FAMILY HEALTHCARE OF HAGERSTOWN

201 S. Cleveland Avenue
Hagerstown, MD 21740
301.745.3777 - www.familyhch.org

____ Family Practice
____ Wells House
____ Dental Practice/Mobile
School Child Attends: _____

GENERAL PATIENT INFORMATION

Last Name	First Name		Middle Name
Social Security Number	Date of Birth (mm/dd/yyyy)	Gender at birth ❑ Male ❑ Female ❑Undifferentiated	Who is your Medical Provider?
Home Address:	City	State	Zip
Mailing Address:	City	State	Zip
Email Address:		Are you transgender? ❑ Yes ❑ No If Yes: ❑ Trans-Male to Female or ❑ Trans-Female to Male	
Cell Phone:	Home Phone:	What is your marital status? (Check one) ❑Single ❑Married ❑Divorced ❑Legally Separated ❑Widowed ❑Domestic Partner ❑Annulled ❑Interlocutory ❑Polygamous ❑Unknown	
Student? ❑Full time ❑Part Time ❑Not a student	Smoker? ❑Yes ❑No		
Do You Work? ❑Yes ❑No	If yes, Who Is Your Employer?	What Is Your Occupation?	
Please select one: ❑Asian ❑Native Hawaiian ❑Other Pacific Islander ❑Black/African American ❑American Indian/Alaskan Native ❑White ❑More than One Race ❑ Decline to Specify			
Please select one: ❑Not Hispanic/Latino ❑Hispanic/Latino ❑Decline to Specify ❑Unknown/Not Reported			
Preferred language:		Do you need an interpreter? ❑Yes ❑No	

EMERGENCY CONTACTS IF I CANNOT BE REACHED:

Date:	Emergency Contact/Designee: (Spouse, Friend, Legal Guardian, or Parent (if the patient is a minor)	
	Relationship:	Phone number
Date:	Emergency Contact/Designee: (Spouse, Friend, Legal Guardian, or Parent (if the patient is a minor)	
	Relationship:	Phone number:

GUARANTOR/RESPONSIBLE PARTY:

Last Name	First Name		Middle Name
Address:	City	State	Zip
Phone Number:	Relationship to Patient:	Gender: ❑ Male ❑ Female	Date of Birth (mm/dd/yyyy)

MEDICAL INSURANCE INFORMATION:

Name of Insurance Company:		Policy #
Policy Holder's Name:	Policy Holder's DOB:	Policy Holder's SS#:
Employer:		Group #

DENTAL INSURANCE INFORMATION:

Name of Insurance Company:		Policy #
Policy Holder's Name:	Policy Holder's DOB:	Policy Holder's SS#:
Employer		Group #

Do you have a provider that you would like to be scheduled with? If so, who? _____

- I authorize Family Healthcare of Hagerstown to release any information relating to my treatment, examination, and/or clinical results to the Emergency Contact(s) above.
- I authorize Family Healthcare of Hagerstown to leave messages on any phone number provided relating to appointment reminders and/or clinical results or information.
- My signature below indicates that all the information provided on this form is true and correct.

_____ _____

Patient/Parent/Legal Guardian Date

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Community Health Center
UDS (Uniform Data System) Information

Date:_____ Patient Name:_____ Date of Birth:_____

In order to continue offering the variety of services that we offer at Family Healthcare of Hagerstown and to continue to receive grant funding, we are required to collect information on every person that receives care. The information is reported as an overall number and is not reported on individual patients:

1) How many people live in your household? _____
   What is the annual income of all family members in your household?_____

2) Have you or anyone in your household done agricultural (farm) work in the last 3 years?
   ❑Yes ❑No

3) If yes, was it migrant farm work in which you traveled from town to town without establishing a permanent residence?
   ❑Yes ❑No

4) If yes, was it seasonal farm work in which you travel and work seasonally and have an established residence in the same area?
   ❑Yes ❑No

5) Are you homeless?
   ❑Yes ❑No

6) If yes, where did you stay/sleep last night?
   ❑Doubled up ❑Shelter
   ❑Street (including a car or other vehicle) ❑Transitional (including hotel/motel)
   ❑Unknown

7) Do you live in public housing?
   ❑Yes ❑No

8) Are you a veteran?
   ❑Yes ❑No

9) What is your occupation or job? _____

Thank you for providing this important information. It will ensure that we are able to provide you with valuable services and programs in the future.

FHH Staff Initials: _____

Revised 04.2019

FAMILY HEALTHCARE OF HAGERSTOWN

201 South Cleveland Avenue, Hagerstown, MD 21740
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Consent Form

Consent to Treat:
I consent to the treatment and procedures that may be performed during my appointment. I have the right to make informed decisions about my healthcare, including the refusal of a treatment or procedure. I understand healthcare students may participate in my care.

Consent to Share Medical Record/Personal Health Information:
I understand that my medical record and/or related personal health information may be shared with the different departments of Family Healthcare of Hagerstown and also with offices that support my care. This information will be shared only to help in my health care assessment and management. Examples of this might be information related to/from pharmacies, laboratories, and referral specialists.

I understand that at any time during the course of my medical treatment, if a referral to a specialist is required, certain laboratory results and/or details from the medical record could be forwarded to the specialist. This will be done solely to assist in my complete evaluation.

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 by completing and submitting an Opt-Out form to CRISP by mail, fax, or through their website at www.crisphealth.org.

Confidentiality:
I understand that Family Healthcare of Hagerstown adopts a very strict policy regarding privacy and confidentiality of my medical information. I have been given information regarding the Notices of Privacy Practices.

Medical Insurance Authorization and Assignment:
I understand all charges are due at the time professional services are rendered. I authorize Family Healthcare of Hagerstown and all its included entities, to furnish information to my insurance carriers concerning my illness and treatments. For those services provided and submitted to my insurance company, I hereby authorize payment of medical benefits to Walnut Street Community Health Center, Inc., DBA Family Healthcare of Hagerstown. I understand I am responsible for any amount not covered by insurance, to include co-pays and fees.

I understand that Financial Assistance is available to qualifying patients.

Acknowledgement of Patient Guidelines, Rights, and Responsibilities:
I acknowledge that I have received the Patient Information Guidelines and Patients' Rights and Responsibilities and agree to abide by the policies of Family Healthcare of Hagerstown.

Advanced Directives:
An Advanced Directive is a form that you complete saying how much medical care you want to receive in the event that you are unable to respond. Do you have an Advanced Directive? ❑Yes ❑ No

Who provides day to day care for the patient? ❑ Self/The Patient ❑ Parent ❑ Other

If other, please provide a name and phone number:_____

Legal Guardian/Healthcare Proxy:

Does the patient have a Legal Guardian or Healthcare Proxy (a person decided by the patient, family, or courts to make healthcare decisions for the patient if the patient is unable to do so)? ❑Yes ❑ No

If yes, we must have a copy for our records.

Name: _____ Relationship:_____ Phone: _____

I understand that this consent and information, in its entirety, will remain in effect as long as I continue to receive health care services at Family Healthcare of Hagerstown.

_____ _____

Signature of Patient/Parent/Legal Guardian Date

_____ _____

Printed Name of Patient Signature of Witness

Consent to give permission to administer Nitrous Oxide

The purpose of this Informed Consent is to provide an opportunity for patients, parents or guardians, to understand and give permission for the use of Nitrous Oxide when provided along with dental treatment.

- Nitrous Oxide is commonly called laughing gas and provides relaxation, although the patient will be awake, fully conscious, aware of surroundings and able to respond rationally to questions and directions.
- Nitrous Oxide is not required to provide the necessary dental care.
- The purpose of Nitrous Oxide is to make the patient more comfortable to receive the necessary dental care with less pain and/or anxiety.
- Nitrous Oxide has limitations and will be administered by way of inhalation route and risks and absolute success cannot be guaranteed.
- Nitrous Oxide has been fully explained to me, including all risks involved. I have been fully informed that temporary complications may include, but are not exclusive of: tingling in the fingers, toes, cheeks, lips, tongue, head or neck area; heaviness in the thighs and/or legs, followed by a lighter floating feeling; resonation in the voice or presence of a hyper-nasal tone; warm feeling throughout body, with flushed cheeks; fits of uncontrollable laughter or giddiness; detachment or disassociation from environment may occur; lightweight or floating sensation with an accompanying "out of body" sensation; sluggishness in motion and slurring and/or repetition of words; feeling of nausea; vomiting; agitation; and/or hallucination. All of these complications are temporary.

My signature indicates that I have read the above consent for Nitrous Oxide and give my permission for myself/my child to have this administered, if necessary. I have informed the dentist of my/my child's complete medical history including any recent surgeries or changes in their medical history involving lung, respiratory, ear infection or common cold. I have also informed the dentist if I/my child is pregnant. I understand that for all private insurances Nitrous Oxide sedation is not a covered service. I agree that I will be responsible for the fee of $63.00 unless I am on the $40.00 slide through FHH. I agree to pay for this at the time of service.

_____ _____

Signature of Patient/Parent/Legal Guardian Date

Please choose service:	
Dental Practice	☐
Family Practice	☐
Both	☐

FAMILY HEALTHCARE OF HAGERSTOWN

201 S. Cleveland Ave, Hagerstown, MD 21740

Family Healthcare of Hagerstown has adopted a Financial Assistance Program for all patients regardless of inability to pay. We offer a Sliding Fee Discount based on family size and total family income. The current maximum income per family may be obtained by calling the Outreach/Enrollment Counselor at 301-393-3467.

Please completely fill out both sides of this application, sign the form and return with the required documents to:

Family Healthcare of Hagerstown
Attention: Outreach/Enrollment Counselor
201 S. Cleveland Ave
Hagerstown, MD 21740

Please note that the information provided on this application is valid for up to one year. Patients are responsible for completing a new application prior to the expiration of their current application.

Patient's Name _____ Date of Birth _____

Street Address _____ S. S. No. _____

City _____ State _____ Zip _____ Home/Cell Phone # _____

How long at this address? _____ Number living in household _____

List Names of Household Members: Relationship
(Please indicate which household member is a Dependent. Dependent is defined as someone who is listed on your Federal Income tax form)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Marital Status: __ Married __ Single __ Divorced __ Separated __ Widowed

Patient's Place of Employment _____ How long employed there? _____

Spouse's/Other Employment _____ How long employed there? _____

Other Employment _____

Are you unemployed? ___ Yes ___ No If yes, are you receiving unemployment income? ___ Yes ___ No
If Yes, What State are you receiving unemployment benefits? __MD, __PA, ___WV
Are you eligible for Medical Assistance? ___ Yes ___ No You could be eligible if you are: disabled, have children in the family under the age of 18, or pregnant.
If yes, have you applied for Medical Assistance? ___ Yes ___ No If Yes, what State ____MD,____PA,____WV
If yes, what was the outcome? ___ Approved ___ Denied If denied within the last 90 days, attach a copy of the denial letter.
Medicaid ID# _____

BE SURE TO COMPLETE BOTH SIDES OF FORM

Income Status:

Gross Monthly Salary $_____ Spouse's/Other's Income $_____

Gross Monthly Salary $_____ Social Security $_____

Unemployment $_____ Disability $_____

Other Income $_____ Child Support $_____

Investment Income $_____ Pension $_____

Total Yearly Family Income $_____

***Proof of Income Is Required. Application will not be processed unless documents below are provided:**

_____ Past 30 days pay stubs
_____ Unemployment compensation statements
_____ Pensions statements
_____ Disability statements
_____ Child support statements
_____ Alimony statements
_____ Social Security statements
_____ Self-employment earnings for business
_____ Current signed 1040 Federal Income Tax Form Did not File Taxes ___
_____ If no income, explanation of how living expenses are paid. If someone else is assisting you, they will need to write a statement. **Statement must include** signature of person making statement, date, and phone number where they can be reached.

I certify that the information provided on this application is true and complete and may be checked for accuracy. I understand that willful falsification and/or omission of information contained in this application will result in denial of financial assistance.

Signature of Applicant _____ Date _____

I authorize FHH to forward financial information provided by me and obtained from other organizations to Meritus Medical Laboratory and/or Quest Diagnostics to determine eligibility for their assistance program.

Signature of Applicant _____ Date _____

To Be Completed by FHH – Do Not Write Below This Line

Received by _____ Date _____

Approved by _____ Date _____ Category _____

Period Approved _____ to _____

FP/MH Fee _____
Dental Fee _____/_____
Insurance_____

Revised 8/2019

FAMILY HEALTHCARE OF HAGERSTOWN

Family Healthcare of Hagerstown
201 S. Cleveland Avenue, Hagerstown, MD 21740
P: 301-745-3777
www.familyhch.org

Patient Rights and Responsibilities

Patient Rights:

1. You have the right to be given patient centered quality care at Family Healthcare of Hagerstown.
2. You have the right to treatment sensitive to your personal values, cultural, and ethnic background.
3. You have the right to be given an explanation of your diagnosis and treatment plan.
4. You have the right to be given information needed to make informed decisions, and to refuse treatment.
5. You have the right to confidentiality.
6. You have the right to review any health records created and maintained by Family Healthcare of Hagerstown.
7. You have the right to know the names and position of people involved in your care.
8. You have the right to be given an explanation of any charges.
9. You have the right to file a complaint.
10. You have the right to choose your provider.

Patient Responsibilities:

1. You have the responsibility to know and follow the rules of Family Healthcare of Hagerstown as indicated by your signature.
2. You have the responsibility to be considerate and respectful of other patients, visitors, and staff.
3. You have the responsibility to participate in your care and treatment.
4. You have the responsibility to ask questions if you do not understand your diagnosis or treatment plan.
5. You have the responsibility to give correct and updated information regarding the following: health, financial status, insurance, name, and contact information.
6. You have the responsibility to pay any charges billed to you.
7. You have the responsibility to give your provider a 72 hour notice for prescription refills.
8. You have the responsibility to arrive on time for appointments.
9. You are responsible to follow the Patient Information Guidelines to cancel or reschedule an appointment.
10. You have the responsibility to use medications as prescribed.

Revised 04.2019

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Patient Information Guidelines

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Family Healthcare of Hagerstown's Notice of Privacy Practices is available by request.

Canceling Appointments

If you must cancel an appointment, we require you to call by 12:00 pm the day before your appointment. Any appointment cancelled after that time will be considered a no show.

No Shows

If you have 3 No Shows within a 6 month period, you will no longer be able to schedule an appointment in advance. You will be required to utilize same day scheduling for all visits.

Medication Requests

We require 3 business days to process all medication requests.

If you need a refill on your medicine please call the Prescription Line at 301-745-3777 and leave your name, date of birth, medication name, dosage, your phone number and what pharmacy you would like the request to be sent to.
Narcotic prescriptions must be picked up at our office by the patient. If for some reason the patient is unable to come into the office, the person picking up the prescription must have a written note by the patient giving permission to pick up the prescription. That person must also produce photo identification. If they arrive without a written note or photo identification, we cannot release the prescription.

Ordered Tests & Results

Please complete your tests within 7 -10 days after your appointment, unless your provider gives you a different date. Test results will be called to your home within 14 business days.

Referrals

If you have an appointment with a specialist, you must call our office at least 3 business days before your appointment in order to request the referral. Referrals with less time will not be honored. If you have an appointment with a specialist and cannot make the appointment, you must call their office and cancel. Many specialists will not see patients after they miss just one appointment without calling them in advance.

Forms

Forms usually take 7-10 business days to be reviewed/completed by a provider. The provider will review the form and if he/she determines an appointment is needed before the form can be completed, you will be called to schedule an appointment.

Smoking and Alcohol

I understand Family Healthcare of Hagerstown, to include the parking lot and entrance, is a Smoke Free facility, to include e-cigarettes. No alcohol will be permitted on the premises. Any person who appears intoxicated will not be seen by a provider and will be asked to leave the premises. I agree to abide by this policy.

Weapons and Violence

It is the policy of Family Healthcare of Hagerstown to provide a safe environment, free from the threat of violence. No weapons of any type will be permitted on the premises. Anyone possessing a weapon will be asked to leave and will be discharged from the practice. Family Healthcare of Hagerstown will not tolerate threats, harassment, aggressive or violent behavior, or other types of inappropriate behavior towards its staff, patients, or visitors. I agree to abide by this policy.

How to Contact Provider During and After Office Hours

Family Healthcare of Hagerstown providers can be reached 24 hours day/7 days a week by calling 301-745-3777.

Patient Centered Medical Home

The Medical Home is an innovative, team-based approach to providing health care services within your current medical office. The patient, his or her primary care provider, and a team of office staff, will coordinate to provide the best health care services to you. In order for us to coordinate your care, please let our staff know if you see any other health care provider outside of Family Healthcare of Hagerstown. Also, please remind any health care provider that you may see, to forward reports to us regarding your care and treatment.

FAMILY HEALTHCARE OF HAGERSTOWN

301.745.3777 ~ www.familyhch.org

Date of Request_____

AUTHORIZATION FOR RELEASE OF PATIENT IDENTIFIABLE HEALTH INFORMATION

This Authorization form is designed to meet the requirements of federal privacy regulations issued by the Department of Health and Human Services at 42 CFR 164.508 and the Annotated Code of Maryland, Title 10 Health General Article 4-301—4-307.

I hearby authorize Family Healthcare of Hagerstown to ____ release to ____obtain from:

_____

(Physician and practice name, Hospital, Attorney, Insurance Company, self, etc)

_____

(Address, City, State, Zip Code) (Phone Number)

The following health information from the medical records of:

_____ _____ _____

Patient Name Date of Birth Social Security Number

Specific Information to be disclosed:

□ Entire Record □ Other (specify) _____

□ Test Results (specify) _____ □ Limitations (specify) _____

□ Most Recent History & Physical, Discharge Summary, Operative Report(s), and Consultation(s)

□ Dental Record

Specific Information to be disclosed: **New Patients**

□ Most recent Office notes □ Mammogram and Pap screening □ Colonoscopy

□ All lab results within 1 year □ Active Consultations □ All radiology reports

Specific Information to be disclosed: **Mental Health**

□ Entire Record □ Medication list □ Therapy Notes □ Progress Notes

□ Limitations (specify) _____ □ Other (specify) _____

This health information is needed for:

□ Personal Use □ Continuing Medical/Dental Care □ School □ Insurance

□ Legal Reasons □ Social Security/Disability □ Military □ Other _____

I do____ I do not ____ wish to have information about HIV/AIDS released under this authorization.

I do ____ I do not ____ wish to have mental health records released under this authorization.

I do ____ I do not ____ with to have information about drug/alcohol abuse treatment released under this authorization.

I also understand that the person giving authorization by a written and dated notice to Family Healthcare of Hagerstown may revoke this authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization expires one year from the date of signature, unless I specify otherwise or revoke it.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information.

I understand authorizing the use or disclosure of the health information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

I understand that I may be charged for copies of my health information.

If you are transferring care, please tell us your reason. Thank you. _____

Signature of Parent/Executor/Legal Representative	Date	Signature of Patient	Date
Witness	Date	Witness	Date

201 S. Cleveland Avenue **Hagerstown, MD 21740** **301-745-3777** **Fax 301-393-3453**

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FAMILY HEALTHCARE OF HAGERSTOWN

Family Healthcare of Hagerstown
Family Practice and Dental Practice
201 S. Cleveland Avenue
Hagerstown, Maryland 21740
301-745-3777

I hereby give my permission for all dental/medical attention necessary to be administered to my child _____, under the direction of the person(s) listed below for one (1) year from date noted.

_____ _____
Parent or Guardian (print name) Parent or Guardian (signature) Date

Address:

_____

_____

Telephone: (h) _____ (w)_____(c)_____

The following person(s) are designated:

1. Name:_____
2. Name:_____
3. Name:_____
4. Name:_____

Walnut Street Community Health Center, Inc. does business as Family Healthcare of Hagerstown (FHH). This health center receives funding through Health and Human Services (HHS) and is a grantee under 42 U.S.C. 254b. FHH has Federal Public Health Services (PHS) deemed status related to certain health or health-related claims under 42 U.S.C. 233(g)-(n). This includes medical malpractice claims for itself and its covered individuals. FHH is a nonprofit organization under section 501(c)3 of the IRS Code. This institution is an equal opportunity provider and employer.