FORM 1 - AUTHORIZATION TO RELEASE HEALTH INFORMATION

Name of Patient: DOB:

I hereby authorize All Day Family Care to release/obtain all medical information with respect to the treatment of the above referenced patient, including information relating to diagnosis or treatment of mental illness or drug or alcohol abuse and /or confidential HIV related information.

Release the Medical Records From:

Method: • Mail • Pick up • Fax

Medical Group Name:________________________________

Address:____

City :_________________State:_______ Zip:_________

Fax: ___________________________________

Phone: ___________________

Send the Medical Records To:

Method: • Mail • Pick up • Fax

Send Records to:___________________________________

Address:____

City :_________________State:_______Zip:__ Fax: _____

____

Phone: ___________________

What is the Purpose of Health Information Release

_Personal
_Primary Care Physician
_Consultation
_New Physician
_Medical Ins. Claim
_Worker's Com
_Social Security Disability
_Life Insurance
_Attorney
_Other: ________________

Describe the Health Information to be Released

Service Dates: from:__________to:__________Information Needed By: ______________________________

_Complete Medical Record
_History and Physical
_Immunization Records
_Hospital Discharge Summary
_Other: ________________________________
_EKG's
_Pathology Reports
_Operative Reports
_Laboratory Results
_Radiology Reports
_Radiology Images
_Hospital Notes
_Clinic Notes
_Billing Information

I understand that All Day Family Care will not condition treatment, payment, enrollment or eligibility for benefits based on my signing this Authorization. I acknowledge that I am signing this Authorization freely, and no one has coerced or pressured me to sign the Authorization. I understand that I may revoke this Authorization at any time by providing written notice to All Day Family Care.

Date: **Signature of Patient or Person granting Authorization on behalf of patient**

Printed Name of Person Signing (If Not the Patient) **Relationship to Patient**

ALL DAY Family Care Clinic
Family Doctor | Family Practice

FORM 2 – PATIENT INFORMATION

Patient's First Name		Middle Name	Last Name (as it appears on insurance card or ID)		
Sex	Marital Status	Date of Birth (Age)	Social Security Number		
Patient's Address			City	State	Zip
Home Phone		Mobile Phone	Email Address		
Pharmacy	Pharmacy Phone		Pharmacy Address		

Employer/School Information

Employer/School	Occupation	Employer/School Phone

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance		**Secondary Health Insurance**	
Insurance Company		Insurance Company	
Member ID	Group Number	Member ID	Group Number
Insured's Name (as it appears on insurance card or ID)			
Insured's Address (if different from patient)			
Insured's Social Security Number	Insured's Birthdate		

Responsible Party

Name (if other than patient)	Phone	Relation to Patient	
Address	City	State	Zip

How did you hear about All Day Family Care Clinic

__ Family/Friend __ Internet Search __ Insurance __ Other Doctors Office __ Direct Mail

Consent for Treatment

The above information is true to the best of my knowledge. Permission is hereby given to the physicians and staff of All Day Family Care to provide ordinary and necessary medical examination, diagnosis, and treatment and administer such therapeutic treatment or services that the physician may order. Ordinary and necessary medical care shall include preventive and prophylactic care, medical procedures as well as laboratory tests. I further consent to routine immunizations for future office visits.

Authorization for Release of Information for Treatment & Payment

I consent to the use and/or disclosure of my health information (including the diagnosis or treatment of mental illnesses, or drug or alcohol abuse and/or confidential HIV-related information) to any person or organization for the purpose of treatment, including coordinating my continuing care and as otherwise authorized by law, conducting certain healthcare operations. This authorization includes the release of all medical information to health care providers who are on staff at All Day Family Care and who are directly involved in my care. I further consent to the use or disclosure of my health information (including mental illness, or drug or alcohol abuse and/or confidential HIV-related information) to any third parties responsible for payment of services furnished to me by or in All Day Family Care. This may include reviewing and/or photocopying and/or electronic release of pertinent health information for the purposes of obtaining payment. In the event that any of the information to be released relates to diagnosis or treatment of mental illness or drug or alcohol abuse and/or confidential HIV-related information, I understand that state and federal law prohibits further disclosure of it without specific written consent of the person to whom it pertains or as otherwise permitted by state and federal law.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, UNDERSTOOD AND AGREED TO THE FOREGOING, AND IS THE PATIENT OR HIS/HER REPRESENTATIVE.

Date Signature of Patient or Person Granting Authorization on Behalf of Patient **Name of Primary Care Provider (PCP)**

If the patient has not signed this form, please print the signor's name, relationship to the patient and, if necessary, explain why the patient did not sign

ALL DAY Family Care Clinic
Family Doctor | Family Practice

FORM 4 - FINANCIAL POLICIES

Fees and Payments
Fees are standard and based on the complexity of your visit. Payment in full is required at the time of your visit and can be made with cash, personal check, money order, Visa, MasterCard, or Discover. Insurance co-payments and deductibles are due at the time of service. We will not bill your secondary insurance for co-payments. If you are unable to pay your co-payment/deductible at your visit, your appointment may need to be rescheduled.

Deductibles: Because more insurance companies are issuing policies with very high deductibles, we will need to collect deductibles that have not been met at time of service. We will be collecting up to $50.00 towards your deductible. Anything over paid or under paid will either be refunded or billed to you accordingly.

While filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. Your insurance is a contract between you, your employer and the insurance company, we are not party to that contract. Before your visit, contact your insurance company to verify that we are participants in your plan, and that the services you intend to receive are covered. In order for us to file a claim, you must present a CURRENT copy of your Insurance Card at each visit and communicate any changes in your personal information.

Not all services are a covered benefit in all policies, so it is very important that you understand the provisions of your individual policy. It is virtually impossible for us to have knowledge of what services each insurance plan covers. **Knowing your insurance benefits is your responsibility**. Insurance companies decide on different services that they will not cover; therefore we can't guarantee payment of all claims by your insurance company. Reduction or rejection of your claim does not relieve you of your financial responsibility unless required by law or our contract with your insurance company.

PLEASE NOTE: Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnoses are made based on medical information, not based on the availability of coverage by Insurance Companies. To request a diagnosis change solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and is considered insurance fraud.
Required at Check-In

Verify Personal Contact Information — Present Current Copy of Insurance Card and Picture ID
Payment of any Outstanding Balance — Payment of Today's Visit

We will verify your coverage at each visit. If we are unable to do so, you will be considered self-pay and will be responsible for the cost of your visit.

Self-Pay
In order to address the needs of our patients without insurance and patients with coverage limitations, we offer a discount off our standard fees. This discount reflects the lower cost involved in billing and collections when a claim does not need to be submitted to a third party payer. In order to qualify, **payment needs to be made in FULL** prior to or on completion of your visit or procedure. Any remaining balance is not eligible for a discount. This discount applies to all medical services provided and is offered only at time of service.

Medicare and Medicaid
We gladly accept Medicare patients and will bill our services at the allowed rate. Medicare regulations may require that you sign an Advanced Beneficiary Notice (ABN) acknowledging that you will be financially responsible for the cost of the visit if we have reasonable doubt that Medicare will make payment for a particular service. Lab work that may not be covered will require a separate ABN signature. If you refuse to sign the ABN, we will be unable to provide the service. We gladly accept patients with Maryland Medicaid and Managed Care Organization (MCO) as well. Your current ID card must be presented at each visit. **IT IS YOUR RESPONSIBILITY TO PROVIDE THE CURRENT INFORMATION AT EACH VISIT**.

Medical Records
In order to be in compliance with Maryland State law and HIPAA regulations, we charge a per page charge, payable in advance, if you would like a copy of your records sent to you or another physician. If you request an electronic copy of your records, we will charge a reasonable fee based on the cost of producing the copy. The medical record copy fee policy is available upon request. As always, if a collaborating physician requests portions of your record to assist in your care, there is no charge.

Miscellaneous Charges
"No-Show": - If no cancellation or reschedule call was received within 24 hours prior to your scheduled appointment we will charge $50.00 for missed appointments. "No-Show" charges need to be paid in full prior to be seen.

Interest Charge - All delinquent accounts past 30 days are subject to a 6% interest rate.

Returned Check Charge - Non Sufficient Funds (NSF) checks are subject to a $25.00 fee (in addition to fees from your bank).

Collections Charge -Accounts that are not paid within 60 days from due date may be sent to our Collection unit and reported to the Credit Bureau. In addition to your outstanding balance, a $25.00 charge will be added to cover our costs. In addition, you may be terminated from the practice and refused service until your account is current. Should the account be referred to an attorney or sent to small claims court for collection, it will be patient's responsibility to pay reasonable attorney fees, court costs, collection expenses and all other costs incurred by All Day Family Care to collect balance owed.

Lab Charges -– Depending on your insurance, you may get a separate bill from the lab facility that performs your lab work. These charges should be discussed directly with the Lab facility.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, UNDERSTOOD AND AGREED TO THE FOREGOING, AND IS THE PATIENT OR HIS/HER REPRESENTATIVE.

____

Date — Signature of Patient or Person Granting Authorization on Behalf of Patient — **Name of Primary Care Provider (PCP)**

____

If the patient has not signed this form, please print the signor's name, relationship to the patient and, if necessary, explain why the patient did not sign

FORM 5 – CONSENT FOR PRESCRIPTION HISTORY

At All Day Family Care, providers use an electronic medical record system that allows electronic prescribing of medications, known as ePrescribing. Medications are sent directly to your pharmacy through a secure electronic prescription connection, which improves the timely, understandable and accurate prescription transmission of your medication information.

- Formulary and benefit transactions – Gives the provider information about which drugs are covered by the drug benefit plan.
- Fill status notification – Allows the providers to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up or partially filled.
- Medication history transactions – Provides the provider with information about your current and past prescription. This allows providers to be better informed about potential medication issues and to use the information to improve safety and quality. Medication history information can assist with prescribed regimens; therapeutic intervention; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

By signing this consent form, you are agreeing that your provider may request and use your prescription medication history from other health care provider and/or third party pharmacy benefit payers for treatment purposes.

Please check only one of the following:

__________ I consent to allow my provider to access all of my medication history

__________ I DO NOT consent to allow my provider to access my medication history.

Patient Name:____ **DOB:** ____________________

____

Signature of Patient or Person Granting Authorization on Behalf of Patient Date:

FORM 6 – PATIENT PROVIDER EMAIL COMMUNICATION FORM

Keep in the Patient's Medical Record

I allow **ALL DAY FAMILY CARE** to use electronic mail (e-mail) to communicate clinical information to me pertaining to health care services that I have received. I acknowledge and understand that e-mail communication may contain my personal and private medical information including, but not limited to, my name, address, date of birth, types and dates of health care services received, medication, insurance coverage information, and/or test results.

I understand that, although **ALL DAY FAMILYCARE** may attempt to protect the privacy of the contents of email sent to me and will take reasonable measures to protect my privacy, ***the e-mail messages sent to me are not encrypted and travel over the Internet. As a result, there is a risk that the e-mail will be intercepted and read by unauthorized third parties.*** In allowing **ALL DAY FAMILY CARE** to send me e-mail, I assume this risk.

I also acknowledge and understand the following as it relates to this e-mail communication:

1. E-mail is not appropriate for conveying information relating to emergency medical matters.
2. If an e-mail has not been answered, I may make an appointment to see/speak with the health care provider to discuss the e-mail message.
3. I will not use e-mail for discussion of sensitive or highly confidential issues; for example, mental health or reproductive issues, etc.
4. Employees of All Day Family Care other than the Provider may have access to my e-mail address and e-mail content such as triage nurses, consulting physicians, and other health care providers that are permitted access to my medical records.
5. I, and not the Provider or All Day Medical Care, am responsible for the security of e-mail communications sent from or stored on my computer.
6. My decision to allow All Day Family Care to communicate with me by e-mail is voluntary, and that treatment is not conditioned upon my election to do so.
7. All Day Family Care or I may stop e-mail communication at any time for any reason.
8. I agree to notify All Day Family Care when my e-mail address changes.
9. I will not hold All Day Family Care responsible for damages resulting from their use of e-mail or the failure of any All Day Family Care information systems used to facilitate the e-mail communication.

The Provider may send medical information to my e-mail address, which is:

Email Address:

The Provider may communicate via email to the designated individual listed below.

Name:	***Relationship to Patient:***	***E-mail Address:***

Patient Name (Print):	***Patient/ Patient Representative Signature:***	***Date:***

FORM 7 – PATIENT PORTAL SIGN UP

Patient Name: ___________________________________Birth Date: ______________________________

As a patient of All Day Family Care, you have access to secure e-mail directly with your provider and care team through the "Patient Portal." Here is a list of how you can use email to communicate with us:

- Request a routine appointment
- Ask your provider a non-urgent question
- Request copies of lab tests, immunization records, medication lists, and other test results (including X-Rays, CAT Scans, etc.)
- Request prescription refills
- We promise not to send you any "Junk" email!

Please let us know if you are interested in using secure email through our Patient Portal. We will get you enrolled in the Patient Portal at your first visit.

☐ Yes, please sign me up for ADFC's Patient Portal. My email address is:
____ *(PLEASE PRINT CLEARLY)*

☐ No, I do not wish to use email at this time.

Patient's Signature: ____Date:____________________

FORM 8 – DESIGNATED CONTACTS

Contact persons with whom we may discuss your care, give test results and account and billing information:

Name______________________________ Relationship_____________________ Phone #_____________

Name______________________________ Relationship_____________________ Phone #_____________

Name______________________________ Relationship_____________________ Phone #_____________

Name ______________________________Relationship ____________________ Phone #_____________

Name ______________________________Relationship ____________________ Phone #_____________

May we leave confidential information on voicemail or answering machines listed below?

Home Phone________________________________ ___Yes __ No

Work Phone ________________________________ ___Yes __ No

Cell Phone __________________________________ ___Yes __ No

Patient Signature: ____ Date:_____________________