CROSSROADS MEDICAL GROUP
A LifeBridge Health Medical Group

4801 Dorsey Hall Drive
Ellicott City, MD 21042

Cheryl Leonardi, M.D.
Mellissa Conti PA-C
Kimberly Weiss, PA-C

Phone: 410-997-4780
Fax: 410-997-3196

Warren M. Ross, M.D.
Joshua Anderson, P.A.
Jamie Garonzik, P.A.
Ruth Webb, NP

Phone: 410-997-5191
Fax: 410-997-7957

Joseph Aleo, M.D.
Parry Moore, M.D.
Marie-Alberte Boursiquot, M.D.
Rupal Desai, M.D.
Indrayani Karkhanis, M.D.
Steven Eversley, M.D.
Adejoke Sijuwade C.R.N.P.

Phone: 410-997-7660
Fax: 410-884-0063

Date of Appointment: _____ Time of Appointment: _____

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:

- Patient Registration (filled out)
- Authorization & Assignment of Insurance Benefits (signed and dated)
- Health Consent to Treatment (signed and dated)
- HIPPA (signed and dated)
- Insurance Card(s) (without insurance card, you will not be seen!)
- Patient History Forms (filled out)
- Medications and/or a list of medications to include the dosage instructions
- Photo ID
- Co-pay - if applicable

** 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.

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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Patient Registration - Please Print Clearly

Patient Name: First, Middle, Last:		Age:	Date of Birth:
Home Address:	City/State	Zip Code:	Last 4 of SS#:
Occupation:	Gender: Gender at Birth:	Cell Phone:	Home Phone:
Pharmacy Name:	Pharmacy Phone #:	Pharmacy Fax #:	
Emergency Contact Person:		Emergency Contact Number:	
Email Address:		Marital Status: Single, Divorced, Married, Widowed	

Billing and Insurance Information

Primary	Insurance Company Name:	ID or Policy Number:	Group/Code:
	Insurance Company Address:	Subscriber's Date of Birth:	Date Effective
	Subscriber's Name:	Relationship to Patient:	
	Subscriber's Address:		
Secondary	Insurance Company Name:	ID or Policy Number:	Group/Code:
	Insurance Company Address:	Subscriber's Date of Birth:	Date Effective:
	Subscriber's Name:	Relationship to Patient:	
	Subscriber's Address:		

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Authorization and Assignment of Insurance Benefits

The undersigned patient or authorized individual acting on behalf of the patient understands and agrees to the following:
1. I authorized payment of medical benefits to the physician(s) rendering service(s).
2. I agree and acknowledge that my signature on this document authorizes my doctor to submit claims for benefits, services rendered, or services to be rendered without obtaining my signature on each claim submitted for myself and/or dependents. I will be bound by this signature as though the undersigned had personally signed the claim.
3. I will pay to the physician any balance due for services rendered. I understand that if full payment is not made on my behalf by my (insurer, legal representation or workman's compensation insurance), I will be responsible for any outstanding balance.

Signature of Patient, Parent/guardian, Guarantor Date

LifeBridge Health Consent to Treatment

1. I am presenting myself as an Outpatient and I voluntarily consent to the rendering of care and treatment as may be ordered by my health care provider, associate or assistant. This includes medical treatments such as x-ray, examinations, laboratory tests and minor procedures my physician/provider may order.
2. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury. I acknowledge that no guarantees have been made to me as to the result of examination or treatment in this office.
3. I understand that I have the right to consent or refuse consent, to any proposed procedure or therapeutic course. I also understand that it is customary, absent emergency or extraordinary circumstance, that no procedures which pose a material risk of harm are performed upon a patient unless and until he/she has had an opportunity to discuss them with the physician or other health professional to my satisfaction.
4. I have had the opportunity to discuss this form, and I understand its contents and what it means. I verify that I have seen and/or received a copy of the Patient Rights and Responsibilities and understand its contents.

Signature of Patient, Parent/guardian, Guarantor Date

Witness Date

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PATIENT AUTHORIZATION

_____ is dedicated to preserving your privacy and personal health information. Our employees are trained in the proper handling of your medical and financial records. We are requesting this Patient Authorization in order to continue to provide the finest medical care possible. Thank you for your assistance.

I authorize _____ to:

1. Call my home and/or work to remind me of upcoming appointments; in the event I am not there, leave a message on the answering machine.
2. Send reminder notices for upcoming appointments or when it is time to schedule an appointment
3. Communicate with me via electronic email. I recognize that email is not a secure form of communication. There is some risk that any protected health information that may be contained in such email may be disclosed to, or intercepted by, unauthorized third parties.
4. Call my home or work and leave a message to contact the office. Make and/or receive calls from pharmacies on my behalf, including prescriptions by FAX.
5. Update my personal demographic information either on the phone or in the office at the time of the appointment.
6. At my request, I give permission to discuss my personal health with the designated person (s) below:

_____ _____
Name Relationship

_____ _____
Name Relationship

I have read and agree to the above policies.

_____ _____
Patient Name Date

_____
Signature of Patient

5/5/2021

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Late to Appointment Policy

If you are an established patient and you arrive 15 minutes late or more to your appointment you will likely be asked to reschedule unless the physician's schedule can still accommodate you. Priority will be given to the patients who arrive on time and you may have to be worked in between them. This may mean you will have a considerable wait. If this is not convenient for you, you may choose to reschedule. One or two late patients cause the entire daily schedule to fall behind. This is an inconvenience to everyone. We strive to see every patient as close to their appointment time as possible.

Likewise, if you are a new patient and you arrive at the scheduled appointment time and not early to complete your forms as instructed and it takes more than 15 minutes to complete the forms and registration process, you may also be asked to reschedule.

We ask that you please be courteous of your provider's valuable time and attention. The physicians, office staff, as well as your fellow patients thank you.

Missed Appointment or "No-Show" Policy

While we make every effort to provide a reminder call at least 24 hours before your appointment, it is your responsibility to remember your appointment. We charge a $30 missed appointment fee to patients who do not keep their scheduled appointment time, or who cancel less than 24 hours in advance. If this should happen more than twice, a $55 charge will be incurred for the third incident. All fees must be paid before a new appointment can be scheduled. After three (3) missed appointments, the practice may at its discretion choose to discontinue your care.

Signature of Patient Date