Corporate Office
6230 Old Dobbin Lane Suite 230
Columbia, MD 21045
(410) 730-3399

PATIENT REGISTRATION

DEMOGRAPHIC INFORMATION (Please Print)

LAST NAME:_____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ SEX: _____ RACE: _____

SOCIAL SECURITY: _____ ETHNICITY: _____

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ MD: _____ ZIP CODE: _____

LANGUAGE: _____ LANGUAGE COUNTRY: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNER ☐ DIVORCED ☐ WIDOWED

Check if applicable: ☐ PREGNANT ☐ NURSING

Whom may we thank for referring you to our practice? _____

CONTACT INFORMATION

HOME PHONE: _____ WORK PHONE _____ EXT: _____

CELL PHONE: _____ EMAIL: _____

EMERGENCY CONTACT INFORMATION (whom may we contact in case of an emergency)

FIRST NAME: _____ LAST NAME: _____

HOME PHONE: _____ CELL PHONE: _____

RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

FAMILY MEMBERS IN THE PRACTICE

_____ (name) _____ (relationship to patient)

_____ (name) _____ (relationship to patient)

_____ (name) _____ (relationship to patient)

_____ (name) _____ (relationship to patient)

PRIMARY CARE/OTHER PHYSICIAN

PHYSICIAN NAME: _____ PRACTICE NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

PHARMACY NAME: _____ PHARMACY PHONE: _____

PHARMACY LOCATION: _____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured/Guardian: _____ **Date:**_____

Centennial Medical Group
Healthcare, Covered

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FirstCall Medical Center
Urgent Care - Labs - X-Rays & Diagnostic

INSURANCE INFORMATION

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF VISIT

PRIMARY INSURANCE

INSURANCE COMPANY: _____ CO-PAY: _____

GROUP #: _____ SUBSCRIBER ID#: _____

INSURED FIRST NAME: _____ INSURED LAST NAME: _____ MI: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

PHONE #: _____ (EXT: _____)

INSURED EMPLOYED BY: _____ BUSINESS ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

BUSINESS PHONE #: _____

ADVANCED DIRECTIVES? ☐ YES ☐ NO WHERE IS IT FILED? _____ (What medical facility?)

ADDITIONAL INSURANCE

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE? ☐ YES ☐ NO

INSURANCE COMPANY: _____ CO-PAY: _____

GROUP #: _____ SUBSCRIBER #: _____

INSURED FIRST NAME: _____ INSURED LAST NAME: _____

SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

PHONE #: _____ (EXT: _____)

INSURED EMPLOYED BY: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

BUSINESS PHONE: _____

EMPLOYMENT STATUS: ☐ Employed ☐ Unemployed ☐ Full Time Student ☐ Part Time Student ☐ Retired

OCCUPATION: _____ BUSINESS NAME: _____

BUSINESS PHONE: _____

DRIVER LICENSE #: _____ STATE ISSUED: _____

IS THIS AN ACCIDENT? ☐ YES ☐ NO

DATE OF INJURY? _____

IS THIS A MOTOR VECHICLE ACCIDENT? ☐ YES ☐ NO

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Signature of Insured/Guardian: _____ **Date:** _____

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Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by Centennial Medical Group and/or FirstCall Medical Center in order to carry out treatment, payment or health care operations. You should review the Practice's Notice of Privacy Practice for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from your front desk staff.

You retain the right to request that we further restrict how your protected health information is release or used to carry out treatment, payment, or health care operations. Our practice is not requested to agree to such requested restrictions; however, if we do agree to your requested restrictions(s), such restrictions are then binding on the Practice.

I agree and consent to Centennial Medical Group and/or FirstCall Medical Center releasing information to me in the following manners:

VIA MAIL — PLEASE INITIAL

- ☐ OK TO MAIL TO HOME ADDRESS _____
- ☐ OK TO MAIL TO WORK ADDRESS _____

VIA HOME TELEPHONE

- ☐ OK TO LEAVE DETAILED MESSAGE _____
- ☐ LEAVE CALL BACK NUMBER ONLY _____

VIA WORK TELEPHONE

- ☐ OK TO LEAVE DETAILED MESSAGE _____
- ☐ LEAVE CALL BACK NUMBER ONLY _____

VIA FAX

OK TO FAX TO: _____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured/Guardian: _____ **Date**:_____

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RECEIPT OF NOTICE OF PRIVACY PRACTICE 2023

WRITTEN ACKNOWLEDGEMENT FORM

We have the Patient Privacy Act/HIPAA notations in our office for your convenience. Please ask if you would like a copy.

My signature below indicated I, (print full name) _____have reviewed the policy and have been given the opportunity to review and ask questions.

Patient Signature: _____ Date: _____

Date of Birth: _____

Signature of Parent or Legal Guardian: _____ Date: _____

Relationship to patient: _____

MISSED APPOINTMENT FEE:

If you miss your appointment without giving our office at least 24-hour notice, you will be assessed a $50 charge.

Initials: _____

DOCUMENTATION FEE:

If you are in need of forms to be completed by our Providers, there is a 24-hour turnaround time and a fee of $40 form completion charge. This includes any forms you present at the appointment as well, except a DOT physical.

Initials: _____

PRESCRIPTION REQUEST

All prescription requests require a 48-72-hour turnaround. In order to simplify the process, please have your pharmacy contact us.

Initials: _____

We have chosen to participate in the Chesapeake Regional Information System for our patients (CRISP), a regional health information exchange serving Maryland and D.C. 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 access to your health information available through CRISP by calling 1-877-952-7477 or competing and submitting an Opt Out form to CRISP by mail, fax, or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

UPDATED 7/1/23

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AUTHORIZATION FORM TO COMMUNICATE MEDICAL AND/OR FINANCIAL INFORMATION TO OTHERS

I, _____ authorize the following individuals:
(PRINT PATIENT NAME)

_____(PRINT) Relationship:_____

_____(PRINT) Relationship:_____

_____(PRINT) Relationship:_____

_____(PRINT) Relationship:_____

to perform the following activities on my behalf with any Physician, Physician Assistant, Nurse Practitioner or Staff Member at Centennial Medical Group / FirstCall Medical Center.

Please check those that you are authorizing:

☐ **FULL ACCESS** to Medical, Financial & Scheduling information

OR

☐ Make and cancel Appointments on my behalf

☐ Request and discuss medical information (including medications)

☐ Handle and discuss financial records and information

☐ Deliver and pick up information to/from CMG/FCMC on my behalf

☐ Other (please describe):_____

_____

_____

This authorization is effective from: _____ to _____ **OR** **Indefinitely** (cicle).

_____ _____ _____
Patient Signature Date of Birth Today's Date

UPDATED 7/1/23

PATIENT FINANCIAL AGREEMENT & ACKNOWLEDGEMENT OF OFFICE POLICIES

1. **PAYMENT** is expected at the time of your visit. We accept cash, check, Visa, Mastercard, Discover, and American Express. Payment will include any unmet deductible, co-insurance, co-payment amount, charges not covered by your insurance company. We will verify eligibility and remaining deductible. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. All non-filed services are expected to be paid at the time of service.

2. **INSURANCE**: We are participating providers with most insurance plans. We will file all claims for these plans. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. As a courtesy to our patients, we will verify your insurance coverage, however, our verification is not a guarantee of benefits payable by your insurance. In order to bill your insurance and to meet filing guidelines we do ask for a copy of your insurance card and a photo ID. If our providers are not listed in your plan's network, you may be responsible for partial or full payment.

3. **POLICY ON NON-COVERED SERVICES**: This office offers access to many medical services and procedures; some of them are deemed as "not covered" by insurance. In some cases, you will be given an ABN (Advanced Beneficiary Notice) for these types of services/procedures before they are provided/performed. You will be responsible for payment in full at the time of service.

4**. INCURRED CHARGES**: Please be advised, Insurance will be billed for any additional treatments you may receive, including, but not limited to: screenings, counseling, and phone consults. If during a preventive exam, a new abnormal finding or a preexisting problem is significant enough to require additional work that meets the key components of a problem-oriented service, it will be reported to your insurance. These additional services may subject to copayment or coinsurance for the member.

5. **FEES**: Returned checks will incur a $50.00 service charge.
No show - $50
We understand that certain situations arise where you are unable to make your appointment. We ask that you please provide us with as much notice as possible if you are unable to make it.

6. **RESPONSIBILITY FOR PAYMENT**: I understand that I, personally, am financially responsible to Centennial Medical Group/First Call Urgent Care for charges not covered by the assignment of insurance benefits and all non-covered charges.

7. **REFERRAL** I understand that I am responsible to provide a referral from another physician if one is required by my insurance to be seen by this practice. If a claim is denied by my insurance company because a referral was not provided at the time of service, I agree to be financially responsible for the full balance for the services provided. Note: if you do not know if a referral is required, please call your insurance

8. **PHYSICAL THERAPY BALANCES** I understand due to the frequency of visits needed for physical therapy I'm aware that my balance may increase rapidly. A payment plan will need to be set up if I'm unable to pay in full

I have read and understand the practice's office and financial policies

_____

Signature of Patient/Guarantor **Date**