CROSSROADS MEDICAL GROUP
A LifeBridge Health Medical Group

Integrative Medicine
AT CROSSROADS
Conventional and complementary medical services

4801 Dorsey Hall Drive. Suite 201
Ellicott City, MD 21042
Phone: 410.997.5191
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Internal & Preventive Medicine

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WELCOME TO OUR PRACTICE!

We want your first visit to be as informative, comfortable, and convenient as possible. To help us make your visit the most positive experience it can be, please bring the following with you to your first appointment:

- Demographics Sheet (filled out)
- HIPPA (signed and dated)
- Insurance Card(s) (without insurance card, you will not be seen!)
- Co-pay - if applicable
- Photo ID
- Patient History Forms (filled out)
- Regulations Form (filled out)

** Please bring a copy of your pharmacy phone and fax numbers with you to your appointment. Our office does electronic prescription refills. **

Finally, please arrive in the office at least **20 minutes** prior to your appointment time.

Date of Appointment:

Time of Appointment:

Thank you in advance foryour cooperation.
I/I/e look forward to a long and healthy relationship!

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COMPLETE PHYSICAL INSTRUCTIONS

Morning Physicals:

1. Nothing to eat after midnight the night before - drink lots of water;
2. Coffee and Tea are permitted -no sugars or creams;
3. No lotions, creams, and/or powders on the body - deodorant is okay and
4. If taking any medications, take them with water.

** If you are unable to fast, please keep your appointment and let the Medical Assistant know.

As a reminder, please arrive in the office at least 20 minutes prior to your appointment time.

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DRIVING DIRECTIONS

FROM 1-95 NOR S:	Take MD-100 W (Exit 43B) Merge onto US-29 S (left exit) Quickly exit onto MD-108 W Turn Right onto Columbia Road at first traffic light Turn Right onto Dorsey Hall Drive at second traffic light
FROM RT. 70 E OR W:	Exit onto US-29 S Exit onto MD-108 W Turn Right onto Columbia Road at first traffic light Turn Right onto Dorsey Hall Drive at second 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 first traffic light Turn Right onto Dorsey Hall Drive at second traffic light
FROM RT 32 WEST OF CLARKSVILLE:	Exit onto MD-108 E Turn Left onto Columbia Road Turn Right onto Dorsey Hall Drive at second traffic light

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Medical History Questionnaire

Name: Date:

Date of Birth

Social History:

			Type, Amount, and Frequency
Alcohol:	Y	N	
Smoking:	Y	N	
Chewing Tobacco :	Y	N	
Street Drugs:	Y	N	
Caffeine:	Y	N	

Do you always wear your seatbelt? **Y** **N**

Do you exercise? Y N How often? Daily Frequently Occasionally

Education:

Occupation:

Hours Worked

Birth Control Method:

Last Menstrual Cycle:

Pregnancy? Y N

Children's Names/Ages:

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Do you have or have you had any of the FOLLOWING:

	Yes/No, When		Yes/No, When
Hypertension:		Stroke:	
Diabetes:		Mental Disorder:	
Liver Disease:		Seasonal Allergies:	
Asthma:		Heart Disease:	
Thyroid Disease:		Cancer:	
Kidney Disease:		Osteoporosis:	
Gerd:		Vascular Disease:	
Anemia:		COPD:	
Arthritis:		Skin Disorders:	

Vaccinations:

	Yes/No, When	Surgeries that you have had
Tetanus:		
Flu Vaccine:		
Pneumo Vax:		
Zostavax (Shingle):		
Gardasil:		
COVID-19:		

Procedures (include month ANd year):

Car Accident (Hospitalized):

Pap Smear:

Mammogram:

OEXAScan:

Colonoscopy:

Eye Exam:

Hearing Test:

Male Testicular Exam:

Chest X-ray:

MRI/MRA:

Ultrasound:

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<u>Do you have problems with any of the following:</u>

Please Explain

Skin Issue:

Vision:

Hearing:

Ears/Nose/Throat:

Respiratory:

Chest Pain:

Shortness of Breath:

Pre-Menopausal:

Menopause:

Urinary Retention:

Frequent Urination:

Difficulty Sleeping:

Joint/ Muscle Pain

STD's/ Infection:

Family Medical History:

Living/Deceased		Age	Major Illnesses/Health Problems	Cause of Death
Father:	L/D			
Mother:	L/D			
Grandmother (M):	L/D			
Grandfather (M):	L/D			
Grandmother (P)	L/D			
Grandfather (P)	L/D			
Aunt (S)	L/D			
Uncle (S)	L/D			
Brother	L/D			
Sister	L/D			

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List of Medications:

	Medication:	Dosage:	Frequency:	What for?
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

List of Supplements

	Name:	Dosage:	Frequency:	What for?
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

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List of Allergies:

Medicine allergies:	Y	N
Food allergies:	Y	N
Environmental/inhaled allergies:	Y	N

	Allergy:	Reaction:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

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Prescription Refill Information

Name:

Pharmacy Name:

Pharmacy Location:

Pharmacy Fax:

Mail Order Pharmacy:

Mail Order Fax Number:

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Patient Registration - Please Print Clearly

Patient Name: First,Middle, Last:			Age:	Date of Birth:
Home Address:		City:	State:	Zip Code:
Occupation:		Social Security #:	Sex:	Home Phone:
Employer:	Address:		Work Phone:	
Emergency Contact Person:			Emergency Contact Number:	
Email Address:			Marital Status: Single, Divorced, Married, Widowed	

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 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 are not covered by my insurance, I agree to be financially responsible for the charges for these services. I do hereby authorize Crossroads Medical Associates, LLC to apply for benefits for services rendered. I request payment 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.

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Billing and Insurance Information

Prim ary Insurance	Insurance Company Name:	ID or Policy Number:	Group/Code:
	Insurance Company Name:	Subscriber's Social Security:	Date Effective
	Subscriber's Name:	Home Phone:	Relationship to Patient:
	Subscriber's Address:	Work Phone:	Subscriber's Date of Birth:
Secondary Insurance	Insurance Company Name:	ID or Policy Number:	Group/Code:
	Insurance Company Name:	Subscriber's Social Security:	Date Effective:
	Subscriber's Name:	Home Phone:	Relationship to Patient:
	Subscriber's Address:	Work Phone:	Subscriber's Date of Birth:

Patient Authorization

I, , hereby authorize Crossroads Medical Associates, LLC to apply for benefits on my behalf for services rendered. I request payment be made directly to Crossroads Medical Associates, LLC. I verify that the information I have reported with regard to the insurance coverage is correct and further authorize the release of any necessary information, 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.

Signature of Subscriber or Beneficiary Date

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Due to new Federal regulations, we need the following information:

Name (print):

Date of Birth:

Preferred Language:

Race:

Ethnic Group (circle one): Hispanic or Non-Hispanic

Patient Printed Name: ________________________________ DOB: _______________

Patient Signature: ___________________________________ Date: _______________

Maintenance Medication Office Visits

For many years our office has required follow-up appointments of 3, 4, or 6-month intervals based on the provider's discretion and the patient's medical conditions that need to be managed. This has always been but in the past couple of years has 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 controlled substances.

Missed Appointment or Last Minute Cancellation Policy

While we make every effort to provide a reminder call, text & email of your appointment through our reminder system this service is a courtesy and it is the patient's responsibility to remember and keep their appointment. We charge $50 for any office visit and $100 for a physical exam or any extended appointment that is cancelled the same day or missed. Our office requires 24 business hours' notice for cancellations. 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.

Forms Completion Fees

Form completions without an appointment are subject to charge at the discretion of the provider. The charge amount is determined by the length of the document. The charge is $25.00. An extensive form will require an in-person visit regardless of the last date of your most recent visit.

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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 visit or if performed a telehealth charge to your insurance for which a copay or deductible will apply. Our practice firmly believes 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 us.

Physical Consent Waiver

A physical consent is provided to patients before their physical exam. This consent provides the patient with the option to consent or decline the provider to address, discuss & bill for things outside of preventative screening topics such as extended problems and treatments, management of your prescription medications, or address acute complaints in combination with a physical appointment. This would add an “office visit” code billed along with the physical appointment & copay may be reapplied. If a patient does not want the possibility of being billed a physical & office visit please decline this waiver & do not go over anything other than preventative screening topics. If a patient chooses not to consent to additional charges a follow up visit will need to be scheduled at a later date to address additional issues.

Online Visit Fee

As you may know, it has become very difficult to practice medicine in the current environment. There are increased costs associated with practice which involve staffing to provide the services that we provide to you. At the same time, there has not been an appropriate increase in payment by insurance companies. In many cases, there has been a reduction in payment.

Our practice provides many services for which there has not been compensation.

Many physicians have left the traditional practice of medicine to do “concierge medicine.” We have resisted this trend because of our desire to provide high quality and affordable care to our patients. A “concierge” practice would be exclusive – that is not the goal of our practice.

Fortunately, insurance companies have recognized this problem and provided us a means by which we can receive additional compensation for the electronic services we provide that have, heretofore, been uncompensated. Any phone or â€œelectronic patient-initiated contactâ€ such as questions and medication refills now have a CPT code that allows our providers to bill and be compensated for this work.

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HIPAA Patient Consent

This notice describes how medical information about you may be used and disclosed, arid how you can get this information. Please review carefully.

1. The General authorization for release of medical records that you sign authorizes your medical care provider, Integrative Medicine Associates ("Provider") to disclose the information in your medical record to the extent needed for the following purposes:
a. 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 case.
b. 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 care
c. For the purpose of Provider's "health care operations." This would include internal quality as 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.
d. For the purpose of other health care provider's 11health care operations: to the extent that they have a treatment relationship with you.
2. A specific Authorization of release of medical records that you may sign authorizes provider to make a specific disclosure that is not covered under section 1, listed 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.
3. You may revoke any authorization provided to Provider by giving the Provider a written notice of revocation. Provider may refuse to treat you if you revoke the general authorization.
4. 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 and civil litigation, or requests/surveys by licensure agencies or the U.S. Department of Health and Human Services.
5. Provider may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest of you.
6. 6. You have the following rights with respect *to* your medical records/information:
a. 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 your provider will not agree to a requested restriction.
b. You have the right to receive confidential communications of your health information and to direct the place and manner of communication.
c. You have the right to inspect and copy your medical records. (Provider is entitled to charge a reasonable fee related to the cost of copying your records.)
d. You have the right to seek to amend your medical records, and if the provider does not agree with your request, to note your objection in the medical record.
e. You have the right to receive an accounting of disclosures that are made to you or with your specific authorization, that fall within the scope of the providers "health care operation" or disclosure made for payment or treatment purposes.
7. 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. Patient's will be provided with revised notices, as appropriate.
8. If a patient believes that his or her privacy rights have been violated, the patient may complain to the 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 far making a complaint.
9. If you as 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.
10. 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.

Please acknowledge receipt and review of this notice by signing below. For further information, please contact our office.

Patient name: ____________________________________ Signature: ___________________________

Date: ________________

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General Authorization for Release of Medical Records

I, patient of Integrative Medicine at Crossroads ("Provider"), understand that my signature below gives provider permission t o the extent necessary, to use my medical record and to provide access to my medical record, while and after I 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 of my care.
3. For the Purpose of Providers "health care operations", including such as an alternative, evaluating provider performance, legal and medical review of care provided, business planning and management, customer service, resolutions of internal grievances and provision of legal and auditing services.
4. For the purpose of other health care providers 11 health care operations", to the extent that they have a treatment relationship with you.

I understand that my permission allows providers to transmit permissible information through any means that is reasonably secure, including vi� 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 the provider may refuse to provide further treatment if I do.

I understand that I have the right to request that the provider restricts how my medical information is used. 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 fully on the patient notice):

1. The right to review and copy my medical record.
2. The right to request an amendment of my medical record.
3. The right to grant or deny access to my records to others.
4. The right to decide how information from my record will be conveyed to others.
5. 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.
6. The right to revoke, in writing, any consent that I provided for access to my records.
7. 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.
8. 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 policies, and I understand that I will give a revised Notice if this occurs.

Patient name: ______________________________ Date: _________________________

Signature: _________________________________

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Disclosure to Family/Friends Treatment Authorization

_____ I do not want Integrative Medicine at Crossroads ("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:

Individual	Relationship	Phone Number
____________________________	______________________________________	_______________________________
____________________________	______________________________________	_______________________________
____________________________	______________________________________	_______________________________
____________________________	______________________________________	_______________________________

The authorizations 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 Integrative Medicine at Crossroads.

Notification Authorization: I· Authorize Integrative Physicians and staff to contact me at the following number(s) for scheduling or to inform me of medical or laboratory test results:

#_____________________________ #____________________________ #___________________________

___I authorize Integrative staff and physicians to leave messages regarding test results.

___I do not authorize Integrative staff and physicians to leave message regarding test results.

Patient name: _____________________________ Date: ________________________

Signature: ________________________________