PARK MEDICAL ASSOCIATES, LLC

10755 FALLS ROAD, SUITE 200 LUTHERVILLE, MD 21093

SELECT PHYSICIAN

☐ BELITSOS ☐ GARG ☐ MOLAVI ☐ MOLINARO ☐ SAVADEL ☐ SIMONSON ☐ STEINER

PATIENT INFORMATION

LAST NAME:		FIRST NAME:	MI:	DOB:
SSN:	☐ M ☐ F ☐ Non-Binary	MARITAL STATUS:	PREFERED LANGUAGE:	
ADDRESS:		CITY:	STATE:	ZIP CODE:
CELL PHONE:	HOME PHONE:	WORK PHONE:	EXT:	
RACE: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Decline to answer	ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer	EMAIL: ☐ EMPLOYED ☐ STUDENT		
NAME OF EMPLOYER:		OCCUPATION:		
EMPLOYER ADDRESS:		CITY/STATE/ZIP CODE:		
EMERGENCY CONTACT NAME:	RELATIONSHIP:	PHONE NUMBER:		
PREFERED PHARMACY:	PHARMACY ADDRESS:	PHARMACY PHONE NUMBER:		

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:		PRIMARY INSURANCE PHONE NUMBER:	
MEMBER ID:	POLICY #:	GROUP #:	
INSURANCE ADDRESS:	CITY/STATE/ZIP CODE:	EFFECTIVE DATE:	
ARE YOU THE POLICYHOLDER? ☐ YES ☐ NO	POLICYHOLDER NAME:	POLICYHOLDER DOB:	POLICYHOLDER RELATIONSHIP:
SECONDARY INSURANCE NAME:		SECONDARY INSURANCE PHONE NUMBER:	
MEMBER ID:	POLICY #:	GROUP #:	
INSURANCE ADDRESS:	CITY/STATE/ZIP CODE:	EFFECTIVE DATE:	
ARE YOU THE POLICYHOLDER? ☐ YES ☐ NO	POLICYHOLDER NAME:	POLICYHOLDER DOB:	POLICYHOLDER RELATIONSHIP:
PRESCRIPTION CARD COMPANY NAME:	PRESCRIPTION CARD PHONE NUMBER:	MEMBER ID:	
RXBIN:	RXGRP:	RXPCN:	EFFECTIVE DATE:

PAYMENT OF BENEFITS

I authorize Park Medical Associates, LLC to file insurance on my behalf and release any medical or other information necessary to process my claims. When applicable, I authorize the payment of benefits directly to the physician. I understand Park Medical Associates participates with Carefirst, Cigna, Johns Hopkins EHP, and the Medicare network. Specialized testing services sent to an outside reference lab will be billed separately by that testing facility. I understand that I am responsible and agree to pay for any balance not covered by my insurance.

Signature:_____ Date: _____

Park Medical Associates, LLC Financial Policy

Thank you for choosing Park Medical Associates as your medical provider. Park Medical Associates is committed to providing all patients with excellent patient services and affordable healthcare. Please read the following to inform you of our current financial policies and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance:** The physicians at Park Medical Associates participate with Johns Hopkins EHP, Cigna, Carefirst BlueCross BlueShield, and Medicare. You may incur a higher bill if you are not insured by a plan we participate in. It is the patient's responsibility to provide the office with current insurance cards and to inform the office of any changes in insurance. We file claims to most insurances on your behalf. However, you are ultimately responsible for payments to Park Medical Associates. Don't hesitate to contact your insurance company with any questions regarding your coverage.
2. **Co-payments, Co-insurances, and Deductibles:** All co-payments, co-insurance, and deductibles must be paid on the day of service. Our practice cannot waive co-payments, co-insurance, and deductibles. This arrangement is part of your contract with your insurance company. The patient is responsible for any non-covered services determined by your insurance plan (including forms). Payments are payable with cash, check (no foreign checks), or credit card (VISA, MasterCard, Discover, AMEX). Any checks returned by your bank will be charged a $25.00 fee.
3. **Non-Covered Services:** Please be aware that some or all of the services you may receive may be noncovered or not considered medically necessary by your insurance company. Please contact your insurance company with any questions regarding your coverage. Any unpaid balances are the patient's responsibility.
4. **Proof of Insurance**: All patients must complete our patient information forms before seeing any physicians. The practice must obtain a copy of your current insurance cards and a valid driver's license. Failure to provide this information will result in delayed or unpaid claims.
5. **Claims Submissions**: Park Medical Associates will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.
6. **Past Due/Non-Payments:** Any past-due balances must be collected before scheduling new appointments. If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will only be accepted if otherwise negotiated. We refer your account to a collection agency if a balance remains unpaid.
7. **Missed Appointments and Cancellations:** Park Medical Associates reserves the right to charge a $75.00 fee for any no-show appointments and appointments canceled within 24 hours. These charges will be your responsibility and will be billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.

I, _____, have read and understand Park Medical Associates' financial policy and agree to abide by its guidelines:

Signature: _____ Date: _____

Park Medical Associates, L.L.C.
Johns Hopkins at Green Spring Station
10755 Falls Road, Suite 200
Lutherville, MD 21093
410-583-7111

WRITTEN ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES OFFERED

I, _____ have been offered a copy of Park Medical Associates
(Please print)
Notice of Privacy Practices. This notice is also available on our website at www.parkmedical.net.

Signature: _____ Date: _____

PATIENT CONSENT FORM

Authorization for Release of Protected Health Information to a Trusted Individual (Family Member, Friend, etc.)

___ I do NOT want my information released to any individual.
___ I authorize Park Medical Associates to tell the Trusted Individual(s) named below about my prognosis and treatment plans, diagnosis, test findings, radiology reports and laboratory results either in person or by telephone. The Individual is also authorized to order my medication refills.

Trusted Individual Information: (please print clearly)

Name: _____ Relationship to Patient _____ Phone _____

Name: _____ Relationship to Patient _____ Phone _____

Name: _____ Relationship to Patient _____ Phone _____

Consent to Email Communication between Patient and Park Medical Associates Doctors and Staff

By providing my email address below I am consenting to sending and receiving email from the Doctors and/or Staff. Emails could consist of (but are not limited to) having test results or other information or forms sent to me at my request, and/or communications between myself and my doctor (if the Doctor uses email for communication). **We are committed to keeping your email address confidential.**

I agree that I will NOT use email to communicate any urgent matters to the Doctors or Staff.

I understand that email between Park Medical Associates is secure when sent but not encrypted and therefore is potentially accessible to third parties.

I understand that on my end, anyone who has access to my email account or my unsecured electronic devices will potentially have access to emails sent between Park Medical Associates and myself.

Use of email and its risks are further spelled out in our Notice of Privacy Practices detailed at the top of this page and available in its entirety on our website www.parkmedical.net

___ I decline the use of email.

___ I consent to the use of email. My email address is _____
PLEASE PRINT VERY CLEARLY!

NEW PATIENT QUESTIONNAIRE

PARK MEDICAL ASSOCIATES, LLC ◊ 10755 FALLS RD. SUITE 200 ◊ LUTHERVILLE, MD 21093

Please print this form, complete, and bring with you.

Name:	DOB:	Age:	Date:

	Operation performed & Reason *(include any complications related to surgery/anesthesia)*	Date
1		
2		
3		
4		
5		
6		
7		
8		

	Overnight Hospitalizations *(exclude Operations listed above)*	Date
1		
2		
3		
4		
5		

Medications (include prescription topicals)

	Drug name	Strength	Doses/day
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Drug Allergies

	Drug name	Description of reaction
1		
2		
3		
4		

Vaccines

Name	Yes	No	Date
Tetanus *(in past 10 yrs.)*	☐	☐	
Pneumonia	☐	☐	
Hepatitis A *(2 doses)*	☐	☐	
Hepatitis B *(3 doses)*	☐	☐	
Other (in past 3 yrs.)			

	Have you had:	Date	Result
(If more than one, list only most recent)	**Colonoscopy**		
	Bone density		
	Mammogram		
	GYN examination		
	Eye examination		
	Stress test		
	****MRI/CT scan** *(indicate part of body)*		
(in the past 12 months)	****Blood work**		
	****Chest X-ray**		
	****Ekg**		

*** Bring reports if possible. (Actual films are not required.)*

Pregnancies	Number:	Live births:	Complications:

Pre-visit instructions for laboratory tests:

► Fast after 12:00 midnight the night before the exam. ► Patients may have water, black coffee, plain tea the morning of the exam. ► Medications are to be taken as usual except for patients using insulin. ► Patients taking insulin should bring a light breakfast and their insulin. Inject insulin & eat breakfast after blood is drawn.

Please complete "Family Medical History" on the next page.

FAMILY MEDICAL HISTORY

Name:		DOB:	Age:	Date:

IMMEDIATE FAMILY	Living? Yes	No	Age	Include ALL sisters, brothers, daughters, sons, and indicate health status for each. Significant health issues (or cause of death)
☐ Mother	☐	☐		
☐ Father	☐	☐		
☐ Sister ☐ Brother	☐	☐		
☐ Sister ☐ Brother	☐	☐		
☐ Sister ☐ Brother	☐	☐		
☐ Sister ☐ Brother	☐	☐		
☐ Sister ☐ Brother	☐	☐		
☐ Sister ☐ Brother	☐	☐		
☐ Sister ☐ Brother	☐	☐		
☐ Sister ☐ Brother	☐	☐		
☐ Daughter ☐ Son	☐	☐		
☐ Daughter ☐ Son	☐	☐		
☐ Daughter ☐ Son	☐	☐		
☐ Daughter ☐ Son	☐	☐		
☐ Daughter ☐ Son	☐	☐		
☐ Daughter ☐ Son	☐	☐		
☐ Daughter ☐ Son	☐	☐		
☐ Daughter ☐ Son	☐	☐		

DISTANT RELATIVES	PLEASE REPORT ANY DISEASES OR SIGNIFICANT HEALTH ISSUES IN GRANDPARENTS, AUNTS, UNCLES, AND COUSINS. (INDICATE SPECIFIC RELATIVE, *e.g. MATERNAL* COUSIN)
Cancer	
Type :	Relative(s):
Type :	Relative(s):
Type :	Relative(s):
Type :	Relative(s):
Type :	Relative(s):
Rheumatoid arthritis, gout, or other crippling arthritis *(indicate diagnosis for each relative affected)*	
Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:
Serious psychiatric illness *(nervous breakdown, mental hospitalization, suicide attempt)*	
Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:
Coronary artery disease *(heart attack, angioplasty, bypass surgery).* **Indicate approximate age of onset for each relative.**	
Aneurysm:	**Stroke:**
Kidney disease:	**Peptic ulcer disease:**
Kidney stones:	**Tuberculosis:**
Diabetes:	**High blood pressure:**
Other significant diseases *(include those that "run in the family")*:	
Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:

Thank you for helping us with this information. We look forward to seeing you.

Patient Questionnaire

Name: _____

Date of Birth: _____

1. Have you had a pneumonia vaccination? (Please Circle)

YES **NO**

If yes, type of pneumonia vaccination received? (Please Circle)

Pneumovax Prevnar

Date/ Location: _____

2. If you are between the age of 50-75, have you had any of the following: (Please Check all that apply and list date and location if applicable)

☐ Colonoscopy in the last 9 years _____

☐ Stool testing for hidden blood in the last 2 years_____

☐ Cologuard _____

3. If you are over the age of 65, have you had any fall related injuries recently? (Please Circle)

YES **NO**

Date/ Location: _____

☐ Are you afraid of falling?

PREVENTATIVE MEDICINE/ANNUAL PHYSICALS NOTICE

Many insurance companies have changed their policies regarding annual exams and physicals. For example, Medicare calls these visits "Annual Wellness Visits." Other insurance may call these visits Preventative Medicine, Health Maintenance, Routine Physicals, etc. These visits are designed to optimize your health by reviewing health goals and ordering screening tests. Most insurance covers a limited physical exam, including recommendations for healthy lifestyle choices (i.e., exercise, diet, smoking cessation, etc.) and screening for common medical conditions (i.e., high blood pressure, cholesterol, depression, and other age and gender-specific issues.) These visits are **not** designed to provide assessment and management of acute or chronic medical conditions, such as asthma, diabetes, behavior management, pain, acne, injury, or any health-related issue that happens to coincide with your annual visit. As your primary healthcare provider, Park Medical Associates welcomes and encourages discussion of any concerning issues or topics. We wish to provide follow-ups for any ongoing health-related problems you may have.

To offer a comprehensive evaluation and maximize your insurance reimbursement simultaneously, our physicians may provide preventative and diagnostic services during the same visit when appropriate. Most preventive services are 100% covered. However, problem-oriented services may be subjected to deductibles and co-insurances. If both services are offered, two visit codes will be billed with the appropriate modifier indicating the types of services. Additionally, EKGs and lab tests will be billed as preventative services if performed for screening. Be aware that some tests are not considered screening tests and will be billed with the appropriate medical diagnoses.

Park Medical Associates strives to provide excellent patient services and affordable health care. Thank you for understanding our need to bill appropriately for the services offered while remaining sensitive to your insurance coverage.

I, _____, have read and understand Park Medical Associates' Preventative Medicine/Annual Physical Notice and agree to its guidelines.

Signature: _____ **Date:** _____