CROSSROADS MEDICAL GROUP
A LifeBridge Health Medical Group

- Joseph J Aleo, MD
- Parry A. Moore, MD
- Marie-Alberte Boursiquot, MD, FACP
- Rupal R. Desai, MD
- Indrayani Karkhanis, MD
- Diane Kepner, MD
- Steven H. Eversley, MD – SUITE 226

4801 Dorsey Hall Drive, suite 201 & 226
Ellicott City, MD 21042

Monday – Friday: 8:00am – 4:00pm
Phone: 410-997-7660 Text 410-846-0563 Fax: 410-884-0063

Welcome to our medical practice!

We want your first visit to be as informative, comfortable, and convenient as possible and we thank you for choosing our office!

To assist you in setting up an appointment with us, please complete all forms and provide the requested information below.

- Insurance Card(s)
- Patient History Forms (filled out)
- Medications and/or a list of medications to include the dosage instructions
- Photo ID (without ID, you will not be seen!)
- Any records from your previous PCP preferably vaccines and lab work

Once you return all requested information and packet, we will provide some appointment options to get you scheduled. Items can be returned by:

- Drop off (you will receive return call for scheduling)
- Fax (410-884-0063)
  - Forms can also be completed online @www.crossroadsmd.com via our Patient Portal

DRIVING DIRECTIONS

FROM 1-95 NOR S:	Take MD-10 W (Exit 43B) Merge onto US-29 S (Left exit) Quickly exit onto MD-108 W Turn right onto Columbia Road at 1st traffic light Turn right onto Dorsey Hall Drive at 2nd traffic light
FROM RT. 70 E OR W:	Exit onto US-29 S Exit onto MD-108 W Turn right onto Columbia Road at 1st traffic light Turn right onto Dorsey Hall Drive at 2nd traffic light
FROM RT 32 EAST OF US 29:	Exit onto US-29 N Exit onto MD 108 W Turn right onto Columbia Road at 1st traffic light Turn right onto Dorsey Hall Drive at 2nd traffic light
FROM RT 32 WEST OF CLARSKVILLE	Exit onto MD-108 E Turn right onto Columbia Road at 1st traffic light Turn right onto Dorsey Hall Drive at 2nd traffic light

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Patient registration form

PLEASE PRINT CLEARLY

ACCOUNT #: _____

PATIENT NAME: First	Last	Middle Initial	**DATE OF BIRTH**	**GENDER:** ☐ MALE ☐ FEMALE	
HOME ADDRESS				**GENDER AT BIRTH:** MALE ☐ FEMALE ☐	
				IDENTIFY AS:	
CITY:	**STATE:**	**ZIP CODE:**	**SOCIAL SECURITY NO.**	**PRIMARY PHONE#**	
OCCUPATION:	**RACE/ETHNICITY:** ☐ HISPANIC/LATINO ☐ ASIAN ☐ OTHER ☐ BLACK/AFRICAN AMERICAN ☐ WHITE/ CAUCASIAN			**CELL PHONE #**	
EMERGENCY CONTACT	**EMERGENCY NUMBER**			**MARITAL STATUS:** ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED	
E-MAIL ADDRESS	**ALLERGIES TO MEDICATION:**				

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

Our policy is that the patient is ultimately responsible for all fees for services rendered. Whether or not your insurance company pays in full, a portion, or no portion, your medical bill is a matter between you and your insurance carrier.

I realize verification of insurance coverage is my responsibility, In the event that the listed medical services is not covered by my insurance. I agree to be financially responsible for the charges for there services.

I do hereby authorize Crossroads Medical .Associates, LLC to apply for benefits for services rendered for services rendered. I request payments to be made directly to Crossroads Medical Associates, LLC. I verify that the information reported regarding my coverage is correct and further authorize the release of any necessary information for any claim to my insurance company.

Sign Here x_____

BILLING INSURANCE INFORMATION

Primary Insurance

INSURANCE COMPANY NAME	**ID NUMBER:**	**GROUP NAME:**
SUBSCRIBER NUMBER	**SUBSCRIBER'S DATE OF BIRTH**	**RELATIONSHIP TO PATIENT**

Secondary Insurance

INSURANCE COMPANY NAME	**ID NUMBER:**	**GROUP NAME:**
SUBSCRIBER NUMBER	**SUBSCRIBER'S DATE OF BIRTH**	**RELATIONSHIP TO PATIENT**

PATIENT AUTHORIZATION

I, _____, hereby authorize Crossroads Medical Associates< LLC to apply for benefits on my behalf for services rendered. 1 request payment be made directly to Crossroads Medical Associates, LLC.

I certify that the information I have reported with regard to my insurance is correct and further authorize the release of any necessary inforination, including medical information for this or any related claim, to the above-named insurance company. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked at any time in writing.

_____	_____		_____	_____	
DATE	PATIENT SIGNATURE	AT COMPLETION	DATE	PATIENT SIGNATURE	AT COMPLETION
_____	_____		_____	_____	
DATE	PATIENT SIGNATURE	AT COMPLETION	DATE	PATIENT SIGNATURE	AT COMPLETION

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4801 Dorsey Hall Drive
Suite 201 & 226
Ellicott City MD,
21042
Phone (410) 997 – 7660 / Fax (410) 884 - 0063

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please PRINT Legibly

Patient information

Name: _____ Date of Birth: _____ _____

Previous doctor information

Name: _____

Office phone #_____ Office Fax #:_____

Address: _____City, State, Zip: _____

I authorize the above referenced facility to release my past medical history to Crossroads Medical Group for my continuation of care.

Please send the last:

- EKG
- Colonoscopy
- Lab reports for 5 years
- Radiology
- Immunization records
- Relevant surgical history

Address records to.

Medical records Dept:
4801 Dorsey Hall Drive
Suite 201 & 226
Ellicott City MD, 21042
Fax (410) 884 - 0063

Signature : _____ Date: _____ _____

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Patient Printed Name: _____ DOB:_____
Patient Signature:_____ Date:_____

Maintenance Medication Office Visits

For many years our office has required follow up appointments of either 3-, 4- or 6-month intervals based on the providers discretion and the patients medical conditions that need to be managed. It has always been but has in the past couple of years been enforced that ALL patients require a minimum of a 6-month appointment for evaluation and management of ANY maintenance medications regardless of how long the patient has been taking the medication and 3-month appointments for prescriptions that are a controlled substance.

Missed Appointment or Last-Minute Cancellation Policy

While we make every effort to provide a reminder Call, Text and Email of your appointment through our reminder system, this service is a Courtesy, and it is the patient responsibility to remember and keep their appointment. We charge a $50 fee for any Office Visit, $75 for a New Patient visit and $100 for a Physical Exam or any extended appointment that is cancelled same day or missed. Our office requires a notice of 24 business hours for a cancellation. Messages left after hours or over the weekend not retrieved until the day of your appointment are still considered a Last-Minute cancellation. Although this is NOT a new policy, yet one that has been enforced over the past couple of years, we appreciate your understanding.

Form Completion Fees

Form Completions without an appointment are subject to a charge determined by the length of the document. $15 for a single page simple form and $25 for multiple pages. An extensive form will require an in person visit regardless of the last date of your most recent visit.

After-Hours Service Charges

Our office offers 24-hour coverage for our patients. Any calls forwarded to the provider on call after business hours that result in Medical Advice, Refills on Medications or Medical treatment will be charged a telephone Or if performed a Telehealth charge to your insurance for which a copay or deductible will apply.

Our practice firmly believed that a good doctor/patient relationship is based upon understanding and open communication. If you have any questions concerning our policies or need assistance, please contact our office.

CROSSROADS MEDICAL GROUP
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HIPAA DISCLOSURE & AUTHORIZATION

Form 1

_____ _____
Name of Patient Date

_____
Signature

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET THIS INFORMATION. PLEASE REVIEW CAREFULLY.

A) The General Authorization for Release of Medical Records that you sign authorizes your medical care provider, Crossroads Medical Associates ("Provider") to disclose the information in your medical record to the extent needed for the following purposes:

For the purpose of providing treatment to you. This would include sharing information with employees and contractors of Provider, or with other health care providers who are treating you or consulting in your

1.) For the purpose of arranging payment for your care. This would include your insurer or other third party payer who is responsible for paying all or part of the cost of your case.

2.) For the purpose of Provider's "health care operations". This would include such things as internal quality assessment activities, contacting other health care providers regarding medical review of your care, evaluating provider performance, legal and medical review of care provided, business planning and management, resolutions of internal grievances and provision of legal and auditing services.

3.) For the purpose of other health care providers' "health care operations" to the extent that they have a treatment relationship with you.

B) A Specific Authorization for Release of Medical Records that you may sign authorizes Provider to make a specific disclosure that is not covered under section A, above. A Specific Authorization will name the party to whom you are authorizing disclosure., and will contain any limitations on the authority to disclose your records.

C) You may revoke any authorization provided to Provider by giving Provider a written notice of revocation. Provider may refuse to treat you if you revoke the General Authorization.

D) Provider may be required by law, in some cases, to make disclosures of your record that you have not authorized. Examples are subpoenas in criminal or civil litigation, or requests/surveys by licensure agencies or the U.S. Department of Health and Human Services.

E) Provider may contact you to provide appointment reminders o information about treatment alternatives or other health-related benefits and services that may be of interest to you.

F) You have the following rights with respect to your medical records/information:

1. You have the right to request restrictions on the use and disclosure of your medical records/information, however Provider is not required to agree to restrictions not guaranteed by law. You will be informed if provider will not agree to a requested restriction.
2. You have the right to receive confidential communications of your health information and to direct the place and manner of communication.
3. You have the tight to inspect and copy your medical records. (Provider is entitled to charge you a reasonable fee related to the cost of copying your records.)
4. You have the right to seek to amend your medical records, and if Provider does not agree with your request, to note your objection in the medical record.
5. You have the right to receive an accounting of disclosures that are made to you or wit* 7 ur specific authorization, that fall within the scope of the Provider's "health care operation", or disclosure made for payment or treatment purposes.
6. You have a right to retain a paper copy of this notice.

G) Provider is required by law to maintain the privacy of protected health information, and to provide patients with this notice of its duties and practices, as well as changes to those practices. Patients will bc provided with revised notices, as appropriate.

H) If a patient believes that his or her privacy rights have been violated, the patient may complain to Provider, or to the Secretary of the U.S. Department of Health and Human Services. To complain to Provider, please write or call us with the details. Provider will not retaliate in any way against a patient for making a complaint.

I) If you es a patient believe that your privacy rights have been violated *and* wish to notify our practice, please call our office and ask to speak with the designated Privacy Complaints Contact Person.

J) Provider reserves the right to change privacy practices, and to make its new policies effective for all protected health information that Provider maintains. If such changes are made, Provider will issue an updated "Notice to Patients" to all of Provider's patients.

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HIPAA Disclosure & Authorization
Form 2

Name of Patient *(please print)* _____ Date _____

Signature _____

1, patient of Crossroads Medical Associates ("Provider"), understand that my signature below gives Provider permission to the extent necessary, to use my medical record and to provide access to my medical record, while and after 1 am treated by Provider, for the reasons that follow:

1 For the purpose of providing medical treatment to me, including release of information to other Health care providers with whom I am already in treatment.
2 For the purpose of arranging for payment for my care.
3 For the purpose of Provider's "health care operations", including such thing as as alternative, evaluating provider performance, legal and medical review of care provided, business planning and management, customer service, resolution of internal grievances and the provision of legal and auditing services.
4 For the purposes of other health care providers' "health care operations", to the extent that they have a treatment relationship with you.

I understand that my permission allows Provider to transmit permissible information through any means that is reasonably secure, including via e-mail, assuming that reasonable protective measures are taken to preserve the confidentiality of the information.

I understand that I may revoke this authorization at any time, but that Provider may refuse to give me further treatment if I do.

I understand that 1 have the right to request that Provider restricts how my medical information is used. **If I wish to request a restriction** I will initial here: _
(In this case, Provider will give me a separate form to fill out which will also be used for provider to indicate whether
or not Provider agrees to the requested restriction)

I understand that I have a number of rights identified below (*These rights are listed more fully on the Patient* Notice
provided fo *me by Provider).'*

- the right to review and copy my medical record
- the right to request an amendment of my medical record
- the right to grant or deny access to my record to others
- the right to decide how information from my record will be conveyed to others
- the right to complain about how my medical record is handled to the Secretary of the U.S. Department of Health and Human Services and to Provider
- the right to revoke, in writing, any consent that I provided for access to my records
- the right to authorize Provider to give information about my care to relatives or friends, to the extent of their involvement with my care or payment
  the right to review a record of access to my medical record

I understand that I have the right to either grant or deny access to my medical record, and that my specific written permission will be sought if access is requested for any reason not set forth above, or in most cases, for the release of psychotherapy notes.

The provider may decide to change some of the above-stated polices, and I understand that I will given a revised Notice if this occurs.

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HIPAA Disclosure & Authorization
Form 3

_____ _____
Name of Patient *(please print)* Date

_____ _____
Signature Date of birth

_____I do not want Crossroads Medical Associates ("Provider") to disclose any information concerning my care or treatment by Provider to individuals without my express written consent or legal authorization.

_____I authorize Provider to disclose information related to my care and treatment to the following individuals:

_____ _____
_____ _____
_____ _____
_____ _____

The authorization provided for above are subject to the following limitations and restrictions:

_____

_____

TREATMENT AUTHORIZATION:

I_____authorize medical treatment of myself or my minor child by physicians at Crossroads Medical Associates.

NOTIFICATION AUTHORIZATION PLEASE COMPLETE BELOW:

I authorize Crossroads' physicians and staff to contact me at the following number(s) for scheduling or to inform me of medical or laboratory test results:_____
_____ do not _____ authorize leaving the results of such tests at the number (e.g. on answering machine or voicemail). Additional instructions or restrictions:

_____
_____

CROSSROADS MEDICAL GROUP
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Patient Medical History Form 1

ACCOUNT #: _____

PATIENT NAME: First	Last	Middle Initial	DATE OF BIRTH	GENDER: MALE ☐ FEMALE ☐ GENDER AT BIRTH: MALE ☐ FEMALE ☐
TODAY'S DATE:	WORK PHONE#:			CELLPHONE#
EMERGENCY CONTACT NAME:	EMERGENCY CONTACT PHONE #			RELATIONSHIP PATIENT:
MARITAL STATE: SINGLE ☐ MARRIED ☐ WINDOWED ☐ SEPARATED ☐	IF MARRIED, SPOUSES NAME			
PHARMACY NAME & ADDRESS				
DO YOU ALLERGIES TO ANY MEDICATIONS, X-RAY OR OTHER SUBSTANCES? ☐ YES ☐ NO IF YES, PLEASE LIST NAME(S) OF MEDICINE(S) AND TYPE(S) OF REACTION				

PAST MEDICAL HISTORY AND REVIEW OF SYMPTOMS: PLEASE CHECK IF YOU HAVE HAD ANY PROBLEMS IN THE PAST OD ARE CURRENTLY COMPLAINING OF ANY OF THE FOLLOWING CONDITION OR SYMPTOMS

HIGH BLOOD PRESSURE	ASTHMA	ULCERS
DIABETES	BRONCHITIS	CHANGES IN BOWfi L HABITS
CANCER	RHEUMATIC FEVER	LOW BACK PROBLEMS
CHEST PAIN/TIGHTNESS	GALLBLADDER DISEASE	HEMORRHOIDS
SHORTNESS OF BREATH	ANXIETY	COLITIS
SWOLLEN ANKL	DEPRESSION	HEPATITIS/JAUNDICE
PALPITATIONS	ALCHOHOL ABUSE	FREQUENT URINATION
LIGHTHEADEDNESS	DRUG ABUSE	KIDNEY DISEASE
HEADACHES	UNEXPLAINED WEIGHT GA IN/LOSS	KIDNEY STONES
HEAD / NECK RADIATION	NAUSEA	DIFFICULTY URINATING
ARTHRITIS	VOMITING	THYROID DISEASES
GOUT	INDIGESTION	BLOOD DISORDERS
PNEUMONIA	ABDOMINAL DISCOMFORT	ANEMIA
PERSISTENT COUGH	CONSTIPATION	SKIN DISEASES
TUBERCULOSIS (TB)	DIARRHEA	OTHER
HAY FEVER	BLOOD TN STOOL	

DESCRIBE ALL CHECKED ITEMS:

DID YOU HAVE ANY UNUSUAL CHILDHOOD ILLNESSES? YES NO IF SO, PLEASE EXPLAIN: _____

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Patient Medical History Form 2

Patient Name: _____ DOB:_____

Surgical history:

PLEASE LIST SURGERIES YOU HAVE UNDERGONE AND THE APPROXIMATE DATE OF YEAR

TYPE OPERATION:	DATE:

HAVE YOU HAD ANY PROBLEMS WITH ANESTHESIA IN THE PAST? YES NO

PLEASE LIST ANY HOSPITALIZATIONS YOU HAVE UNDERGONE, OTHER THAN SURGERY, AND THE APROXIMATE DATE OR YEAR

HOSPITALIZATION REASON:	DATE:

HAVE YOU HAD ANY PROBLEMS WITH ANESTHESIA IN THE PAST? YES NO

MEDICATIONS: PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING OVER-THE-COUNTER MEDICATIONS, VITAMINS, HERBS ETC.

DRUG NAME	DOSE/FREQUENCY	DRUG NAME	DOSE/FREQUENCY

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Patient Medical History Form 3

Patient Name: _____ DOB:_____

HEALTH MAINTENANCE:

PLEASE INDICATE THE APROXIMATE DATES OF YOUR LAST TEST IF APPLICABLE:

MAMMOGRAM		PAP SMEAR		BREAST EXAM	
COLONOSCOPY		STOOL TEST		PROSTATE EXAM	
CHOLESTEROL CHECK		EYE EXAM		CHEST X-RAY	
BONE DENSITY (DEXA)		EKG		STRESS TEST	

IMMUNIZATIONS HISTORY: HAVE YOU HAD

TETATUS/DIPTHERIA OR TETANUS/DIPTHERIA/PERTUSSIS IMMUNIZATION		☐ YES ☐ NO	WHEN
HEPATITIS B IMMUNIZATION		☐ YES ☐ NO	WHEN
FLU (INFLUENZA) FLU		☐ YES ☐ NO	WHEN
PNEUMONIA VACCINATION:			
PNEUMOVAX		☐ YES ☐ NO	WHEN
PREVNAR		☐ YES ☐ NO	WHEN
SHINGLES VACCINATION:			
ZOSTAVAX	DOSE 1 _____	DOSE 2 _____	
SHINGRIX	DOSE 1 _____	DOSE 2 _____	
COVID	DOSE 1 _____	DOSE 2 _____	BOOSTER_____
OTHER		☐ YES ☐ NO	

HAVE YOU EVER HAD THE FOLLOWING ILLNESSES (APROXIMATELY WHAT AGE) – CHICKENPOX: MUMPS; MEASLES? _____

SOCIAL HISTORY:

DO YOU USE TOBACCO PRODUCTS?	☐ YES ☐ NO	WHAT TYPE & HOW MANY PER DAY?
HAVE YOU PREVIOUSLY USED TOBACCO AND QUIT?	☐ YES ☐ NO	WHEN DID YOU QUIT?
DO YOU DRINK ALCOHOL?	☐ YES ☐ NO	HOW MANY DRINKS PER DAY/WEEK?
DO YOU WEAR SEATBELTS?	☐ YES ☐ NO	ALWAYS USUALLY NEVER
DO YOU DRINK CAFFEINATED BEVERGES?	☐ YES ☐ NO	WHICH TYPE & HOW OFTEN?
ARE YOU SEXUALITY ACTIVE?	☐ YES ☐ NO	DO YOU USE CONTRACEPTIVES? WHAT TYPE?
DO YOU FOLLOW ANY SPECIAL DIET? (SOUTH BEACH, LOW, CARB /FAT/ SODIUM)	☐ YES ☐ NO	WHICH ONE?

WHAT IS YOUR RACE/ETHNICITY?_____ WHERE WERE YOU BORN? _____

WHAT IS YOUR OCCUPATION? HOUR PER WEEK? ARE THERE ANY STRENOUS OR HARMFUL JOB-RELATED CONDITIONS? (EXPOSURE TO ASBESTOS, CHEMICALS, PAINTS OR OTHER HAZARDOUS MATERIALS)?

_____

DO YOU EXERCISE REGULARLY? IF SO, WHAT TYPES OF PHYSICAL ACTIVITY AND HOW OFTEN?

_____

HAVE YOU EVER ENGAGED IN ANY ACTIVITY THAT HAS PUT AT RISK FOR AIDS? ☐ YES ☐ NO

EXPLAIN:_____

DO YOU HAVE A GUN IN YOUR HOUSE? DO YOU KEEP IT UNLOADED & OUT OF CHILDREN'S REACH?

☐ YES ☐ NO ☐ DO NOT OWN A GUN

ARE YOU IN A RELATIONSHIP IN WHICH YOU HAVE BEEN PHYSICALLY (slapped, kicked, punched, bruised etc.) BY YOUR PARTNER? ☐ YES ☐ NO

DO YOU EVER FEEL AFRAID OF YOUR PARTNER? ☐ YES ☐ NO

DO YOU HAVE A "LIVING WILL"? ☐ YES ☐ NO

DO YOU HAVE A DONOR CARD? ☐ YES ☐ NO

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Patient Medical History Form 4

Patient Name: _____ DOB:_____

Family History:

If any genetic family members have one of the Chronic Medical Conditions (but not limited to) listed below, please fill out on the Chart and specify if they are living or deceased and the approximate age of onset.

Pertinent Medical Problems:		
Hypertension	Mental Illness	Cancer to include:
Heart Disease include type	Drug or Alcohol Addiction	brain, breast, colon,
High cholesterol	Bleeding disease	lung, melanoma
Diabetes (Type if Know)	Osteoporosis or Rhuematoid Arthritis	prostate, blood, cell,
Stroke or Aneurysm		or other

family Member:	Medical Problems:	Age of onset:	(D) or (L) Age of (D)
Mother:			
Father:			
Sibling|s) (total number):			
Maternal Grandmother:			
Maternal Grandfather:			
Paternal Grandmother:			
Paternal Grandfather:			
Other Family Members:			