PARK MEDICAL ASSOCIATES, LLC **PARK MEDICAL LABORATORY**
10755 FALLS RD. SUITE 200 LUTHERVILLE, MD 21093

PATIENT REGISTRATION: Fill in online and print, or print and fill out using black ink. Use the [TAB] key or Right Arrow key to move to the next field. To move backward, use the Left Arrow key. Pressing F1 in select fields will provide helpful hints on how to enter the data.

Primary Physician:

☐BELITSOS ☐BYRD ☐HADLEY ☐MAGAZINER ☐MOLAVI ☐MOLINARO ☐NEWMAN ☐POZEFSKY
☐PRESSMAN ☐SAVADEL ☐SEIFTER ☐SHISHODIA ☐SIMONSON ☐STEINER ☐WILKENFELD

PLEASE PRINT **Today's Date**: **Appt. Date**: **Appt. Time**:

PATIENT INFORMATION

LAST NAME	FIRST	MI	Social Security #	JHH HIST#

ADDRESS	REFERRING DOCTOR

CITY	STATE	ZIP or Postal Code	COUNTRY	SEX ☐M ☐F	DATE of BIRTH	MARITAL STATUS ☐M ☐S ☐W ☐D ☐Other

PREFERRED LANGUAGE: ☐ English ☐ Other (please specify) ☐ Decline to answer

RACE: ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ White ☐ Decline to answer

ETHNICITY: Are you of Hispanic Origin? ☐ YES ☐ NO ☐ Decline to answer

HOME PHONE	CELL PHONE	WORK PHONE	EXT

eMAIL ADDRESS

NAME OF EMPLOYER	OCCUPATION

EMPLOYER ADDRESS

CITY	STATE	ZIP

☐ EMPLOYED STUDENT: ☐ FULL-TIME ☐ PART-TIME

SPOUSE'S NAME	
SPOUSE'S OCCUPATION	SPOUSE'S DATE OF BIRTH
SPOUSE'S EMPLOYER	
SPOUSE'S EMPLOYER'S ADDRESS	

CITY	STATE	ZIP

SPOUSE'S WORK PHONE	EXT	SPOUSE'S' CELL PHONE

PERSON TO NOTIFY IN CASE OF EMERGENCY	RELATIONSHIP

WORK PHONE	EXT

HOME PHONE	CELL PHONE

PHARMACY NAME

PHARMACY ADDRESS

PHARMACY PHONE

INSURANCE COMPANY INFORMATION

NAME OF PRIMARY INSURANCE	NAME OF SECONDARY INSURANCE

ADDRESS	ADDRESS

CITY	STATE	ZIP	CITY	STATE	ZIP

PHONE	EFFECTIVE	PHONE	EFFECTIVE

POLICY #	GROUP #	POLICY #	GROUP #

IS POLICY HOLDER THE PATIENT? YES ☐ NO ☐ IS POLICY HOLDER THE PATIENT? YES ☐ NO ☐

POLICY HOLDER LAST NAME	FIRST	MI	POLICY HOLDER LAST NAME	FIRST	MI

ADDRESS	ADDRESS

CITY	STATE	ZIP	CITY	STATE	ZIP

SOCIAL SECURITY #	SEX	DATE OF BIRTH	SOCIAL SECURITY #	SEX	DATE OFBIRTH

RELATIONSHIP OF THE PATIENT TO THE POLICY HOLDER	RELATIONSHIP OF THE PATIENT TO THE POLICY HOLDER

EMPLOYER OF POLICY HOLDER if not listed above	EMPLOYER OF POLICY HOLDER if not listed above

PAYMENT OF BENEFITS

I authorize Park Medical Associates and Park Medical Laboratory to file insurance on my behalf and release any medical or other information necessary to process my claims. When applicable, I authorize payment of benefits directly to the physician or laboratory. I understand that Park Medical Laboratory and the physicians of Park Medical Associates (excluding John Aucott, M.D.) participate in all Cigna (except Worker's Comp) and CareFirst networks. I understand that the physicians and the lab also participate with EHP. I understand that the Park Medical physicians do ***not*** accept Medicare assignment (except for Dr. Seifter). I understand that the physicians and the lab do ***not*** participate with any other commercial insurance or HMO. Park Medical Laboratory participates with Medicare. Specialized testing services sent to an outside reference lab will be billed separately by that testing facility. I understand that I am responsible and agree to pay for any balance not covered by my insurance.

Signature _____ Date _____

PARK MEDICAL ASSOCIATES LLC FINANCIAL POLICY (FP++) Eff. 6/1/18

We would like to thank you for choosing Park Medical Associates as your medical provider. We pride ourselves on providing all patients with excellent patient service. Billing costs have risen enormously and we ask your help in controlling these costs. To keep you informed of our current financial policies, please read the following, and sign at the bottom. We ask that you keep a copy of this document for future reference.

Insurance

The physicians of Park Medical Associates participate with EHP, Cigna and CareFirst BlueCross BlueShield. They are authorized to provide services to Medicare patients, but they do not accept Medicare assignment (except for Dr. Seifter). Park Medical Laboratory participates with Medicare, EHP, Cigna & BCBS for lab tests. It is the patient's responsibility to provide our office with a copy of your current insurance card, and to inform us of any changes in insurance. Although we file claims for most insurance plans on your behalf, you are ultimately responsible for payment of the bill.

Copays, Co-insurance, Deductibles, and Non-covered Services

Copays are payable at the time of service. We accept cash, check (no foreign checks), or credit card (VISA, MasterCard, Discover and American Express). Co-pays, co-insurance and deductibles cannot be waived by our practice, as they are requirements placed on you by your insurance carrier. You are responsible for any non-covered services as determined by your insurance plan (including forms). If you have an insurance plan with whom we do not participate, you are responsible for our bill in full.

Past Due Balances

You will be asked to pay any past due balances when making appointments or before seeing the physician. If your balance is especially high, you can set up a payment plan with a Patient Service Coordinator or Billing Coordinator.

Returned Checks

A $25 charge will be added to your account for any check returned by your bank.

Finance Charge/No Show Fee/Cancellation Fee

If your bill is over 90 days old, we will impose a finance charge of $15. This fee will help to offset the excessive monthly costs involved in continuing to send overdue bills. If you are on a payment plan, and meet your monthly payment obligation, a finance charge will not be assessed. We reserve the right to charge a fee of $75 for no show appointments and a $50 cancellation fee for appointments cancelled within 24 hours at the doctor's discretion.

Collections Fee

If after 2-3 months a balance remains unpaid, we will send the account to our collections attorneys. We will impose a collections fee of one third of the outstanding bill to cover the fee charged to us by the collection agency.

_____

Signature Date

_____

Print Name

Park Medical Associates, L.L.C.
Johns Hopkins at Green Spring Station
10755 Falls Road, Suite 200
Lutherville, MD 21093
410-583-7111

WRITTEN ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES OFFERED

I, _____ have been offered a copy of Park Medical Associates
(Please print)
Notice of Privacy Practices. This notice is also available on our website at www.parkmedical.net.

Signature: _____ Date: _____

PATIENT CONSENT FORM

Authorization for Release of Protected Health Information to a Trusted Individual (Family Member, Friend, etc.)

___ I do NOT want my information released to any individual.
___ I authorize Park Medical Associates to tell the Trusted Individual(s) named below about my prognosis and treatment plans, diagnosis, test findings, radiology reports and laboratory results either in person or by telephone. The Individual is also authorized to order my medication refills.

Trusted Individual Information: (please print clearly)

Name: _____ Relationship to Patient _____ Phone _____

Name: _____ Relationship to Patient _____ Phone _____

Name: _____ Relationship to Patient _____ Phone _____

Consent to Email Communication between Patient and Park Medical Associates Doctors and Staff

By providing my email address below I am consenting to sending and receiving email from the Doctors and/or Staff. Emails could consist of (but are not limited to) having test results or other information or forms sent to me at my request, and/or communications between myself and my doctor (if the Doctor uses email for communication). **We are committed to keeping your email address confidential.**

I agree that I will NOT use email to communicate any urgent matters to the Doctors or Staff.

I understand that email between Park Medical Associates is secure when sent but not encrypted and therefore is potentially accessible to third parties.

I understand that on my end, anyone who has access to my email account or my unsecured electronic devices will potentially have access to emails sent between Park Medical Associates and myself.

Use of email and its risks are further spelled out in our Notice of Privacy Practices detailed at the top of this page and available in its entirety on our website www.parkmedical.net

___ I decline the use of email.

___ I consent to the use of email. My email address is _____

PLEASE PRINT VERY CLEARLY!

NEW PATIENT QUESTIONNAIRE

PARK MEDICAL ASSOCIATES, LLC ◊ 10755 FALLS RD. SUITE 200 ◊ LUTHERVILLE, MD 21093

Please print this form, complete, and bring with you.

Name:	DOB:	Age:	Date:

	Operation performed & Reason *(include any complications related to surgery/anesthesia)*	Date
1		
2		
3		
4		
5		
6		
7		
8		

	Overnight Hospitalizations *(exclude Operations listed above)*	Date
1		
2		
3		
4		
5		

Medications (include prescription topicals)

	Drug name	Strength	Doses/day
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Drug Allergies

	Drug name	Description of reaction
1		
2		
3		
4		

Vaccines

Name	Yes	No	Date
Tetanus *(in past 10 yrs.)*	☐	☐	
Pneumonia	☐	☐	
Hepatitis A *(2 doses)*	☐	☐	
Hepatitis B *(3 doses)*	☐	☐	
Other (in past 3 yrs.)			

	Have you had:	Date	Result
(If more than one, list only most recent)	**Colonoscopy**		
	Bone density		
	Mammogram		
	GYN examination		
	Eye examination		
	Stress test		
	****MRI/CT scan** *(indicate part of body)*		
(in the past 12 months)	****Blood work**		
	****Chest X-ray**		
	****Ekg**		

** *Bring reports if possible. (Actual films are not required.)*

Pregnancies	Number:	Live births:	Complications:

Pre-visit instructions for laboratory tests:

► Fast after 12:00 midnight the night before the exam. ► Patients may have water, black coffee, plain tea the morning of the exam. ► Medications are to be taken as usual except for patients using insulin. ► Patients taking insulin should bring a light breakfast and their insulin. Inject insulin & eat breakfast after blood is drawn.

Please complete "Family Medical History" on the next page.

FAMILY MEDICAL HISTORY

Name:		DOB:	Age:	Date:

IMMEDIATE FAMILY	Living? Yes	No	Age	Include ALL sisters, brothers, daughters, sons, and indicate health status for each. Significant health issues (or cause of death)
☐ Mother	☐	☐		
☐ Father	☐	☐		
☐ Sister ☐ Brother	☐	☐		
☐ Sister ☐ Brother	☐	☐		
☐ Sister ☐ Brother	☐	☐		
☐ Sister ☐ Brother	☐	☐		
☐ Sister ☐ Brother	☐	☐		
☐ Sister ☐ Brother	☐	☐		
☐ Sister ☐ Brother	☐	☐		
☐ Sister ☐ Brother	☐	☐		
☐ Daughter ☐ Son	☐	☐		
☐ Daughter ☐ Son	☐	☐		
☐ Daughter ☐ Son	☐	☐		
☐ Daughter ☐ Son	☐	☐		
☐ Daughter ☐ Son	☐	☐		
☐ Daughter ☐ Son	☐	☐		
☐ Daughter ☐ Son	☐	☐		
☐ Daughter ☐ Son	☐	☐		

DISTANT RELATIVES	PLEASE REPORT ANY DISEASES OR SIGNIFICANT HEALTH ISSUES IN GRANDPARENTS, AUNTS, UNCLES, AND COUSINS. (INDICATE SPECIFIC RELATIVE, *e.g. MATERNAL* COUSIN)
Cancer	
Type :	Relative(s):
Type :	Relative(s):
Type :	Relative(s):
Type :	Relative(s):
Type :	Relative(s):
Rheumatoid arthritis, gout, or other crippling arthritis *(indicate diagnosis for each relative affected)*	
Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:
Serious psychiatric illness *(nervous breakdown, mental hospitalization, suicide attempt)*	
Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:
Coronary artery disease *(heart attack, angioplasty, bypass surgery).* **Indicate approximate age of onset for each relative.**	
Aneurysm:	**Stroke:**
Kidney disease:	**Peptic ulcer disease:**
Kidney stones:	**Tuberculosis:**
Diabetes:	**High blood pressure:**
Other significant diseases *(include those that "run in the family")*:	
Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:

Thank you for helping us with this information. We look forward to seeing you.