FAMILY MEDICINE
SHADY GROVE

15215 Shady Grove Road, Suite 304
Rockville, MD 20850
(301) 284-8990 / F#: (301) 569-4293

PERSONS AUTHORIZED TO HAVE ACCESS TO MY MEDICAL INFORMATION

(Example: Your spouse calls the office requesting to know the results of you recent labs, are we allowed to give it to them?)

Name: _____ Relationship: _____ Ph #: _____

Name: _____ Relationship: _____ Ph #: _____

Name: _____ Relationship: _____ Ph #: _____

Practice Policies

AGREEMENT OF FINANCIAL RESPONSIBILITY

☐ Initials

I understand that it is my responsibility to know my insurance plan and its deductibles, co-insurance and copays. **I also understand that if my deductible has not been met, or a percentage is my responsibility, the office expects payment at the time services are rendered.** ***Payment for charges from earlier visits not covered by your insurance is due at the time you check in.*** Filing insurance claims is a courtesy that we extend to our patients, you are responsible for any balance after your insurance processes your claim. If not paid within 120 days, FMSG will begin various collection activities including, but not limited to submitting the past due account to a collection agency.

INSURANCE CARD AND ID POLICY

☐ Initials

I understand that I must bring a physical insurance card and a current form of ID to **every appointment**. Without both physically present, I may be asked to reschedule my appointment. Pictures of the insurance card or photo ID on your phone will not be accepted. Nor can we accept for copies to be emailed to the office as that is a violation of HIPAA Regulations.

CONTROLLED MEDICATION POLICY

☐ Initials

I understand that this office does **NOT** dispense and refill chronic pain and sleep medications. If needed, the office will give me a referral for pain management.

FEE FOR FORMS

☐ Initials

The charge for completion of forms is $35 or more based on complexity of the form and time needed to complete. Payment of fee is due up front. Please allow for 5 business days, unless the doctor is out of the office. Some forms require a more complex evaluation prior to completion and may require an additional visit to complete the form.

PRESCRIPTION REFILL POLICY

☐ Initials

Contact our office through the **'patient portal'** for all prescription refills. Our office requires 2 business days' notice on ALL refill requests. You may call us at the office number, but the phone lines can get busy and reduces the efficiency.

Initials

SELF PAY POLICY

In order to address the needs of our patients without insurance, we offer a 30% discount off our standard fees. **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 is offered only at time of service. This policy does not apply to any miscellaneous charges.

Initials

MEDICAL RECORDS POLICY

• Processing Fee for both Disk and Paper - $10 / CD – $15 + $2 postage if mailed • Paper – 45 cents per page + Postage (based on weight) if mailed **We require 2 week notice for all medical records request.**

Signature: _____ Date: _____

Name of Representative/Guardian: _____ Relationship: _____

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Missed Appointment Policy

_____ _____

Patient's Name Date of Birth

We want to thank you for choosing us as your healthcare provider. In an effort to give you and all of our patients the best possible care we request that you review our policy regarding missed appointments.

A missed appointment is when you fail to show up for an allotted appointment time, without a phone call or cancellation notice of at least 24 hours. Please remember that we have reserved appointment times especially for you. Therefore, we require at least a 24 hour notice in order to reschedule your appointment. This will enable us to offer your cancelled appointment time to other patients. If you are unable to keep your scheduled appointment time, please call our office at least 24-hours in advance in order to avoid a missed appointment fee. **This fee is not covered by your insurance and would be due upon check-in at your next appointment.** Your phone call is critical in helping us provide continuous care to all of our patients. ***Appointments scheduled and cancelled on the same day are subject to fees.*** If you fail to give us 24-hours' notice, you will be charged the following fees:

- Doctor's Visit - $35.00 (Mon-Fri) $70.00 (Saturday)

_____
Initials

*I understand that I will no longer be allowed to schedule appointments after my **2nd** Missed Appointment and will only be seen on a walk in basis.*

I have read and understand the policy stated above:

_____ _____
Signature of Patient or Legal Representative Today's Date

_____ _____
Printed Name of Legal Representative Relationship

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Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by Family Medicine Shady Grove for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Family Medicine Shady Grove. I understand that diagnosis or treatment of me by Dr. Manisha Kalra may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Family Medicine Shady Grove is not required to agree to the restrictions that I may request. However, if Family Medicine Shady Grove agrees to a restriction that I request, the restriction is binding on Family Medicine Shady Grove and Dr. Manisha Kalra.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Manisha Kalra or Family Medicine Shady Grove has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Family Medicine Shady Grove Notice of Privacy Practices prior to signing this document. The Family Medicine Shady Grove Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Family Medicine Shady Grove. The Notice of Privacy Practices for Family Medicine Shady Grove is also provided at 15215 Shady Grove Road, Suite 304, Rockville, MD 20850. This Notice of Privacy Practices also describes my rights and the Family Medicine Shady Grove duties with respect to my protected health information.

Family Medicine Shady Grove reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

Name of Patient Date of Birth

_____

Signature of Patient or Personal Representative

_____

Name of Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

Consent to Obtain External Prescription History

I authorize **Family Medicine Shady Grove** and its affiliated providers to view my external prescription history via the RxHub service.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

_____	_____
Patient Name	DOB
_____	_____
Signature of Patient or Personal Representative	Date
_____	_____
Name of Personal Representative	Relationship

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SHADY GROVE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES *ACUSE DE RECIBO DEL AVISO SOBRE PRÁCTICAS DE PRIVACIDAD*

Notice to Patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

Aviso al Paciente:
Estamos obligados a ofrecerle una copia de nuestro aviso de prácticas de privacidad, que establece la forma en que puede usar y / o divulgar su información de salud. Por favor firme este formulario para acusar recibo de la notificación. Usted puede negarse a firmar este reconocimiento, si así lo desea.

_____

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.
Reconozco que he recibido una copia del Aviso Prácticas de Privacidad de esta oficina.

_____

Patient name / *Nobre del Paciente* *DOB/FDN* *Name of Representative / Nombre del Representante*

_____

Signature / *Firma* *Relationship/Relacion* Date / *Fecha*

FOR OFFICE USE ONLY / *PARA USO DE LA OFICINA*

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because */ Hemos hecho todos los esfuerzos para obtener el reconocimiento escrito del recibo de nuestro Aviso de Privacidad de este paciente, pero no se pudo obtener porque*:

□ The patient refused to sign / El paciente se negó a firmar.
□ Due to an emergency situation it was not possible to obtain acknowledgement / Debido a una situación de emergencia no era posible obtener un reconocimiento.
□ Language Barrier / Barrera de Idioma
□ Other (Please provide specific details) / Otros (indique los detalles específicos)

_____
_____
_____

_____ _____
Employee Signature Date

Revised 02/2020