MENON MEDICAL CENTER LLC
REGISTRATION FORM

(Please Print)

Today's Date _____

PATIENT INFORMATION

Patient's Name Last	First	Middle	○ Mr. ○ Mrs. ○ Dr. ○ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Sex ❑M ❑F ❑ Other _____

Street Address	Race:	Primary Phone #
City State	Zip Code	Secondary Phone #
Occupation	Employer	Email Address

Referred by

Other Family Members Seen Here _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No.
Is this person a patient here?	❑ Yes ❑ No		
Employer Name :			Employer Phone No.

Is this patient covered by insurance? ❑ Yes ❑ No Type of Plan? ❑ HMO ❑ PPO ❑ POS

Please indicate primary insurance ❑ Medicare ❑ Carefirst / BCBS ❑ Aetna ❑ Cigna ❑ GEHA

❑ First Health ❑ Humana/Tricare ❑ Other _____

Subscriber's Name	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if applicable) Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Patient	Home Phone No.	Work Phone No.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Menon Medical Center LLC or insurance company to release any information required to process my claims.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

Menon Medical Center LLC

MEDICAL HISTORY QUESTIONNAIRE

*Name*_____ *Age*_____ *Date*_____

Past Medical History

Cardiac
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ OTHER_____

Respiratory
- ☐ Cough
- ☐ Asthma
- ☐ COPD
- ☐ OTHER_____

Digestive:
- ☐ Gastroesophageal Reflux
- ☐ Peptic Ulcer Disease
- ☐ Liver Disease
- ☐ Hemorrhoids
- ☐ Colitis
- ☐ OTHER_____

Urinary
- ☐ Prostate enlargement
- ☐ Kidney Stones
- ☐ Urinary Infections
- ☐ Kidney Failure
- ☐ OTHER_____

Endocrine:
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Osteoporosis
- ☐ Steroids
- ☐ OTHER_____

Hematologic:
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Transfusions
- ☐ Cancer - What kind?_____
- ☐ OTHER _____

Neurologic
- ☐ Headaches
- ☐ Stroke
- ☐ Seizures
- ☐ OTHER_____

Vision
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Cataracts
- ☐ OTHER_____

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Eating Disorder
- ☐ OTHER_____

Muscular
- ☐ Back Pain
- ☐ Arthritis
- ☐ OTHER _____

Allergies (please list)

Medications (please list with doses)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Surgical History (please list with dates)

_____
_____
_____
_____

Social History

Do you smoke tobacco? Yes No
If so, how much?_____
Do you drink alcohol? Yes No
If so, how much?_____
What is your occupation?_____
Who do you live with?_____

Family History

Mother (circle one) Living Deceased Age_____
Medical Problems_____

Father (circle one) Living Deceased Age_____
Medical Problems_____

Any Relatives with the following:
Colon Cancer Y N Who?_____
Breast Cancer Y N Who?_____
Prostate Cancer Y N Who?_____
Heart Problems Y N Who?_____

Preventative Medical History

When was your last.....?
Tetanus Shot_____
Flu Shot _____
Pneumovax _____
Colonoscopy_____
Bone Density _____

Menstrual Period_____
PAP smear _____
Mammogram_____

MENON MEDICAL CENTER LLC

FINANCIAL POLICY (Effective 2/1/2015)

Thank you for choosing our practice! The following financial policy is provided to help you understand your responsibility towards your Health Care Provider.

1. Payment is required at the time of service.

2. For your convenience we accept cash, check, MasterCard, and Visa.

3. If you have health insurance that we accept, it is your responsibility to give us complete and accurate information regarding your insurance at every visit.

   a. If we participate with your health insurance plan
      - We will bill your health insurance company for services rendered (both primary and secondary insurance plans, if applicable).
      - You are responsible for the payment of co-payments, co-insurance, deductibles, and any charges not covered by your insurance policy. Co-payments are due at the time of service.

   b. If we do not participate with your health insurance plan
      - Payment in full is required at the time of service.
      - We can provide you with the necessary billing information so you may submit a claim to your insurance company directly.

4. If you have Medicare: As a participating provider, we will bill Medicare directly for services rendered.
   You will be responsible for your annual deductible and co-payments.

5. If you have no health insurance payment in full is required at the time of service.

6. We kindly request that you give us a 24-hour notice if you are unable to keep your appointment. Failure to do so will result in a missed appointment fee of $25.00.

7. Forms and letters that the doctor is requested to fill out, will be charged $25/ form.

8. In the event we receive a returned check, a fee of $35.00 will be charged to your account and payment due upon receipt of your statement.

9. Patients who request non-urgent health services after hours (4:30p.m.- 8 a.m.) or telephone consults during office hours, may be charged $40-$60, depending on the nature of the problem at the doctor's discretion.

10. Should your account go to collections due to non-payment, you will be responsible for all collection and attorney fees.

11. It is your responsibility to update us with any change in your home address, telephone numbers, so we can reach you in a timely fashion.

If you have any questions, please do not hesitate to contact us. We are here to assist you any way possible.

My signature below signify that I have read and fully understand my financial responsibilities under this policy.

_____

Signature of Patient (or legally responsible individual) Date

MENON MEDICAL CENTER LLC
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Date:

Patient's name:

Patient's Date of Birth:

I understand Dr.Menon's staff members will attempt to reach me by telephone. If I am unavailable-

☐ I **DO NOT** authorize Menon Medical Center ("Provider") to disclose any information concerning my care or treatment to individuals without my express written consent or legal authorization.

☐ I **authorize** Provider to disclose information related to my care and treatment to the following named individual(s):

	Name	**Phone Number(s)**	**Relation to patient**
1			
2			
3			

Provider may leave message on answering machine#: _____

Provider may post normal lab results to patient portal: _____

The authorizations provided for above are subject to the following limitations or restrictions:

_____

_____

_____

_____

Signature of Patient (or legally responsible individual) Date

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HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date February 1, 2015

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

This Notice is provided to you pursuant to the Health Insurance Portability and Accountability Act of 1996 and it's implementing regulations ("HIPAA"). It is designed to tell you how we may, under federal law, use or disclose your Health Information.

I. We May Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here is One Example of Each:

We may provide your Health Information to other health care professionals- including doctors, nurses and technicians --for purposes of providing you with care.

Our billing department may access your information- and send relevant parts- to other insurance companies or government programs to allow us to be paid for the services we render to you.

We may access or send your information to our attorneys or accountants in the event we need the information in order to address one of our own business functions.

II. We May Also Use or Disclose Your Health Information Under the Following Circumstances without Obtaining Your Prior Authorization:

To Notify and/or Communicate with your Family. Unless you tell us you object, we may use or disclose your Health Information in order to notify your family or assist in notifying your family, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in any communications with your family and others.

As Required by Law.

For Public Health Purposes: We may use or disclose your Health Information to provide information to state or federal public health authorities, as required by law to prevent or control disease, injury or disability; to report child abuse or neglect; report domestic violence; report to the Food and Drug Administration problems with products and reactions to medications; and report disease or infection exposure.

For Health Oversight Activities: We may use or disclose your Health Information to health oversight agencies during the course of audits, investigations, certification and other proceedings.

In Response to Civil Subpoenas or for Judicial and Administrative Proceedings: We may use or disclose your Health Information, as directed, in the course of any civil administrative or judicial proceeding.

However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person.

To Law Enforcement Personnel: We may use or disclose your Health Information to a law enforcement official to identify or locate a suspect, fugitive, material witness or missing person, comply with a court order or grand jury subpoena and other law enforcement purposes.

To Coroners or Funeral Directors: We may use or disclose your Health Information for purposes of communicating with coroners, medical examiners and funeral directors.

For Public Safety: We may use or disclose your Health Information in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

To Aid Specialized Government Functions: If necessary, we may use or disclose your Health Information for military or national security purposes.

For Worker's Compensation: We may use or disclose your Health Information as necessary to comply with worker's compensation laws.

Ill. For All Other Circumstances, We May Only Use or Disclose Your Health Information After You Have Signed an Authorization. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time.

IV. State Law Impact. To the extent that state law is more restrictive with respect to our ability to use or disclose your Health Information, or to the extent that it affords you greater rights with respect to the control of your Health Information, we will follow state law. This may arise if your Health Information contains information relating to HIV/AIDS, mental health, alcohol and/or substance abuse, genetic testing, among others.

V. You Should Be Advised that We May Also Use or Disclose Your Health Information for the Following Purposes:

Appointment Reminders: We may use your Health Information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.

VI. Your Rights.

1. You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with your request.

2. You have the right to receive your Health Information through confidential means through a reasonable alternative means or at an alternative location.

3. You have the right to inspect and copy your Health Information. We may charge you a reasonable cost-based fee to cover copying, postage and/or preparation of a summary.

4. You have a right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will provide you with information about our denial and how you can disagree with the denial.

5. You have a right to receive an accounting of disclosures of your Health Information made by us, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with family; and/or for certain government functions, to name a few.

6. You have a right to a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact us.

VII. Chesapeake Regional Information Systems for our Patients (CRISP) notice

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 completing and submitting an Opt-Out form to CRISP by mail fax or through their website 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.

VIII. Our Duties

We are required by law to maintain the privacy of your Health Information and to provide you with a copy of this Notice. We are also required to abide by the terms of this Notice. We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all your Health Information- even if it was created prior to the change in the Notice. If such amendment is made, we will immediately display the revised Notice at our office. We will provide you with another copy, of this Notice at any time, upon request.

MENON MEDICAL CENTER LLC

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I, (patient name)_____acknowledge and agree that I have reviewed a copy of the HIPAA notice of privacy practices.

_____

Signature of Patient Date

_____

Signature of Patient's Legal Representative (if applicable) Date