Potomac Region Medical Associates

14300 Gallant Fox Lane Ste.118
Bowie, Maryland 20715
Phone (301-805-4348

1600K Crystal Square Arcade
Arlington, VA 22202
Phone: 703-418-1870

Patient Information Form

Social Security # _____ Email Address_____

Date of Birth (mm/dd/yy) _____ Sex (M/F)_____

Last Name_____**First Name**_____**M.I**_____

Street Address_____

City_____ State_____ Zip Code _____

Home Phone# _____-_____-_____ Work Phone#_____-_____-_____

Cell Phone# _____- _____-_____

How did you hear about us?_____

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐

Place of Employment_____

Street Address_____

City_____ State_____ Zip Code_____

Pharmacy and address;_____ Number:_____

Primary Insurance/ Insured's Name_____

Relationship to Insured Self ☐ Spouse ☐ Child ☐ Other☐

Member ID#_____ Group#_____

City_____ State_____ Zip Code_____

Insurance Verification Telephone # _____

Secondary Insurance Insured's Name _____

Relationship to Insured Self ☐ Spouse ☐ Child ☐ Other☐

Member ID#_____ Group#_____

City_____ State_____ Zip Code_____

Insurance Verification Telephone #_____

Emergency Contact_____ Phone #_____

Choice of Provider

I am aware that I may choose my usual provider and at this time I choose the following provider to be my usual provider. I understand that this provider may not be available for all scheduled appointments, but Fit for Life will make an effort to provide continuity of care by scheduling you with your chosen provider.

- Dawne Carroll, MD
- Miriam Martin, MD
- Jennifer Young, Nurse Practitioner
- Kamilah Ray-Boyd, Certified Physician Assistant
- Ann Parker, Nurse Practitioner
- Naroby Bush, Certified Physician Assistant
- Agnes Kallon, Nurse Practitioner

_____ _____

Signature Date

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND TO FILE A COPY OF PATIENTS SIGNATURE FOR INSURANCE PURPOSES:

I, the undersigned, hereby authorize the release of any and all medical information required to review and process claims to my insurance carrier(s). I further authorize the Fit for Life Medical Center, Inc., Inc. to request payment from my insurance carrier(s) for medical benefits for services rendered to my covered dependent(s) or myself. I understand that I agree to be personally responsible for payment to Fit for Life Medical Center, Inc., Inc. in the event that benefits are not paid by my insurance carrier(s).

STATEMENT OF ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by Fit for Life Medical Center, Inc., Inc. I assign and authorize payments to Fit for Life Medical Center, Inc., Inc. Physicians/Providers. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusion, coverage limit, and lack of authorization or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. In addition, I understand that it is my responsibility to notify Fit for Life Medical Center, Inc., Inc. for any changes in insurance coverage or if I have another insurance company serving as my primary insurer.

FIT FOR LIFE MEDICAL CENTER, INC. INC.
CONSENT FOR TREATMENT:

I hereby authorize Fit for Life Medical Center, Inc. ***Medical Providers,*** **to carry out treatment which includes but not limited to the administration and performance of all treatments, the administration and prescribing of any needed medications, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures, laboratory specimens and of other medically accepted laboratory tests, all of which in the judgment of the providers may be considered Medically Necessary or advisable.**

I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as the result of examination or treatment at Fit for Life Medical Center, Inc.

I understand that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation.

A photo copy of this consent shall be considered as a valid original.

I certify that I have read and fully understand the above information and consent fully and voluntarily to its contents, and also certify that I have been given a copy of the office Policy and Procedures and HIPAA Privacy Form

_____ _____

Signature Date

DISCLOSURE OF MY PROTECTED HEALTH INFORMATION:

I authorize Fit for Life Medical Center, Inc. to disclose my Protected Health Information either via phone, fax, email or paper copy to: (please check all that apply and describe)

- My Spouse (Full Name)_____
- My Family Member (Full Name)_____
- Non Custodial Parent (Full Name)_____
- Care taker (Full Name)_____
- Other (Full Name)_____

_____ _____

Signature Date

Our office provides Early Morning, Day, Evening Saturday and Sunday appointments!

Our staff is committed to providing you with quality health care. To make your visit here as comfortable as possible, we are providing you with a list of office policies and procedures in advance. This may help avoid any questions that may arise regarding our office policies and procedures.

Office Policies

1. **Prescription Refills:** To obtain a refill of your current prescription, please call our office for more expedient response; or your pharmacy and the pharmacist will contact our office for a refill authorization. We will refill a prescription **only** if there is an existing problem that is reflected in your health records. All patients must be seen in our office to obtain a prescription for any new problems or conditions. In addition, you must have been seen by one of our providers in the recent past. Requests for refill will attempt to be completed at the end of each business day, however, refill request can take up to 48-72 hours. Provider will not stop taking care of patients to complete prescription refills.
   Prior Authorizations for medication may take up to 3-7 days for approval.

2. **Referrals:** Patients covered by insurance that requires referrals for specialist must be seen by a provider in the office prior to granting any referrals. Referral request cannot be authorized over the phone. For existing referrals to be renewed, please make your requests at least 72 hours in advance. Referrals can be picked up by patient, faxed or eSCRIBE to specialist office by our staff.

3. **Inclement Weather:** Our office staff will make every reasonable effort to keep our office open during inclement weather. If you are unable to travel due to the weather, please contact our office to notify our staff immediately. Well will make every effort to notify you in advance if our office will be closed. If you should have any questions of concerns during this period or are uncertain as to whether our office is open for services, please contact the office.

4. **Record Reproduction:** Your medical records are the property of our office. We are required by law to keep all files intact. There is a clerical fee associated with the reproduction of your records. The base fee is $15.00 and .63 cents per page, in accordance with the guidelines by the Medical and Chirurgical Facility of Maryland. If you are in need of obtaining a copy of your record, please contact our office as soon as possible and complete an Authorization to Release form. A copy of which is available on your Patient Portal. Payment of the clerical fee must be received at least 24 hours in advance. Records will then be available for pick-up during normal business hours. Reproduction of your medical record can take up to five days after your request.

5. **Business Office Hours:**
   Mon: 9:00am-5:00pm **Wed:** 9:00am-5:00pm **Fri:** 9:00am-4:00pm
   Tues: 9:00am-5:00pm **Thurs:** 9:00am-5:00p
   The hours listed above are for the administrative staff. If you have a question regarding your bill, please contact Tracy Tyler within these hours.

6. **Provider Office Hours: Maryland:**
   Mon: 7:30am-5:00pm **Wed:** 9:00am-7:00pm **Fri:** 9:00am-4:00pm
   Tues: 9:00am-5:00pm **Thurs:** 9:00am-5:00pm **Sat:** 8:30am12:00pm (Every other)

Sun: Once per month

7. **Provider Office Hours: Virginia:**

Mon: 8:30am-12:00pm **Wed:** Closed **Fri:** 9:00am-4:00pm
Tues: 9:00am-5:00pm **Thurs:** 9:00am-5:00pm **Sat:** 8:30am12:00pm (Once per month)

8. **Clinical Advice during office hours:**

Providers are available to answer your clinical question during office hours, however, the Provider does not stop caring for the patients currently on the schedule to answer your phone calls.
The policy of the practice is for the staff member who is answering the phone to make a "patient case' with as much information as possible for the Provider. The provider will attempt to address their Patient Cases at the end of each work day which includes calling patient's back.
There are times where the Provider will direct a ***staff member*** to call the patient back with detailed instructions.

Providers are not able to make diagnoses over the phone and some questions cannot be answered with a phone call. The patient will be directed to make an appointment!

9. **Clinical Advice after office hours:**

There is a Provider available for clinical advice or emergency situations after office hours. Patients are to call the main number (301) 805-4348 which will connect them to the Provider on call. The Provider will answer all after hour call within 60 minutes after a message if left. Providers are free to determine which calls require a call back after hours and which call can be returned to next business day. In life threatening emergency situations, the patient should call 911.

10. **Completion of Forms:**

The patient will be asked to make an appointment to see the Provider to complete forms so that all information is obtained. There is a charge associated with the completion of forms which include but are not limited to:

Simple Forms	**$15.00**
FMLA Forms:	**$35.00**
Disability Forms:	**$35.00**

Patients should be sure that they speak to their Provider regarding the specific issues involving the forms that the patient needs completed. Patients who leave forms to be completed and the Provider is not aware of their issue or disability, the form will be returned and the patient will need to schedule a follow-up appointment to discuss the issues or problems

Lab Services:

Your insurance company may or may not pay for some lab work that our Providers may deem necessary to perform on you.

- Fit for Life Medical Center, Inc. performs the following lab work during yearly complete physical examinations. CBC; Chemistry; Urinalysis; Vitamin D deficiency; Thyroid Panel and Cholesterol Panel, STD screen and HIV. (*may not be inclusive based on your condition)*
- You may also require lab work during the course of your treatment throughout the year.
- All specimens that are sent to a lab require a 3 to 14 day turnaround time.

It is your responsibility to check with your insurance company prior to your appointment to be sure the lab work is covered and notify our staff prior to drawing your blood.

Fit for Life Medical Center, Inc. Inc. will not be responsible for cost associated with lab work not covered by your insurance company!!!!!!

Terms and Conditions:

1. **Appointments:** All patients are expected to arrive on time for their scheduled appointment time. ***Any patient arriving more than 15 minutes late may be rescheduled***

2. **Cancelled Appointments: I**f you are unable to keep you appointment, you must notify the office as soon as possible. You are welcome to leave a detailed message with the answering service. Appointment which are not cancelled 24 hours in advance, will be charged a $25.00 no show fee.

3. **Payment of fees:** Co-payments are due upon arrival for your appointment. Any outstanding balances must be paid prior to being seen by the Provider. If you would like to make payment arrangements on your account with our billing department, this must be done prior to your appointment date. All cancellation fees must be paid in full before any other appointments are made with our office. If you are a cash patient, please remember to bring your payment with you for your appointment. If you are unable to make a payment at the time of service, your appointment may be rescheduled.

4. **Weight Control Service:** Charges for obesity care and weight control are not covered by health insurance. Patients that would like to enroll in our weight loss program are required to pay for these services.

   Travel Immunization: We do not accept insurance for our travel health services. If you have health insurance that covers travel immunizations we will provide you with a super bill to submit to your insurance company for reimbursement.
   THE PATIENT IS RESPONSIBLE TO KNOW THE IMMUNIZATIONS THAT THEY NEED PRIOR TO BEING SEEN BY THE PROVIDER

5. **Payment Method:** Cash or charge may pay for all services provided by our office. We accept all major credit cards. We do not accept checks for payment of co-payment fees. If you have any questions regarding your payment method, please ask our front desk staff member.

6. **Contact Information:** Fit for Life Medical Center, Inc. request that all patients provide accurate and updated personal contact information which may include, but not limited to home and personal cell phone(s), emails and home addresses. This information will be used to contact patients to notify them of their scheduled appointments, collection of debt and/or other non-private information.

7. **Collection charges:** Our office will make every effort to avoid sending your account to a collection office. It is your responsibility to provide our office with any change in address, phone number, and insurance company information. Failure to notify us with these changes may result in a delinquent balance because we were unable to contact you or your insurance company for payment.

Account balances overdue by 90 days are subject to be reported to the credit bureau.

Fit for Life Medical Center, Inc. Inc. reserves the right to refuse to schedule future appointments for overdue accounts!

PATIENT RIGHTS AND RESPONSIBILITES

You have the right to:

1. Be treated with courtesy, dignity and respect.
2. Know the name of Doctors, Physician Assistant, Nurse Practitioners and other people caring for you.
3. Be told by your care giver what your condition is, what treatment they recommend, how they expect your condition to change, and what follow-up care is needed.
4. Know the reason for giving you various test and treatments and the names of the persons giving them to you.
5. Know the benefits, risks and discomforts of any procedure or treatment recommended for you.
6. An explanation of all papers our staff asks you to sign.
7. Expect that staff will respect your personal privacy to the fullest extent allowed by the care you need.
8. Expect that records related to your care remain confidential.
9. Arrange for a meeting with another provider for a second opinion
10. Choose to change providers.
11. The services of Fit for Life Medical Center, Inc. Inc. that is necessary for your care will be given without regard to race, color, creed, national origin, age, sex, sexual preference, political party, religion or disability.
12. Refuse to participate in research projects.
13. Examine and receive an explanation of all charges.
14. Express spiritual and cultural beliefs that do not harm others or interfere with their care.

You have the responsibility to:

1. Show a current ID and insurance card at every visit.
2. Treat others with courtesy, dignity and respect.
3. Give, upon request, necessary records for registration, billing, ability to pay, and authority to consent.
4. Give correct and complete information about your present symptoms, past illnesses, hospitalizations, emergency room/urgent care visits, medicines you are taking and other questions about your health.
5. Ask questions if you do not understand papers you are asked to sign or information given to you.
6. Take part in your care.
7. Keep appointments and be on time.
8. Pay your co-pay at the time of service.
9. Tell the administrative staff when you are not pleased with your care
10. Accept the results if you refuse treatment or do not follow the Providers instructions.
11. Consider the rights of other patients and staff and to help control noise.
12.

PATIENT PORTAL:

Patient Portal facilitates better communication with your physician's office by providing convenient and secure access from the comfort and privacy of your home or office.

Your patient portal will provide patients with:

- **Timely electronic access to changes in health information**
- **Electronic copies of their health record**
- **Clinical summaries after each office visit**
- **Ability to send messages to the practice requesting refills, appointments and ask clinical questions**

To access the Patient Portal the following directions below:

- **Type in the Tool bar:** https://3015.portal.athenahealth.com
- **Go to: create an Account**
- **Complete steps 1-3**
- **Create your pin (must be 5-13 digits)**
- **Sign in**