PATIENT DEMOGRAPHIC FORM

MARYLAND CENTER FOR ARTHRITIS AND REGENERATIVE CARE

DATE:

PATIENT INFORMATION

Last Name | First Name | Middle Initial

Date of Birth | Social Security Number | Gender ○ Male ○ Female

Marital Status: Married | Single | Divorced | Life Partner | Separated | Widowed | Language:

Home Address | Apt # | City | State | Zip Code

Home Phone | Cell phone | Work Phone

Email Address | Employment Status

Employer | Address | Phone

Primary Care Physician | Phone | Referring Physician | Phone

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient: Self | Spouse | Parent | Other

Last Name | First Name | Middle Initial

Date of Birth | Social Security Number

Home Address | Apt # | City | State | Zip Code

Home Phone | Cell phone | Work Phone

Email Address

Employer | Address | Phone

INSURANCE INFORMATION

Primary Insurance Company | Policy # | Group #

Claims Address | Policy Holders Employer (If other than Patient)

Patient's Relationship to Insured | Policy Holders Name (If other than Patient)

Subscriber's Social Security # | Date of Birth | Gender Male Female

Secondary Insurance Company | Policy # | Group #

Claims Address | Policy Holders Employer (If other than Patient)

Patient's Relationship to Insured | Policy Holders Name (If other than Patient)

Subscriber's Social Security # | Date of Birth | Gender Male Female

Signature: | Date:

Financial Policy

Welcome to the Maryland Center for Arthritis and Regenerative Care

We are pleased to have you as our patient. Maryland Center for Arthritis and Regenerative Care is dedicated to providing quality, accessible, and cost-effective health care services to our patients and we strive to make every visit a positive experience. This information was designed to provide our patients with a detailed explanation of our financial policies. We realize this information may not always address your specific situation and encourage you to let us know if you have any questions.

Registration
The registration process is a vital link in your visit to Maryland Center for Arthritis and Regenerative Care. Information gathered provides us with contact information as well as ensures your claims will be filed to the correct insurance company.

Upon arrival at any Medical Office site, you will be asked for basic information.

- *Current patient information: name, address, telephone number, employer, and emergency contact.*
- *Current insurance card.*
- *Driver's License or State ID*

Please arrive at least ten minutes prior to your appointment time. Having information readily available will assist us in making the check-in process easier for you. Information obtained in the registration process is kept in your confidential medical record.

You will be asked to make co-payments at the Registration Desk at the time of service. For your convenience, we can also handle your payments on your account at the Registration Desk. We accept cash, check, debit cards and major credit cards (MasterCard, Visa, Discover & American Express).

Co-payments
Co-payments will be collected at the time of your visit. Please check with your insurance company for the requirements and provisions of your policy to determine the dollar amount of your co-payment prior to your appointment.

NSF Checks
There will be a $20.00 charge for all returned checks.

Liabilities
Maryland Center for Arthritis and Regenerative Care does not protect third party liability charges. It is the obligation of the responsible party to settle any outstanding liability charges. Maryland Center for Arthritis and Regenerative Care cannot act as administrator to resolve financial arrangements. The balance for services rendered is considered due in full at the time of the services.

Participation with Insurance Companies
Maryland Center for Arthritis and Regenerative Care reserves the right to determine which insurance companies or programs we participate with on an annual basis.

General Insurance Policy
As a convenience to you, our Insurance Staff will file a claim on your behalf provided we have your current insurance policy information available. However, it is impossible for our staff to determine your coverage and payment levels, since each insurance company offers many options as part of their health care coverage package.

Our staff cannot guarantee that your insurance carrier will pay all or even part of your claim. Your insurance policy is a contract between you and your insurance carrier. Ultimately, the patient is responsible for their medical office charges. Patients should resolve disputed coverage issues directly with their insurer or employer. It is the patient's responsibility to know the details of their insurance contract and if Maryland Center for Arthritis and Regenerative Care is a network provider for their particular plan.

When your insurance company processes your claim, they will provide you with an Explanation of Benefits (EOB). This EOB will explain what the insurance company has agreed to pay. Most insurance companies agree to pay only a percentage of the charges with the remaining balance being the responsibility of the patient. The EOB may use the term "Usual, Customary and Reasonable" (UCR). Insurance companies develop UCRs independently of one another. Maryland Center for Arthritis and Regenerative Care maintains only one fee schedule and it is developed independently of the insurance company UCRs. Therefore, because of policy deductibles, co-payments, non-covered services and UCRs, you may have a balance due after insurance pays. No UCR adjustments will be honored unless the clinic has a signed contract in effect with that specific insurance carrier.

Medicare Policy
Federal law requires all physicians to file claims to Medicare.
Maryland Center for Arthritis and Regenerative Care accepts Medicare assignment. This means we agree to accept Medicare's allowance on services provided to you. You will still be responsible for your annual deductible, the co-payment, and any non-covered services specified by Medicare. If you carry a supplemental plan to Medicare, please be sure we have your policy information so that a claim can be filed for you.

General Credit Policies
All accounts are payable upon receipt of your first statement. Credit is extended as a courtesy,

and arrangements will be based on demonstrated needs. If you are not covered by a medical insurance plan, payment is expected at the time services are provided. If you are from outside the Tri-State area you will be required to pay for your services prior to being seen regardless of your insurance status/coverage. Payment in full or the amount not covered by your insurance carrier may be required prior to receiving care if you have a present/previous clinic account turned over to a collection agency, you currently have an overdue balance, or if you have a recent bankruptcy case.

Any account that has had a minimum of three balances turned over to a collection agency will be reviewed for a Credit Withdrawal of Care. Upon receipt of payment in full on those balances the Credit Withdrawal of Care may be rescinded.

Hardship
Patients who are having financial difficulties may qualify for a reduction in a repayment plan or a financial adjustment on their account. They will be required to complete a financial form and include the necessary information to process their application.

Missed Appointments
We reserve the right to charge for missed appointments and for cancelled appointments if the cancellation is not made 24 hours prior the time of the scheduled appointment. These charges will be your responsibility and will be billed directly to you. Please help us serve you better by keeping your scheduled appointment or by cancelling prior to the day of the scheduled visit.

Questions Regarding Your Account
If you have questions regarding your account please contact our Patient Accounts Staff at the following telephone numbers:

Billing questions:

Office Staff,

410-650-9804

Credit Card Payments:
We accept debit cards and credit cards (MasterCard, Visa, Discover & American Express)

410-650-9804

Thank you for your cooperation in helping us serve you with the highest quality, accessible and cost-effective health care services.

VERIFICATION:	
☐ Patient Acknowledges Receipt of Financial Policy	
☐ Patient Refused Acknowledgement of Receipt of Financial Policy for the following reason(s):	
Patient Signature	Date

HIPAA PRIVACY NOTICE

PLEASE REVIEW THIS NOTICE CAREFULLY. IT DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU MAY GAIN ACCESS TO THAT INFORMATION.

POLICY STATEMENT

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your medical condition and the care and treatment you receive from the Practice and other health care providers. This Notice details how your PHI may be used and disclosed to third parties for purposes of your care, payment for your care, health care operations of the Practice, and for other purposes permitted or required by law. This Notice also details your rights regarding your PHI.

USE OR DISCLOSURE OF PHI

The Practice may use and/or disclose your PHI for purposes related to your care, payment for your care, and health care operations of the Practice. The following are examples of the types of uses and/or disclosures of your PHI that may occur. These examples are not meant to include all possible types of use and/or disclosure.

- Care – In order to provide care to you, the Practice will provide your PHI to those health care professionals directly involved in your care so they may understand your medical condition and needs and provide advice or treatment. For example, your physician may need to know how your condition is responding to the treatment provided by the Practice.
- Payment – In order to get paid for some or all of the health care provided by the Practice, the Practice may provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide your health insurance carrier with information about health care services you received from the Practice so the Practice may be properly reimbursed.
- Health Care Operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

AUTHORIZATION NOT REQUIRED

The Practice may use and/or disclose your PHI, without a written Authorization from you, in the following instances:

1. De-identified Information – Your PHI is altered so that it does not identify you and, even without your name, cannot be used to identify you.

2. Business Associate – To a business associate, who is someone the Practice contracts with to provide a service necessary for your treatment, payment for your treatment and/or health care operations (e.g., billing service or transcription service). The Practice will obtain satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI.
3. Personal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
4. Public Health Activities – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease, injury or disability. This includes reports of child abuse or neglect.
5. Federal Drug Administration – If required by the Food and Drug Administration to report adverse events, product defects, problems, biological product deviations, or to track products, enable product recalls, repairs or replacements, or to conduct post marketing surveillance.
6. Abuse, Neglect or Domestic Violence – To a government authority, if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes the disclosure is necessary to prevent serious harm or if the Practice believes you have been the victim of abuse, neglect or domestic violence. Any such disclosure will be made in accordance with the requirements of law, which may also involve notice to you of the disclosure.
7. Health Oversight Activities – Such activities, which must be required by law, involve government agencies involved in oversight activities that relate to the health care system, government benefit programs, government regulatory programs and civil rights law. Those activities include, for example, criminal investigations, audits, disciplinary actions, or general oversight activities relating to the community's health care system.
8. Judicial and Administrative Proceeding – For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.
9. Law Enforcement Purposes – In certain instances, your PHI may have to be disclosed to a law enforcement official for law enforcement purposes. Law enforcement purposes include: (1) complying with a legal process (i.e., subpoena) or as required by law; (2) information for identification and location purposes (e.g., suspect or missing person); (3) information regarding a person who is or is suspected to be a crime victim; (4) in situations where the death of an individual may have resulted from criminal conduct; (5) in the event of a crime occurring on the premises of the Practice; and (6) a medical emergency (not on the Practice's premises) has occurred, and it appears that a crime has occurred.

10. Coroner or Medical Examiner – The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death, or to a funeral director as permitted by law and as necessary to carry out its duties.
11. Organ, Eye or Tissue Donation – If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.
12. Research – If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI such as approval of the research by an institutional review board, the de-identification of your PHI before it is used, and the requirement that protocols must be followed.
13. Avert a Threat to Health or Safety – The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
14. Specialized Government Functions – When the appropriate conditions apply, the Practice may use PHI of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veteran Affairs of eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military service. The Practice may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities including the provision of protective services to the President or others legally authorized.
15. Inmates – The Practice may disclose your PHI to a correctional institution or a law enforcement official if you are an inmate of that correctional facility and your PHI is necessary to provide care and treatment to you or is necessary for the health and safety of other individuals or inmates.
16. Workers' Compensation – If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.
17. Disaster Relief Efforts – The Practice may use or disclose your PHI to a public or private entity authorized to assist in disaster relief efforts.
18. Marketing - Face to face communication directly with the patient or promotional gifts of nominal value do not require authorization. All other situations require separate authorization.
19. Required by Law – If otherwise required by law, but such use or disclosure will be made in compliance with the law and limited to the requirements of the law.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization, which you may revoke at any time.

APPOINTMENT REMINDER

The Practice may, from time to time, contact you to provide appointment reminders. The reminder may be in the form of a letter or postcard. The Practice will try to minimize the amount of information contained in the reminder. The Practice may also contact you by phone and, if you are not available, the Practice will leave a message for you.

TREATMENT ALTERNATIVES/BENEFITS

The Practice may, from time to time, contact you about treatment alternatives it offers, or other health benefits or services that may be of interest to you.

YOUR RIGHTS

You have the right to:

- Revoke any Authorization, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.
- Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.
- Receive confidential communications of PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.
- Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed. The Practice may charge you a fee for the cost of copying, mailing or other supplies associated with your request.
- Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you have the right to submit a written statement of disagreement.

- Receive an accounting of non-routine disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period which may not be longer than six years and may not include the dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a 12 month period will be free, but the Practice may charge you for the cost of providing additional lists in that same 12 month period. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.
- Receive a paper copy of this Privacy Notice from the Practice upon request.
- To file a complaint with the Practice, please contact the Practice's Privacy Officer. All complaints must be in writing.
- If your complaint is not satisfactorily resolved, you may file a complaint with the Secretary of Health and Human Services, Office for Civil Rights. Our Privacy Officer will furnish you with the address upon request.
- To obtain more information, or have your questions about your rights answered, please contact the Practice's Privacy Officer.

PRACTICE'S REQUIREMENTS

The health care office:

- Is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice upon request.
- Is required to abide by the terms of this Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
- Will not retaliate against you for making a complaint.
- Must make a good faith effort to obtain from you an Acknowledgment of receipt of this Notice.
- Will post this Privacy Notice in its lobby and on the Practice's web site, if the Practice maintains a Web site.

PATIENT ACKNOWLEDGEMENT OF
RECEIPT OF NOTICE OF PRIVACY RULES

I, _____ have received notice of our privacy practices for the office of Maryland Center for Arthritis and Regenerative Care.

Please Print Name: _____

Please Sign: _____

Date: _____

I decline to sign the Acknowledgement because:
_____

_____

_____

WOMAC Osteoarthritis Index

PAIN

The following questions concern the amount of pain you are currently experiencing in your knees. Indicate the level of knee pain associated with:

	None	Mild	Moderate	Severe	Extreme
1. Walking on a flat surface					
2. Going up or down stairs					
3. At night, while in bed					
4. Sitting or laying					
5. Standing upright					

STIFFNESS

The following questions concern the amount of stiffness you have throughout the day:

	None	Mild	Moderate	Severe	Extreme
1. On first awakening in the morning					
2. When first getting out of bed					
3. After sitting, lying or resting later in day					

PHYSICAL FUNCTION

The following questions concern your physical function. By this we mean your ability to do tasks and move around by yourself. If you use an assistive device, please say here what kind: _____

What degree of difficulty do you have:

	None	Mild	Moderate	Severe	Extreme
1. Descending (going down) stairs					
2. Ascending (going up) stairs					
3. Sitting					
4. Rising from sitting					
5. Standing					
6. Bending to floor					
7. Walking on a flat surface					
8. Getting in/out of car					
9. Going shopping					
10. Putting on socks/stockings					
11. Taking off socks/stockings					
12. Rising from bed					
13. Laying in bed					
14. Getting in/out of bath					
15. Getting on/off toilet					
16. Heavy duties (Mowing lawn)					
17. Light duties (cleaning/cooking)					

Name: _____ S.S.#:_____ Date: _____