Initials

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent in writing, except where we have already made disclosures in trust on your prior consent.

_____
Initials

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Laurel Medical Associates for any services furnished to me

by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which I have coverage, and information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

_____
Initials

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information.

_____ _____
Patient's Printed Name Patient's Date of Birth

_____ _____
Patient/Legal Representative Signature Date

_____ _____
Relationship to Patient Witness Date

The following names listed below are the names of people that I would like to be involved in or have access to my protected health information on a routine basis. I give permission for and its affiliated companies to share my protected health information with:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

MEDICATION LIST

Name: _____/_____

Last First

DOB: _____

MM/DD/YYYY

Medication	Dosage	Date Started	Recent Refill

Updated 01/23/2020

LAUREL MEDICAL ASSOCIATES
Patient Waiver

CREDIT AND PAYMENT POLICIES

Our goal is to provide you with the highest quality care at a reasonable/reduced cost compared with other practices. Your estimated financial responsibility will be assessed at the time of check-in and payment will be collected accordingly. **For patients utilizing insurance, copayments for the day's treatment will be collected when you check-in for your appointment.** Your insurance contract is between you and your carrier. As a Courtesy to you, we will submit claims to most carriers. However, it is your ultimate Responsibility to pay the required copayments, deductibles, coinsurances, or uninsured amounts at the time of service. **Self-pay patients will be expected to pay for services in full at the conclusion of their appointment.**

Signature _____ Date_____

PATIENT MISSED APPOINTMENT POLICY
(office appointments only)

We are committed to fully assisting you with your Health Care needs and thus, you are expected to attend all of your appointments. We are reserving this time specifically for You. If you need to cancel or reschedule your appointment, please do so 24-hours prior to your appointment time. A $65 fee will be charged for sessions missed without such prior notification. This fee will be due prior to your next treatment (insurance is not responsible for this fee). All cancellations and no shows are documented in our system as part of your record. We understand there are occasional emergency situations and we appreciate your consideration of our time. In instances of repeated non-compliance with scheduled visits, we reserve the right to discontinue care. By signing below, you agree to this policy.

Signature _____ Date_____