UNIVERSITY of MARYLAND
CHARLES REGIONAL MEDICAL GROUP

PATIENT REGISTRATION FORM (4/2018)

PLEASE PRINT CLEARLY

Today's Date: _____ Appointment Location: _____

PATIENT DEMOGRAPHICS

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

Alias/Nickname: _____ Birthdate: _____ Age: _____

Sex: [ ] M [ ] F Social Security # _____ Marital Status (Circle One): S M D

Religion: _____ Language: _____ Interpreter Needed: [ ] Yes [ ] No

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Unknown [ ] Declined to Answer

Check all Race Categories the patient self-identifies as:

- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White / Caucasian
- ☐ Declined to Answer

Patient Physical Address: ***If PO Box is used for mailing please list as Mailing Address***

Street Address: _____

City: _____ State: _____ Zip Code: _____ County:_____

Please check the box below if the address is;

☐ **Temporary** from _____ to _____ ☐ **Confidential**

Patient Mailing Address: ***Complete if different from Permanent Address***

Street Address: _____ P.O. Box: _____

City: _____ State:_____ Zip Code:_____ County:_____

Contact Phone Numbers: Home: _____ Work: _____

Cell / Mobile: _____ Email: _____

Preferred Communication Method(s): [ ] Mail [ ] Phone [ ] My Portfolio *(Please ask us about this new web based service)*

HOW DID YOU HEAR ABOUT US?

[ ] Billboard [ ] Email [ ] Friend/Family [ ] Google/Search [ ] Health Fair [ ] Home Mailer [ ] Magazine/Newspaper

[ ] Movie Theater [ ] Seminar [ ] Social Media [ ] Transit Bus [ ] Other _____

EMERGENCY CONTACT INFORMATION

Name(s): _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

PATIENT REGISTRATION FORM (4/2018)

SPOUSE INFORMATION *(Complete If Applicable)*

Name: _____ Cell / Mobile: _____

Employer: _____ Work Phone: _____

PARENT INFORMATION *(Complete if Patient is a Minor)*

Patient Lives With: [ ] Mother & Father [ ] Father [ ] Mother [ ] Other: _____

Is a Legal Custody Agreement in Place? [ ] Yes [ ] No
If yes, you MUST provide our office with a copy of the custody agreement. In cases of divorce or separation where no custody agreement exists, both parents have equal rights regarding decisions and information concerning the patient's medical care.

Father's Name: _____

SS# _____ Birthdate: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Ph: _____ Cell:_____

Employer: _____

Work Phone: _____

Mother's Name: _____

SS# _____ Birthdate: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Ph: _____ Cell:_____

Employer: _____

Work Phone: _____

PATIENT EMPLOYMENT or STUDENT STATUS

Employment: [ ] Full Time [ ] Part Time [ ] Retired [ ] Active Military [ ] Not Employed
[ ] Student - Full Time [ ] Student - Part Time [ ] Disabled: Date: _____

Occupation: _____ Employer: _____ Work Phone: _____

Employer Address: _____

COORDINATION OF MEDICAL CARE

Primary Care Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

Preferred Pharmacy: _____ Phone Number: _____

FINANCIALLY RESPONSIBLE PARTY

☐ Patient ☐ Spouse ☐ Parent(s) ☐ Legal Guardian ☐ Other_____

Please complete this section if you checked Legal Guardian, Other, or if only <u>one</u> parent is the guarantor.

Last Name: _____ First Name: _____ Middle: _____

Social Security #: _____ Gender: _____ Date of Birth: _____ Age: ____

Billing Address: _____

City: _____ State:_____ Zip Code:_____ County:_____

Phone Number(s): _____ _____

PATIENT REGISTRATION FORM (4/2018)

INSURANCE

Please inform the Front Desk staff if this visit is related to an Auto Accident, Workers Compensation, or Disability Claim

Primary Insurance: _____

Policy#: _____ Grp#: _____ Ins Phone: _____

Insurance Address: _____

Policy Holder's Name: _____ Relationship To Patient: _____

Policy Holder's Birthdate: _____ Policy Holder's SS#: _____

**** If there is No Secondary Insurance, please circle: NONE***

Secondary Insurance:_____

Policy#: _____ Grp#: _____ Ins Phone: _____

Insurance Address: _____

Policy Holder's Name: _____ Relationship To Patient: _____

Policy Holder's Birthdate: _____ Policy Holder's SS#: _____

AFFIRMATION

By signing below, I represent that the information given by me to UMCMG is accurate to the best of my knowledge.

_____ _____

Patient or Responsible Party Signature **Date**

_____ _____

Patient / Responsible Party Name (PRINT) **Relationship to Patient**

UNIVERSITY of MARYLAND
CHARLES REGIONAL MEDICAL GROUP

UNIVERSITY OF MARYLAND CHARLES REGIONAL MEDICAL GROUP CONSENT FOR TREATMENT, FINANCIAL RESPONSIBILITY AND HEALTHCARE OPERATIONS

UNIVERSITY OF MARYLAND CHARLES REGIONAL MEDICAL GROUP (UM CRMG), for the purposes of this consent, includes all physician offices and other facilities providing healthcare services which are part of UM CRMG

REQUEST, AUTHORIZATION AND CONSENT FOR TREATMENT: I voluntarily request, authorize, and consent to care including medical and/or surgical treatment and diagnostic, radiology, and laboratory examinations and procedures by physicians, residents, nurses and other technical staff of **UM CRMG**. I understand and agree that healthcare professionals in training, which may include but are not limited to residents, fellows, medical/nursing/dental students may assist or participate in providing hospital and/or medical care to me. I understand that these professionals in training work under the direction or supervision of my physician or other healthcare professional and may perform or observe some of the health services I receive and specifically consent to.

I understand that the extent and severity of my injury or illness is not known at this time. I further understand and agree that the practice of medicine is not an exact science and that no guarantees have been made as to the results of either physician practice care and medical and/or surgical treatment or examinations. If applicable, I give **UM CRMG** permission to appropriately dispose of any specimens/tissue (such as blood samples, PAP smears, skin tags, etc.) taken from my body. Once disposed of, these specimens/tissues cannot be retrieved. I hereby authorize **UM CRMG** to retain, preserve and use for scientific or teaching purposes or dispose of at their convenience, any specimens or tissues taken from my body during any hospital/clinic procedure(s).

INDEPENDENT CONTRACTORS: I understand that some healthcare providers providing services to me may not be employees of **UM CRMG**. Some healthcare providers providing services to me may be independent contractors who have been granted the privilege of using the **UM CRMG** facilities to provide services for and on behalf of **UM CRMG**. I understand that if the employment status of a healthcare provider is important to me in making treatment and other healthcare decisions, I may inquire as to the employment status of the healthcare provider caring for me.

INSURANCE CERTIFICATION AND ASSIGNMENT: I hereby certify that the information given by me in applying for payment under titles XVIII and XIX of the Social Security Act and/or by any other third party payers is correct. I assign to **UM CRMG** all benefits for care due to me under the terms of said policies and programs but not to exceed the regular charges for similar services. I assign payment to the physician(s) rendering medical services and I assign payment for the unpaid charges of the physician(s) for whom the **UM CRMG** is authorized to bill in connection with its services. I understand that I am responsible for payment of any health insurance deductibles, coinsurance, or any other expenses incurred which are not paid by any insurers or other third party payers.

MEDICARE AUTHORIZATION: I request payment of authorized Medicare benefits be made on my behalf for any service furnished me by **UM CRMG**, including physician services. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

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PHOTOGRAPHY and/or Video Record: The persons caring for you may need to photograph and/or record you to document a medical condition, help with the diagnosis and/or treatment of a condition, and/or to help plan the details of surgery. Photographs and/or recordings taken for these clinical reasons do not require your written permission.

PRIVACY OF INFORMATION: (please check √ one)

_____ - I ACKNOWLEDGE receipt of a copy of the Notice of Privacy Practices which explains how [AFFILIATE NAME] may use and disclose protected health information; or

_____ - I REFUSE receipt of a copy of the Notice of Privacy Practices which explains how [AFFILIATE NAME] may use and disclose protected health information.

USE AND DISCLOSURE OF SUBSTANCE USE DISORDER PATIENT RECORDS: If I receive treatment for a substance use disorder at a program within **UM CRMG**, I consent to the program disclosing these records to others within **UM CRMG** and to other affiliates of University of Maryland Medical System that treat me for purposes of my treatment, quality improvement and other healthcare operations and care coordination. This consent will expire one year after I am no longer a patient of **UM CRMG** or other affiliates of University of Maryland Medical System. I may revoke this consent at any time except to the extent that the program, **UM CRMG**, or other University of Maryland Medical System affiliates have already acted in reliance on my consent.

GUARANTEE OF ACCOUNT: I acknowledge responsibility for this account and assume and guarantee payment of all hospital and physician charges, including copayments and deductibles and non-covered charges rendered to me during this visit. Should this account be referred to an attorney for collection, I agree to pay attorney fees, collection expenses, and interest at the highest rate authorized by law. I understand that I may be billed separately for services provided to me or on my behalf during this period of treatment by independent professional groups or hospital based physician services (radiology, pathology etc.).

WIRELESS COMMUNICATION: I expressly consent and authorize **UM CRMG** and its agents to:

a. Contact me at any telephone number, including wireless numbers, email addresses, or unique electronic identifiers or modes that I provided to **UM CRMG** at any time associated with me or my account;
b. Communicate with me using any current or future means of communication, including but not limited to, automated telephone dialing systems, artificial or pre-recorded messages, SMS text messages, or other forms of electronic messages; for any reason related to the services received at **UM CRMG** or services received at **UM CRMG** in the future, including operations and quality matters, such as patient satisfaction surveys, and collection of amounts owed on my account; and
c. Leave answering machine and voicemail messages, in compliance with applicable laws, for any reason related to the services provided by **UM CRMG** or services to be provided by **UM CRMG** in the future, including operations and quality matters, such as patient satisfaction surveys, and collection of amounts owed on my account.

I further promise to immediately notify **UM CRMG** if any telephone number, email address or other unique electronic identifiers or modes that I provided to **UM CRMG** change or are no longer used by me.

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I certify that I have read this Consent and am the patient OR parent/guardian of the patient OR am duly authorized as patient's agent to execute its terms. By signing below, I represent that the information given by me is accurate to the best of my knowledge.

_____
Print Patient Name

_____ _____
Print Responsible Party Name Relationship to Patient

_____
Signature

_____ _____ _____
Date Time Witness Name & Signature

FORM NOT SIGNED:

_____ REFUSED _____ UNABLE (if unable proceed to verbal consent)

TO BE USED FOR VERBAL CONSENT:

ON _____ AT _____ O'CLOCK,
DATE TIME

_____
Print Name of Person Giving Consent

The terms of this Consent were reviewed with the patient, parent/guardian of the patient, or the duly authorized agent of the patient verbally and such individual provided verbal consent to the terms set forth herein.

_____ _____
Print Witness Name Witness Signature

UNIVERSITY of MARYLAND
CHARLES REGIONAL MEDICAL GROUP

The University of Maryland Charles Regional Medical Group complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. University of Maryland Charles Regional Medical Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The University of Maryland Charles Regional Medical Group provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you believe that the University of Maryland Charles Regional Medical Group has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Corporate Compliance and Business Ethics Group, 900 Elkridge Landing Road, First Floor, Linthicum, MD 21090, 410-328-4141, compliance@umm.edu.You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Compliance Director is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-868-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

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Authorization to Disclose Health Information
(Excluding Medical Records/PHI)

Patient Name: _____ **Date of Birth:** _____ **Date:**_____

Authorization to Disclose Health Information

I, _____**,** grant permission for the following person(s) to obtain information regarding medical care, and speak with the provider, and/or staff regarding the patient listed above.

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Patient or Responsible Party Signature **Date**

_____ _____
Patient / Responsible Party Name **Relationship to Patient**