



15825 Shady Grove Rd. Suite 140 Rockville MD, 20850 | 5530 Wisconsin Ave Suite 530 Chevy Chase MD, 20815 | 5413 W Cedar Lane Suite 203C Bethesda MD, 20814
 20410 Observation Dr. Suite 210 Germantown MD, 20876 | 18550 Office Park Dr. Montgomery Village MD, 20886 | 43810 Central Station Dr. Suite 160 Ashburn VA, 20147
 2639 Connecticut Ave. Suite C100 Washington DC, 20008 | 1115 U Street NW Suite 201 Washington DC, 20009
 Phone: 301-869-9776

NEW PATIENT REGISTRATION FORM

MRN: _____

Date: ____/____/____

Email Address:

Preferred Provider:

Patient Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ SSN: _____

Address:

City: _____ State: _____ Zip Code: _____

Please check primary phone Home Phone Cell Phone Work Phone

Martial Status: Widowed Divorced Gender: _____
 Single Married Life Partner Male Female

Race: _____ Ethnicity: _____ Preferred Language: _____

Occupation: _____ Employer: _____

Primary Insurance Information

Check if same as patient

Primary Insurance Name:

Name of Policy Holder: _____ DOB: _____ SSN: _____

Relationship to the patient: _____ Employer: _____

Policy #: _____ Group #: _____

Secondary Insurance Information (Only if Applicable)

Secondary Insurance Name:

Name of Policy Holder: _____ DOB: _____ SSN: _____

Relationship to the patient: _____ Employer: _____

Policy #: _____ Group #: _____



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IN CASE OF EMERGENCY

Name of friend or relative:

Relationship to patient:

Home Phone #:

Cell Phone #:

The information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Comprehensive Primary Care & Associates, L.L.C. or insurance company to release any information required to process my claims.

Patient/Parent/Guardian Signature

Today's Date

* Please note: Although you have selected a Preferred Provider at CPC, there may be circumstances in which he/she is not available for appointment as desired. However, CPC has multiple providers who are willing to provide you care if this provider is not available.



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I, _____ authorize the release of my private health
Patient's Name
information to _____
Name *Relationship*

I understand this information may include test results, referral information, scheduling, cancelation, or confirming appointments, as well as any other medical information pertinent to my care.

I acknowledge that this authorization is valid throughout my relationship with **Comprehensive Primary Care & Associates, L.L.C.** I understand that I may revoke this agreement at any time by submitting a request in writing.

OR

I, _____ do not want my private health
Patient's Name
information released to anyone at this time. Should I choose to designate someone at a later date, I will submit that request in writing.

SIGN BELOW

Patient's Signature

Today's Date



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BILLING

Patients must pay co-pay before each visit. Any returned check will be subject to a \$30.00 charge. After three bills, the account will go to collections. We are happy to make payment arrangements with you.

Our goal is to provide you with the best medical care possible. Annual physical exams give us a chance to address your overall physical and emotional health. The **preventative** care we provide during a physical also includes *an assessment of dietary and exercise habits, review of vaccinations, discussion of screening tests, lifestyle behaviors, etc.* We often look in on chronic stable problems such as high blood pressure, arthritis, and/or other ongoing controlled medical conditions.

Regular office visits differ from the **preventative** and wellness care provided at a physical because they focus on *other new ongoing or poorly controlled medical concerns.* These types of problems need to be addressed in an appointment separate from a **preventative** or physical exam. If, however, we adequately cover required preventative and wellness care during the physical, sometimes we will have time to discuss new problems identified by you or the physician.

We would like to correct a misperception that is occurring regarding “double charges”. Please note that the insurance companies do allow providers to address additional complaints beyond a physical examination. If new problems are found or poorly controlled problems are addressed, an additional office evaluation code will be generated *in addition* to a preventative physical examination code. Essentially, part of the visit is preventative, but part of the visit is not part of a wellness exam.

Therefore, this generates another charge to the insurance company which in turn may require you to pay your copayment, coinsurance or deductible charge.

INITIAL _____

APPOINTMENTS

Once an appointment has been made, please respect the time that has been reserved in our office schedule for you. **There will be a \$50.00 charge for missed appointments and appointments not cancelled within 24 hours.** We make every attempt to give our patient a courtesy call reminding you of your appointment time, but it is your responsibility to make sure you have this information so you do not miss your appointment.

INITIAL _____

REFERRALS

Your insurance company, not this office, establishes referral policies. **Please note that referrals require up to 72 hours to process.** When requesting a referral, please include your name, date of birth, insurance company name, insurance ID number, specialist name, specialty, and reason for visit. We will notify you when your referral is ready for pick up or we can send it to you via USPS Mail. We will automatically send it via facsimile or electronically to your specialist. Same day referrals are limited to medical emergencies. **WE DO NOT BACK DATE REFERRALS**, per your insurance and our office policies. If you are unsure whether your insurance plan requires referrals, please ask the front desk or you may call your insurance company.

INITIAL _____



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LAB SERVICES FOR AETNA

Our preferred laboratory is LabCorp, we are able to draw and collect specimens for this insurance, but you maybe subject to a copayment and/or a deductible. Please note , that you are fully responsible for any and all charges.

INITIAL _____

PRESCRIPTION REFILLS

In order to provide quality healthcare, please obtain an adequate supply of medication to last you until your next appointment. Your provider will give you enough refills to last until the next office visit. For example, blood pressure and cholesterol medication necessitate an office visit every 6 months. If you running out of medication please inform our medical assistant so that we may arrange for a one-time 30 day supply. In addition, we do not refill controlled substances without seeing the patient ever. For instance, Percocet, Vicodin, Tylenol #3, or the generics of any of those medications will not be refilled over the phone so please do not ask. Antibiotics are frequently over prescribed, we will only prescribe an antibiotic if we see you for your illness, and then only at the providers discretion. Coming in is not a guarantee you will receive antibiotics.

INITIAL _____

LAB RESULTS

Effective January 4, 2010, we will no longer mail results of any kind. We have implemented a new feature to improve result access for patients. This will allow patients to access a portion of their medical record securely online.

If your results are of concern due to abnormal, we will make every effort to promptly contact you. Please be sure this office has your correct telephone numbers. If you are contacted regarding abnormal results, you may be asked to schedule a follow up appointment with your provider. We understand that some patients may not have access to the web or may still want an actual copy. If you wish to obtain an actual copy of your report, you may do so by making prior arrangements with the medical assistant to pick up a copy, which we will leave at the front desk. You may also send in a self-addressed stamped envelope and we will be happy to mail you a copy.

We apologize for any inconvenience and thank you for your understanding during this transition. If you do not hear from us within 10 days after completing the test, it is your responsibility to call and obtain these results.

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PRIOR AUTHORIZATION

Your insurance company, not this office, sets medication formularies. We make every effort to adhere to these formularies, which frequently change. Effective January 1, 2006 if the medication prescribed to you is not covered by your insurance, we will be happy to change the medication to an alternative on your formulary-preferred list.

INITIAL _____

PATIENT FORMS

There will be a \$25.00 fee for all forms that are dropped off during unscheduled appointments. In order to be exempt from this charge you will need to schedule an appointment with a provider. If your forms are not available at the time of service you have 7 days to drop them off to avoid the fee. After 7 days the \$25.00 form fee will apply.

INITIAL _____

MEDICAL RECORDS

To obtain medical records from our office please send in a signed request with the following information:

Your full name, address, billing information, social security number, date of birth, and part of records you are requesting. For example, the entire chart or just lab results. You can mail or fax your request to this office.

INITIAL _____

ADVANCE DIRECTIVES

Advance Directives are available at the front desk. If you would like one to fill out please ask the receptionist. Once completed please return it to any of the staff here in the office so that it can be scanned into your chart.

By signing below, I certify that I have read and completely understand the office policies of Comprehensive Primary Care

Signature

Date

Print Name



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Consent to Obtain External Prescription History

I, _____, whose signature appears below, authorize Comprehensive Primary Care and its providers to view my external prescription history via eClinical Works EHR system. I understand that this includes but is not limited to prescription history from other unaffiliated medical providers, insurance companies, and/or pharmacy benefit managers may be viewable by provider and staff at Comprehensive Primary Care. This also may include prescriptions dating back several years.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTOOD THE CONSENT TO
OBTAIN EXTERNAL PRESCRIPTION HISTORY

Patient Signature _____

Date _____



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Comprehensive Primary Care & Associates, L.L.C. is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our organization and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Comprehensive Primary Care & Associates, L.L.C.

Date: _____

Name: _____

Signature: _____

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____

Done!

(FOR USE OF CPC ONLY)

Date acknowledgement received: _____

-OR-

Reason acknowledgement was not obtained:

