CROSSROADS MEDICAL GROUP
A LifeBridge Health Medical Group

Please check provider you wish to see

Joseph Aleo, MD *not accepting new patients*
Parry Moore, MD *not accepting new patients*
☐ Rupal Desai, MD
☐ Diane Kepner, MD
☐ Sara Mills, MD
☐ Matthew Poffenroth, MD
☐ Steven H. Eversley, MD &Tyeisha Wilkins-Witherspoon CRNP, **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

Welcome to Crossroads Medical Group!

We're delighted to have you join our practice and want your first visit to be as **informative, comfortable, and convenient** as possible. Thank you for choosing our office for your care!

To help us schedule your appointment efficiently, please complete and return the following items:

- **Insurance card(s)**
- **Patient history forms** (fully completed)
- **Current medications-** a list including dosage instructions
- **Photo ID** *(required — patients cannot be seen without ID)*
- **Records from your previous primary care provider**, including vaccination history and recent lab results, if available

Once all items are received, we'll provide you with available appointment options.

You may return your completed forms and documents by:

- **Drop-off** at our office
- **Fax:** (410) 884-0063
- **Email:** (please call for the correct address)

You may also complete forms online at **www.crossroadsmd.com** and submit them through our **Patient Portal** as attachments.

Please note: Registering for the portal does not replace completing these forms. You will need to complete it in the office before your appointment if time permits, or you may be rescheduled.

We look forward to meeting you and providing excellent care!

Office Policies and Procedures (*revised 11/2025)*

Maintenance Medication Office Visits

Our office requires follow-up appointments at **3-, 4-, or 6-month intervals**, depending on your provider's discretion and the medical conditions being managed.

- **All patients** must be seen **at least every 6 months** for evaluation and management of **any maintenance medication**, regardless of how long the medication has been prescribed.
- **Controlled substances** require follow-up visits **every 30–90 days**, as determined by your provider.

Regular follow-ups ensure safe, effective, and compliant medical care for all patients

Missed Appointment or Late Cancellation Policy

While we make every effort to remind patients of upcoming appointments via **phone, text, and email**, it remains **the patient's responsibility** to attend scheduled visits.

To avoid a fee, please cancel appointments at least **24 business hours in advance**.

Fees for missed or same-day cancellations:

- $50 – Regular office visit
- $75 – New patient visit
- $100 – Physical exams or extended appointments

Please note: Messages left after business hours or over the weekend that are retrieved on the day of your appointment will still be considered a last-minute cancellation.

Although this policy has been in effect for several years, we sincerely appreciate your continued understanding and cooperation.

Administration and Form Completion Fees

Completion of medical forms is subject to a fee, depending on the type and complexity of the document.

- **Fees range:** $10.00 – $100.00
- Extensive forms may require an **in-person appointment**, regardless of when your last visit occurred.
  Additionally, **insurance authorization requests** for medications or procedures are subject to a **$25.00 processing fee**.

After-Hours Service Charges

Our office provides **24-hour on-call coverage** for established patients.

Any calls to the provider after business hours that result in:

- **Medical advice**, **Medication refills**, or **medical treatment** will be billed as a **telephone visit** or **telehealth service** to your insurance. Applicable **copies or deductibles** will apply.

Office Policies and Procedures *(continued)*

Office Surveillance Policy

Your Safety Is Our Priority

At Crossroads Medical Group, we take the safety and comfort of our patients, visitors, and staff seriously. To help maintain a secure and welcoming environment, our office uses **video-only surveillance in certain public areas**.

Where Cameras Are Located

Cameras are placed in **public spaces only**, such as:

- Waiting rooms and reception areas
- Hallways and entrances
- Parking lots and outside building areas

No cameras are ever placed in exam rooms, restrooms, or anywhere private medical care or conversations take place.

How Footage Is Used

Video footage helps us:

- Keep everyone safe
- Protect property and prevent theft
- Review incidents or security concerns

All recordings are viewed only by **authorized management** when necessary and are stored securely for a limited time before being deleted.

Your Privacy Matters

We follow all federal and state privacy laws, including **HIPAA**, to make sure your personal health information remains confidential. Surveillance footage **never includes sound or private medical discussions or patient care activities**.

If you have questions or concerns about this policy, please reach out to our **Office Manager or Privacy Officer**.
We're happy to explain how we keep our space safe and respectful of everyone.

We Value Communication

Our practice believes a strong doctor–patient relationship is built on **trust, understanding, and clear communication.**
If you have any questions about these policies or need further clarification, please contact our office. We are happy to assist you!

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We're happy to assist you!

My signature confirms that I have reviewed and signed the office policy form, and a copy is available if requested.

Patient name: _____ Signature: _____Date: _____

Authorization to release Medical Records

4801 Dorsey Hall Drive

Suite 201 & 226

Ellicott City MD,

21042

Phone (410) 997 – 7660 / Fax (410) 884 - 0063

Please PRINT Legibly

Patient information

Name: _____Date of Birth: _____

Previous doctor information

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**
- **3 Office notes**

Address records to:

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

Signature: _____ Date: _____

Notice of Privacy Practices (HIPAA form 1)

Revised Date: 11/12/2025
Patient Name: **First** _____ **Last** _____ **Date of Birth:**_____

This notice explains how your medical information may be used and shared — and how you can access it. Please read carefully.

A. How We May Use and Share Your Health Information

When you sign a **General Authorization for Release of Medical Records**, you allow Crossroads Medical Associates ("Provider") to use or share your medical information for the following reasons:

1. **Treatment:**
   We may share information with our team members or other health care providers involved in your care. This helps coordinate your treatment, referrals, and consultations.
2. **Payment:**
   We may use and share your information with your insurance company or another payer to arrange payment for your medical care.
3. **Health Care Operations:**
   We may use your information for office operations such as:
   a. Quality improvement and peer review
   b. Provider performance evaluations
   c. Business management and planning
   d. Legal and compliance reviews
   e. Internal audits and grievance resolutions
4. **Other Providers' Operations:**
   We may share information with other health care providers for their operational purposes if they are involved in your treatment.

B. Specific Authorization

If you sign a **Specific Authorization for Release of Medical Records**, we will release information only to the person or organization you name and only within the limits you describe.

C. Revoking an Authorization

You may revoke any authorization by submitting a **written notice** to our office.
Please note: if you revoke your General Authorization, we may be unable to continue your care.

D. Disclosures Required by Law

Sometimes, we are legally required to share information without your authorization. Examples include:

- Subpoenas in criminal or civil cases
- Requests from licensing or accreditation agencies
- Inquiries by the U.S. Department of Health and Human Service

Notice of Privacy Practices *(continued)*

E. Communications from Our Office

We may contact you for the following reasons:

- Appointment reminders
- Information about treatment options
- Information about services or benefits that may interest you

F. Your Rights

You have important rights regarding your medical information:

1. **Request Restrictions:**
   You can ask us to limit how we use or share your information. While we review your request, we may not be able to agree to all restrictions.
2. **Confidential Communications:**
   You can request that we contact you in a specific way (for example, only at home or by mail).
3. **Access to Your Records:**
   You may inspect or request a copy of your medical record. A reasonable copying fee may apply.
4. **Request an Amendment:**
   You may request corrections to your medical record. If we do not agree, your statement of disagreement will be added to the record.
5. **Accounting of Disclosures:**
   You may request a list of times we share your information for reasons other than treatment, payment, or operations.
6. **Paper Copy of This Notice:**
   You are entitled to a paper copy of this notice at any time.

G. Our Responsibilities

We are required by law to:

- Maintain the privacy of your protected health information
- Provide you with this notice explaining our privacy practices
- Follow the terms of the notice currently in effect

If we change our privacy practices, we will update this notice and make it available to you.

H. Complaints

If you believe your privacy rights have been violated, you may file a complaint with:
Crossroads Medical Associates
[Insert Address / Phone Number]
or with the **U.S. Department of Health and Human Services (HHS).**
We will never retaliate against you for filing a complaint.

I. Contact Information

If you have any questions or wish to report a privacy concern, please contact our **Privacy Officer** at: 410-997-7660

J. Changes to This Notice

We may change our privacy practices at any time. Any updates will apply to all medical information we maintain and will be posted in our office and on our website.

General Authorization for Use and Disclosure of Medical Information (HIPAA form 2)

Crossroads Medical Associates ("Provider")

I, _____, a patient of Crossroads Medical Associates ("Provider"), understand that by signing this authorization, I am giving permission for Provider to use and disclose my medical information, as necessary, during and after my care, for the following purposes:

1. Treatment

To provide medical treatment to me, including the release of information to other health care providers who are currently treating me or assisting with my care.

2. Payment

To arrange and obtain payment for my medical care from insurance companies or other payers responsible for all or part of my medical costs.

3. Health Care Operations

To conduct activities necessary for Provider's business and operations, such as:

- Quality assessment and improvement
- Evaluation of provider performance
- Medical and legal review of care provided
- Business planning and management
- Customer service and internal grievance resolution
- Auditing and compliance

4. Other Providers' Operations

To share information with other health care providers for their operational purposes, when they have a treatment relationship with me

Secure Transmission

I understand that my information may be transmitted through secure means, including email or other electronic methods, when reasonable precautions are taken to protect confidentiality.

Request for Restrictions

I understand that I have the right to request restrictions on how my medical information is used or shared.
If I wish to request a restriction, I will initial here: _____
Provider will provide a separate form to complete **(HIPAA form 3)**. The provider will indicate whether or not the requested restriction can be granted.

General Authorization for Use and Disclosure of Medical Information *(continued)*

My Rights

I understand that I have the following rights regarding my medical information (as detailed in the Provider's *Notice of Privacy Practices*):

- The right to review and obtain a copy of my medical record
- The right to request an amendment or correction to my medical record
- The right to grant or deny access to others
- The right to decide how my information is shared with others
- The right to authorize Provider to share information with family or friends involved in my care or payment
- The right to review a record of who has accessed my medical record
- The right to file a complaint with Provider or with the U.S. Department of Health and Human Services if I believe my privacy rights have been violated
- The right to revoke, in writing, any consent or authorization previously granted

Changes to Privacy Practices

I understand that Provider may update or change its privacy practices and will provide me with a revised **Notice of Privacy Practices** if such changes occur.

Acknowledgment and Signature

By signing below, I acknowledge that I have read and understand this authorization and agree to the use and disclosure of my medical information as described above.

Patient Name: _____
Patient Signature: _____
Date: _____

Witness (if applicable): _____
Date: _____

Authorization for Disclosure, Treatment, and Communication Preferences (HIPAA form 3)

Patient Information

Name of Patient (please print): _____ **Date of Birth:** _____
Signature: _____ **Date:** _____

Disclosure of Medical Information

☐ **I do not authorize** Crossroads Medical Associates ("Provider") to disclose any information concerning my care or treatment to any individual without my **express written consent** or **legal authorization**.

☐ **I authorize** Provider to disclose information related to my care and treatment to the following individual(s) ***not doctors***

Name: _____ **Contact #:** _____

Name: _____ **Contact #:** _____

Name: _____ **Contact #:** _____

Name: _____ **Contact #:** _____

Treatment Authorization

I authorize the physicians and staff at Crossroads Medical Associates to provide medical evaluation and treatment to **myself** or my **minor child** as medically necessary.

Patient/Parent/Guardian Signature: _____ **Date:** _____

Notification Authorization

I authorize Crossroads Medical Associates' physicians and staff to contact me for scheduling purposes or to provide information about my medical or laboratory test results at the following number(s):
Phone Number(s): _____

Please check one:
☐ **I authorize** Provider to leave messages, including test results, at this number (e.g., voicemail or answering machine).
☐ **I do not authorize** Provider to leave messages at this number.

Additional Instructions or Restrictions:

Patient Medical History

Patient Information

Today's Date: _____

Patient Name: **First** _____ **Last** _____ **Middle Initial** _____

Date of Birth: _____ **Cell Phone #:** _____ **Home Phone #:** _____

Legal Gender: ☐ Male ☐ Female **Gender at Birth:** ☐ Male ☐ Female **Preferred Pronouns:** _____

Emergency Contact Information

Name: _____ **Phone #:** _____ **Relationship to Patient:** _____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated

Pharmacy Information **Pharmacy Name & Address:** _____

Allergies ☐ **No known allergies**

☐ **Yes** — Please list any **medications, X-ray dyes, or other substances** and describe your reaction(s):

Past Medical History & Review of Symptoms

Please check any that apply or that you have had **in the past** or are **currently experiencing**:

Cardiac / Vascular	Respiratory	Gastrointestinal	Neurological / Musculoskeletal	Other / General
☐ High Blood Pressure	☐ Pneumonia	☐ Indigestion	☐ Head/Neck Radiation	☐ Diabetes
☐ Chest Pain/Tightness	☐ Tuberculosis (TB)	☐ Abdominal Discomfort	☐ Low Back Problems	☐ Cancer
☐ Shortness of Breath	☐ Hay Fever	☐ Constipation	☐ Arthritis	☐ Thyroid Disease
☐ Swollen Ankles	☐ Asthma	☐ Diarrhea	☐ Gout	☐ Blood Disorders
☐ Palpitations	☐ Bronchitis	☐ Blood in Stool	☐ Rheumatic Fever	☐ Anemia
☐ Lightheadedness	☐ Persistent Cough	☐ Ulcers	☐ Skin Diseases	☐ Anxiety
☐ Headaches		☐ Gallbladder Disease		☐ Depression
		☐ Colitis		☐ Alcohol Abuse
		☐ Hepatitis/Jaundice		☐ Drug Abuse
		☐ Changes in Bowel Habits		☐ Unexplained Weight Gain/Loss
		☐ Nausea/Vomiting		
		☐ Frequent Urination		
		☐ Kidney Disease / Stones		
		☐ Difficulty Urinating		

Other Conditions or Details (please describe any checked items): _____

Medical History *(continued)*

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

Childhood Illnesses

☐ No unusual childhood illnesses ☐ Yes — Please explain:_____

Surgical History

Please list any surgeries you have undergone and the approximate date or year.

Type of Operation / Procedure	Approximate Date or Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever had any problems with anesthesia?

☐ Yes ☐ No If yes, please describe: _____

Hospitalizations (Other Than Surgery)

Please list any hospitalizations you have had and the approximate date or year.

Reason for Hospitalization	Approximate Date or Year
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever had any complications during a hospital stay?

☐ Yes ☐ No

If yes, please describe: _____

Current Medications

Please list **all medications you are currently taking**, including **prescriptions, over-the-counter medicines, vitamins, and herbal supplements.**

Drug Name	Dose/Frequency	Drug Name	Dose/Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Preventive Health & Social History

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

Preventive Health Screenings

Please indicate the approximate date of your most recent test, if applicable.

Test / Screening	Approximate Date	Test / Screening	Approximate Date
Mammogram	_____	Pap Smear	_____
Breast Exam	_____	Colonoscopy	_____
Stool Test	_____	Prostate Exam	_____
Cholesterol Check	_____	Eye Exam	_____
Chest X-Ray	_____	Bone Density (DEXA)	_____
EKG	_____	Stress Test	_____

Immunization History

Please check the box that applies and include the approximate date, if known.

Vaccine	Yes	No	Date / Dose(s)
Tetanus/Diphtheria or Tdap	☐	☐	_____
Hepatitis B	☐	☐	_____
Influenza (Flu)	☐	☐	_____
Pneumonia (Pneumovax)	☐	☐	_____
Pneumococcal	☐	☐	_____
Shingles – Dose 1	☐	☐	_____
Shingles – Dose 2	☐	☐	_____
COVID – Dose 1	☐	☐	_____
COVID – Dose 2	☐	☐	_____
COVID – Booster	☐	☐	_____
Other	☐	☐	_____

Childhood Illnesses

Please indicate if you have had any of the following illnesses, and at approximately what age:

Chickenpox: _____ Mumps: _____ Measles: _____

Social History

Tobacco Use

☐ Yes ☐ No If yes, type and amount per day: _____

If you have quit: ☐ Yes ☐ No When did you quit? _____

Alcohol Use

☐ Yes ☐ No If yes, number of drinks per day/week: _____

Caffeine Use

☐ Yes ☐ No If yes, type and frequency: _____

Seatbelt Use

☐ Always ☐ Usually ☐ Never

Preventive Health & Social History *(CONTINUED)*

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

Sexual Activity

☐ Yes ☐ No If yes, do you use contraceptives? ☐ Yes ☐ No

Type of contraceptive: _____

Diet

☐ Yes ☐ No If yes, specify (e.g., low carb, low fat, low sodium, South Beach, etc.): _____

Exercise

☐ Yes ☐ No If yes, type of activity and frequency: _____

Occupation

Job Title: _____ Hours per week: _____

Are you exposed to hazardous materials (e.g., asbestos, chemicals, paints, etc.)?

☐ Yes ☐ No If yes, please describe: _____

Birthplace: _____ **Race/Ethnicity:** _____

HIV / AIDS Risk

Have you ever engaged in activities that could put you at risk for HIV/AIDS?

☐ Yes ☐ No If yes, please explain: _____

Firearms in Home

☐ Yes ☐ No ☐ Do not own a gun

If yes, is it unloaded and secured away from children? ☐ Yes ☐ No

Safety & Relationships

Have you ever been physically harmed (slapped, kicked, punched, bruised, etc.) by your partner?

☐ Yes ☐ No

Do you ever feel afraid of your partner?

☐ Yes ☐ No

Advance Directives

Do you have a "Living Will"? ☐ Yes ☐ No

Do you have a Donor Card? ☐ Yes ☐ No

Family History

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

Instructions:

If any of your **genetic family members** have (or had) one of the chronic medical conditions listed below, please complete the chart below.
Include whether they are **living (L)** or **deceased (D)**, the **approximate age of onset**, and—if deceased—the **age at death**.

Pertinent Medical Conditions (Check all that apply if relevant to your family history):

☐ Hypertension (High Blood Pressure)
☐ Heart Disease (Type: _____)
☐ High Cholesterol
☐ Diabetes (Type I ☐ / Type II ☐ / Unknown ☐)
☐ Stroke or Aneurysm
☐ Mental Illness (Specify: _____)
☐ Drug or Alcohol Addiction
☐ Bleeding Disorder
☐ Osteoporosis ☐ Rheumatoid Arthritis
☐ Cancer (Type: ☐ Brain ☐ Breast ☐ Colon ☐ Lung ☐ Melanoma ☐ Prostate ☐ Blood/Cell ☐ Other: _____)

Family Member Health History

Family Member	Pertinent Medical Problems	Age of Onset	Living (L) / Deceased (D)	If Deceased, Age at Death
Mother	_____	_____	☐ L ☐ D	_____
Father	_____	_____	☐ L ☐ D	_____
Sibling(s) (Total #: _____)	_____	_____	☐ L ☐ D	_____
Maternal Grandmother	_____	_____	☐ L ☐ D	_____
Maternal Grandfather	_____	_____	☐ L ☐ D	_____
Paternal Grandmother	_____	_____	☐ L ☐ D	_____
Paternal Grandfather	_____	_____	☐ L ☐ D	_____
Other Family Member(s)	_____	_____	☐ L ☐ D	_____

Patient Registration and Financial Policy Form

Patient Information

Today's Date: _____

Patient Name: **First** _____ **Last** _____ **Middle Initial**_____

Date of Birth: _____ **Cell Phone #:** _____ **Home Phone #:** _____

Preferred Phone #: _____ **Social Security #:** _____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated

Preferred Method of communication for Appointment reminders ☐ Call ☐ Text ☐ Email

Legal Gender: ☐ Male ☐ Female **Gender at Birth:** ☐ Male ☐ Female **Preferred Pronouns:**_____

Home Address: _____ **City:** _____**State:** _____**Zip:**_____

RACE/ETHNICITY: ☐ Hispanic/Latino ☐ Asian ☐ Black/African American ☐ White/Caucasian ☐ Other:

Emergency Contact Information

Name: _____**Phone #:** _____ **Relationship to Patient:**_____

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, in part, or not at all, your medical bill remains a matter between you and your insurance carrier.

I understand that it is **my responsibility** to verify my insurance coverage. If the services provided are **not covered** by my insurance, I agree to be **financially responsible** for all charges.

I hereby authorize **Crossroads Medical Associates, LLC** to apply for benefits for services rendered and request that payment be made directly to **Crossroads Medical Associates, LLC**. I verify that the information I have provided regarding my insurance coverage is accurate and authorizes the release of any necessary information required to process claims with my insurance company.

Patient Signature: _____ Date: _____

Billing and Insurance Information

Primary Insurance

Name: _____ **ID Number:**_____ **Group Number:** _____

Subscriber Name: _____**Subscriber DOB:** _____**Relationship to patient:** _____

Secondary Insurance (if applicable)

Name: _____ **ID Number:**_____**Group Number:**_____

Subscriber Name: _____**Subscriber DOB:** _____**Relationship to patient:**_____

Patient Authorization

I, _____, hereby authorize **Crossroads Medical Associates, LLC** to apply for benefits on my behalf for services rendered and request that payment be made directly to **Crossroads Medical Associates, LLC**.
I certify that the information provided regarding my insurance coverage is **accurate and complete**, and I authorize the release of any necessary information, including medical information, for this or any related claim, to the insurance company listed above.
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:** _____