FAMILY MEDICINE
SHADY GROVE

Name: _____
DOB: _____ Date: _____

Medications: Please list current prescriptions and non-prescription medications including vitamins.

Ex: Levothyroxine 50 MCG Once a day _____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies/Reactions: Please list allergies to medication or food

☐ No Known Allergies to medication or food

Example: Codeine – Rash _____ _____ _____
_____ _____ _____

Past Medical History: I have been diagnosed by a doctor with: Please check all that apply.

Heart Disease
___ Abnormal EKG
___ Angina
___ Heart Attack
___ Heart Murmur
___ High Blood Pressure
___ High Cholesterol
___ High Triglycerides
___ Stroke
___ Carotid Stenosis

Endocrine
___ Diabetes (Type: 2 / 1) *(Circle One)*
___ Thyroid Disease

Lung
___ Asthma
___ COPD / Emphysema
___ Tuberculosis
___ Blood Clot (Lungs)

Neurology
___ Epilepsy
___ Headaches / Migraines *(Circle One)*
___ Stroke

Mental Health
___ ADD/ADHD *(Circle One)*
___ Anxiety
___ Bipolar Disorder
___ Depression

GI
___ Acid Reflux / GERD
___ Colitis
___ Diverticulitis
___ Esophagitis
___ Gallstones
___ Gastritis / Stomach Ulcers
___ Hemorrhoids
___ Hepatitis A / B / C *(Circle One)*
___ Pancreatitis

Vascular
___ Blood Clot (Arm / Leg) *(Circle One)*
___ Phlebitis
___ Varicose Veins

Musculoskeletal
___ Arthritis
___ Disk Problems
___ Gout
___ Osteoporosis / Osteopenia *(Circle One)*

Skin
___ Eczema
___ Melanoma
___ Psoriasis

STD
___ Chlamydia
___ Genital Herpes
___ Genital Warts
___ Gonorrhea
___ HIV/ AIDS
___ Syphilis

Eye
___ Cataracts
___ Glaucoma

Genitourinary/GYN
___ Cystitis
___ Endometriosis
___ Kidney Stones
___ Ovarian Cyst
___ Pelvic Problem
___ Prostate Problem

Breast
___ Fibrocystic Disease
___ Mastitis

Cancer
Breast - Colon - Lung - Prostate - Ovarian - Skin

Age at cancer diagnosis:
_____ yrs old

Other Diagnoses: _____
_____

Surgeries/Hospitalizations & Dates:

Example: Left knee surgery 10/2007 _____ _____ _____
_____ _____ _____

Family History: Please check all that apply. ☐ ***Adopted/Unknown***

L – Living
D - Deceased
U - Unknown

	Circle Status for **all**	Asthma	Arthritis	Cancer	Dementia	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Depression or Anxiety	Stroke	Thyroid Disorder
Example	***(L) D U***			***Breast***			***X***	***X***		***(D) A***		
Father	L D U									*D A*		
Mother	L D U									*D A*		
Dad's Father	L D U									*D A*		
Dad's Mother	L D U									*D A*		
Mom's Father	L D U									*D A*		
Mom's Mother	L D U									*D A*		
#___ Brother(s)	L D U									*D A*		
#___ Sister(s)	L D U									*D A*		
#___ Sons	L D U									*D A*		
#___ Daughters	L D U									*D A*		

If you do not have any brothers/sisters or sons/daughters write a zero so we know you did not miss this section.

Please continue the form on the other side

Social History: Must be filled for patients 13 yrs or older

Occupation: _____ Marital Status: _____ Exercise: _____ # times/ week for _____ hrs.

Tobacco Use: ☐ Yes ☐ No ☐ Past Quit Date: _____ # of cigarettes per day: _____ for _____ years.

Drug Use (past 12 months): ☐ Yes ☐ No Type: _____ last used on: _____

Alcohol Use: ☐ No ☐ Occasional ☐ Daily # of Drinks: _____ per: Day - Wk. - Mo ☐ Beer ☐ Wine ☐ Hard Liquor

Caffeine: ☐ No ☐ Occasional ☐ Daily Drinks per day: _____ ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drinks

Immunizations: Please list the date of the most recent.

Tetanus Shot: _____ Pneumonia Vaccine: _____

Flu Shot: _____ Shingles Vaccine: _____

Screening Test: Please list the date of the most recent tests.

Eye Exam: _____ Bone Density: _____

EKG: _____ Stress Test: _____

Colonoscopy: _____ PSA: _____

Women Only:
(If none please write zero)

1st day of last period: _____

Last Pap Smear: _____

Last Mammogram: _____

# of Pregnancies: _____

# of Living Children: _____

# of Miscarriages: _____

# of Abortions: _____

# of Still Births: _____

(For Office Use)
Vital Signs

Wt: _____ R: _____
Ht: _____ BP: _____
T: _____ HC: _____
P: _____ O2: _____

Vision: ☐ No glasses/contacts
B: _____ L: _____ R: _____

Hearing: L: _____ R: _____

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

Name of Representative/Guardian: _____

Office Use Only

Reviewed By: _____

Date: _____

(PLEASE SIGN SEPARATE CONSENT FORMS TO GET OLD RECORDS FROM OTHER DOCTORS)

Physician Notes: _____

_____

_____

FAMILY MEDICINE
SHADY GROVE

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

PATIENT INFORMATION

Patient's Last Name: _____ First Name: _____ M.I.: _____ Preferred Name: _____

Street Address: _____City: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____ Birth Date: _____ Sex assigned at birth: M / F

Gender you identify with: Male/ Female/ Transgender Male/ Transgender female/ Gender Queer/ Other (please specify): _____

Pronouns: She/her/hers He/him/his They/them/theirs Other (please specify): _____

Relationship Status: Single Married Widowed Divorced Legally Separated

Email: _____ Race: _____ Ethnicity: ☐ Hispanic/Latino / ☐ Not Hispanic/Latino

EMERGENCY CONTACTS

(Must be a person other than a parent/guardian if patient is under 18yrs old)

Name: _____ Relationship: _____ Home #: _____ Cell #: _____

Name: _____ Relationship: _____ Home #: _____ Cell #: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Street Pharmacy is on: _____ City: _____

INSURANCE INFORMATION

(Must be filled in by the patient even if the office scanned your insurance card)

☐ I do not have insurance & will be paying for the visit myself ☐ I will pay out of pocket & need an itemized receipt for reimbursement from my insurance

Primary Insurance: _____ ID#: _____ Group #: _____

Policy Holder: _____ Relationship: _____ Policy Holder DOB: _____

Secondary Insurance: _____ ID#: _____ Group #: _____

Policy Holder: _____ Relationship: _____ Policy Holder DOB: _____

Tertiary Insurance: _____ ID#: _____ Group #: _____

Policy Holder: _____ Relationship: _____ Policy Holder DOB: _____

PARENT(S) / LEGAL GUARDIAN INFO

(Please fill if the patient is under 18 years old)

Parent / Legal Guardian: _____ DOB: _____ Relationship to Minor: _____

Home #: _____ Cell #: _____ Work #: _____ ☐ Guarantor/Responsible Party

Parent / Legal Guardian: _____ DOB: _____ Relationship to Minor: _____

Home #: _____ Cell #: _____ Work #: _____ ☐ Guarantor/Responsible Party

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 FOR VISIT AND LABS/PROCEDURES

☐ 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. **Lab billing is NOT done by our practice and thus any questions related to the lab bills must be directed to the lab directly**. We offer courtesy lab draw service on site provided by Bio Reference lab. I understand it is my responsibility to check with my insurance company what labs are covered and how my policy dictates the coverage, and I will notify the practice at each visit if I would like to use a specific lab. Orders can be given to go to Labcorp or Quest lab upon request. Labs are not ordered ahead of visits without seeing the patient.

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.

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(301) 284-8990 / F#: (301) 569-4293

FEE FOR FORMS

Initials

The charge for completion of forms is $35-50 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

Refills of medications are generally tied with the follow up visits. Make appointments ahead of time to ensure you get refill before medications run out as our office is busy and appointments may not be available until few weeks. 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.

SELF PAY POLICY

Initials

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.

PREVENTATIVE VISIT POLICY

Initials

Annual physicals are preventative visits, and NO refills, referrals or problems will be addressed during this visit. Separate appointments will be required for any of these mentioned reasons. Please do NOT call or message post preventative visit for refills unless you have been seen for the problem. All chronic medications require minimum every 6 month follow ups.

TELEVISIT POLICY

Initials

Televisits can ONLY be conducted if patient is in the state of Maryland physically at the time of the visit. Copays apply like regular in-office visits if your insurance policy indicates you have a copay and will be collected prior to the televisit and any balances on account will also be collected prior to the televisit.

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: _____

FAMILY MEDICINE
SHADY GROVE

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

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 - $50.00 (Mon-Fri) $70.00 (Saturday)

_____
Initials

*I understand that after my **2nd** Missed Appointment*
I will no longer be able to be seen at the practice.

I have read and understand the policy stated above:

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

_____ _____
Printed Name of Legal Representative Relationship

FAMILY MEDICINE
SHADY GROVE

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

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

FAMILY MEDICINE
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 11/2021