



Welcome to Sibley Primary Care

We are pleased to have you join our practice. We understand that starting with a practice can be overwhelming and we've provided this welcome packet to aid with your first and future appointments.

Arriving at Your Appointment



Please arrive at least **30 minutes in advance of your first appointment** to ensure we have the proper validation of insurance and all completed forms. Failure to arrive early for your first appointment may result in cancellation or rescheduling of your appointment.

Appointments



You will need to bring your insurance card and a photo ID with you for each appointment. Please let our staff know if you have had any information changes since your last appointment. If you are unable to provide us with your insurance card, your appointment will need to be rescheduled. You will be asked to fill out new registration forms annually so we may update your information.

Normal office hours are **8 a.m. to noon and 1 to 5 p.m., weekdays**, with the last appointment of the day at 4:30 p.m. We are unable to accommodate walk-ins. If you arrive to your appointment more than 15 minutes late, we may have to reschedule your appointment. If you need to cancel future appointments, please do so at least **24 hours in advance**; a no-show charge will apply that cannot be paid by insurance and must be paid out of pocket. Please note that patients may be discharged from the practice for repeatedly missing appointments.

Our staff makes every attempt to stay on schedule and see you in a timely manner; however, due to unexpected emergencies, we sometimes experience delays. Be assured

that your doctor will spend the necessary time and attention at every visit to ensure your high-quality care. The doctor will always address the primary reason for your appointment, but you may be required to make additional appointments to address additional concerns.

All copays are expected at time of service.

MyChart



We encourage you to sign up for MyChart, **your secure online medical record**. You may sign up for MyChart after an office visit with us, or with any Johns Hopkins provider. Our office can provide guidance on how to set up your account.

With MyChart, you will be able to send messages to your doctor; request appointments, access your health record, view your test results, request prescription refills, pay your medical bills and more—all from your home computer, tablet or smartphone.

Labs



Patients often wonder if they need to have bloodwork done. We usually want to do bloodwork after your first visit. We will provide you with specific orders for the labs that you need, which helps to ensure that your insurance company will cover the labs based on diagnosis.

Please arrive for your lab work after **fasting for at least six (6) hours**, unless you've received other instructions. There may be times when we are not able to perform

lab services in the clinic, in which case we will give you the necessary paperwork to have the blood drawn at an outside laboratory.

Your physician will contact you if there is something urgent to discuss. Otherwise, you will receive a results letter and/or MyChart message within two weeks.

Medications



We believe prescribing appropriate medications are an important element in maintaining good health. If you currently receive any narcotic/controlled substances, you will be asked to complete a **Pain Medication Agreement** for our practice. For other medications, we ask that you bring your pill bottles and the name, address and phone number of your preferred pharmacy to your first visit.

Requests for new medications (including antibiotics) and medication refills will not be taken over the phone or via MyChart during office hours without an appointment and evaluation by the physician.

If you need refills, please leave a detailed message on our **refill line** at **202-537-4400, option 4**, or request the refill through our patient portal (**MyChart**). Your message should include:

- your full name
- date of birth
- the medication name
- dosing and number of refills and
- your pharmacy name and address.

We need all of this information to ensure completion of your refill request. Please call your pharmacy to check the status of your prescription.

Prior Authorizations



There may be an occasion where your insurance company will require a “prior authorization” for a lab test, imaging test or prescription. This process can be confusing and frustrating for all parties involved. There may be forms that need to be completed and this takes time for our office, as well as for your insurance company, to process. If such a process is required, your doctor will let you know if the decision is to switch medications or pay out of pocket. Ultimately, **you are responsible for ensuring that the authorization is complete.**

Urgent Issues



Your calls are important to us and our staff follow-up on voicemail messages as quickly as possible. If you have an urgent health concern that can't wait for a response, we encourage you to go to the nearest Emergency Department or urgent care center. In case of a medical emergency, please dial 911 for assistance. **For after-hours urgent issues**, you may contact the on-call physician by calling the office number, **202-537-4400**, and leaving a message with the answering service. **The on-call physician is available for urgent questions only.**

Referrals



Your insurance may require you to obtain a referral for a specialist and/or require you to come in for an office visit in order to obtain the referral. For referrals requested by phone, please allow two to three business days for processing. Please note that while our physicians are happy to help guide you in finding a specialist, it is ultimately **up to you to follow up with your insurance to make sure the specialist is covered.**

Form Charges



Additional charges may be assessed for special requests including, but not limited to, completion of insurance, disability or personal forms. You may also be asked to schedule a separate appointment to address these needs.

Medical Record Requests



All medical record requests should be directed to the **Johns Hopkins Medical Records** department, which can be reached at **410-338-3439**. Our office is not set-up to fulfill these requests.



Patient Financial Responsibility Agreement

As a courtesy to our patients, we have enrolled in numerous managed care insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly. However, it is not possible for us to keep track of all the individual requirements of each plan.

It is the responsibility of each patient to know the details of his or her insurance plan in addition to any lapses in insurance coverage. Any charges that occur as a result of insurance plan restrictions or lapses in coverage are ultimately the patient's responsibility. Unfortunately, if you do not inform us of special requirements required by your plan and we order medically necessary services, such as lab work, hospitalization or supplies that are not covered by your plan, we may bill you directly for those charges. If current insurance coverage cannot be verified prior to each appointment, payment will be due at the time of service.

The office bills only for services performed by our providers. Laboratories are separate entities and will bill you or your insurance company for services that are performed. If you have any questions about your laboratory bill, please contact them or your insurance company directly.

Providing the highest-quality of medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance plan guidelines, whenever possible. With your cooperation, you should be able to receive all of the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care.

We may charge an upfront **\$35 administrative fee** for completing forms such as disability or insurance and medical records requests. Please be aware that these services may require to seven to 10 days to complete.

When you pay by check you also authorize Sibley Primary Care, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of \$35.

We attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. Sibley Primary Care also reserves the right to charge a no-show fee for patients who miss appointments without calling to cancel within 24 hours of the appointment. The current **no-show fee is \$25** and is subject to change without notice.

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by myself.

BY SIGNING BELOW I ACKNOWLEDGE I HAVE READ AND UNDERSTAND THE FOLLOWING POLICIES.

I ACCEPT THE RIGHTS AND RESPONSIBILITIES OUTLINED WITHIN THEM:

- **Patient financial responsibility including collections, no-show policy**
- **Scheduled appointment agreement**

PATIENT SIGNATURE

DATE

PATIENT PRINTED NAME



**SIBLEY MEMORIAL
HOSPITAL**
JOHNS HOPKINS MEDICINE

Scheduled Appointment Agreement

Your health care is important. **We are not aware of how your insurance company** determines which services/labs are paid and which services/labs are not paid or which are subject to coinsurance or deductible. Some pay only for illness codes, some only for prevention codes and some do not pay for a myriad of other factors.

Our responsibility to the patient is to provide care and order labs based on your individual medical needs, current prevention guidelines and the standard of medical care. There are no medical guidelines to support "routine labs" ordered without a medical evaluation, whether it is a covered benefit or not. **Please take the time to make yourself familiar with your insurance benefits.** Feel free to call the insurance company and ask about coverage. There are many plans and their benefits change often we have no way of knowing what is current for you.

You may schedule an appointment as a **well exam** or **preventive care exam**. In the event that a well exam/preventive care exam consultation results in the diagnosis or treatment of an illness, injury or acute condition, that visit would be covered as a **nonroutine office visit and any applicable copays would apply**. We encourage you to **schedule your well exam separate from a preventive care exam**.

If your insurance company does not cover some or all of these charges, you will be billed directly for the balance indicated as "patient responsibility." Please **do not ask us to re-bill your insurance** by changing the procedure or diagnosis codes. We are unable to make a change once the insurance has been billed.

Laboratory services are provided by **Laboratory Corporation of America (LabCorp)** or **Quest Laboratories** and have no direct financial or other affiliation with Sibley Primary Care. This means the laboratory work done is billed entirely by those individual companies. The services and billing remains the same, regardless of whether you had those laboratory services done at Sibley Primary Care or at an outside laboratory. The laboratory service, therefore, is offered as a convenience to our patients. **If a billing question about a laboratory service occurs**, it is the responsibility of the patient to direct those questions to the laboratory billing department. Please note that we will not change codes after the service is obtained.

I acknowledge that I have read and understand the information above. I understand I will be financially responsible for services that my insurance company indicates are "patient responsibility."

PATIENT SIGNATURE

DATE

PATIENT PRINTED NAME



OUTPATIENT AGREEMENT FORM

OUTPATIENT AGREEMENT FORM

Patient Identification Information

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This form applies to the following Johns Hopkins Medicine ("Johns Hopkins") entities: Johns Hopkins Bayview Medical Center, Clinical Practices of the Johns Hopkins University School of Medicine, Howard County General Hospital, Johns Hopkins Community Physicians, Johns Hopkins Home Care Group, Suburban Hospital, Sibley Memorial Hospital, Johns Hopkins All Children's Hospital and Pediatric Physician Services, Inc. and West Coast Neonatology Inc. and The Johns Hopkins Hospital, Johns Hopkins Imaging, and Ambulatory Surgery Centers.

General Policy: All patients shall be treated without discrimination related to age, race, ethnicity, religion, culture, language, physical or mental disability, social or economic status, gender, sexual orientation, or gender identity or expression.

Consent for Treatment: I, or my representative, agree to have Johns Hopkins providers evaluate and treat my condition. Absent an emergency, if the proposed treatment has significant risks, then an additional informed consent will be obtained. I understand that the practice of medicine is not an exact science, and that no guarantees have been given to me by anyone as to the results or outcomes that may be obtained from examinations, treatments or other healthcare services.

Disclosure & Authorization to Release Information: I hereby authorize Johns Hopkins to release my final diagnosis and other medical information to third parties to determine benefits payable and process claims. I authorize Johns Hopkins to release medical information to my insurance carrier for payment purposes. I authorize Johns Hopkins and/or any physicians who render services to me to release all or part of my medical and billing records for treatment, payment, and operations and for those purposes outlined in the Johns Hopkins Notice of Privacy Practices.

Consent to be Contacted: I agree that by providing my landline, cell phone number(s) or email address, I am giving express consent for Johns Hopkins, its staff, employees, independent contractors, assignees, successors, and agents, to contact me through email or at these numbers, or any number or email address that is later acquired for me and to leave live or pre-recorded messages, text messages or emails regarding my healthcare-related matters, my account, or my bill related to any services I receive. I confirm that any phone number I provide is associated with me and not a third-party. For greater efficiency, calls may be delivered by an auto-dialer. Additionally, for my convenience, emails and text messages may be sent unencrypted, which may present certain risks, including the risk of being intercepted during transmission or viewed by someone other than me. I agree to accept these risks. If I do not wish to receive text messages, I can call 1-800-318-4246 to opt-out. Providing an email address or telephone or cell phone number is not a condition of receiving services.

Physicians Not Employees of the Hospital: I understand that physicians may not be employees of the health system. I understand that my physician may ask other physicians to participate in my care including but not limited to attending physicians, radiologists, surgeons, obstetricians/gynecologists, pathologists, anesthesiologists, neonatologists, physicians interpreting diagnostic studies, consultants and physician assistants. I also agree that physicians in training, students or other qualified health care personnel, under supervision of my physician, may participate in and/or observe my care unless I specifically state otherwise, either verbally or in writing.

Electronic Prescribing: I authorize Surescripts, an electronic prescribing network, to release my medication refill history to my providers for the purpose of continued treatment.

Payment for Services: I understand that Johns Hopkins may bill my health plan for the care I receive. I agree that payments from my health plan may go directly to Johns Hopkins. If I should receive the payments, I understand that I will be responsible for paying Johns Hopkins. I assign the benefits payable for health care services to the physicians and/or organizations furnishing the services. I authorize direct payment to Johns Hopkins and all other providers of service to me, of any insurance, personal injury or other benefits otherwise payable to me or the patient. I acknowledge the financial responsibility for any coinsurance, deductible or other sum not received by the hospital from any third party source for the care and services rendered to me or the patient. I assign my right to appeal a denial of payment to Johns Hopkins for services rendered to me.

I understand that Johns Hopkins may be treated as an out of network provider by my health plan for services rendered at Johns Hopkins. In such case, my copay or deductible may be greater than if services were rendered at an in network facility or lab. This means that your insurance may cover less than expected depending upon your health plan. I understand that I must pay any co-payment or other part of the bill that my health plan says I must pay including a higher deductible or copay as a result of out of network benefits. I know that I may need to pay this before I am treated.

Patients seen in a clinic or outpatient setting may receive multiple bills. The hospital is permitted to bill a fee for outpatient visits, commonly referred to as a "facility fee", for the use of hospital facilities or space, clinics, supplies, tests, procedures, equipment, and non-physician services, including but not limited to the services of non-physician clinicians. I understand that all professional services of physicians are billed separately from the hospital bill. I understand that I am responsible for the charges of all physicians and ancillary services involved in my treatment.

I understand that hospital rates for hospitals located in the State of Maryland are subject to change without notice during the course of my outpatient treatment. This does not apply to Sibley Memorial Hospital, a hospital located in the District of Columbia. This does not apply to Johns Hopkins All Children's Hospital and Pediatric Physician Services, Inc. and West Coast Neonatology Inc. located in Florida.

I understand that at Maryland hospitals I am entitled to a Prompt Payment hospital discount as follows: 2% if payment is made on or before the date of service, or 1% if payment is made within 30 days of the date of the first bill or date of discharge, whichever is earlier. This does not apply to Sibley Memorial Hospital, a hospital located in the District of Columbia, or Johns Hopkins All Children's Hospital and Pediatric Physician Services, Inc. and West Coast Neonatology Inc. located in Florida.

I understand and agree that if my plan does not pay the hospital or doctor, I will have to do so. If my account is sent to a collection agency, I agree to pay all reasonable fees that are required to collect what is due. These fees may include court costs, attorney's fees of 15% of the billed charges and interest at the judicial rate if judgment is entered.

ERISA: If my health plan is subject to ERISA (the Employee Retirement Income Security Act under U.S. law), I agree to have Johns Hopkins act on my behalf to obtain my benefits when Johns Hopkins asks to do so. I also agree that Johns Hopkins can appeal for me if the health plan says it will not pay for my care. I understand that I must comply with the policies and procedures set by my employee benefit plan.

Private Contract: I understand that Johns Hopkins will hold me responsible in any one of the following situations. I may be asked to review and sign the Private Contract form in addition to this form:

- (1) When I choose to have a service that my health plan covers but I do not obtain the required referral or authorization from my health plan.

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- (2) When I choose not to use my health plan and agree to pay for services myself.
- (3) When my health plan does not participate with Johns Hopkins for the services I want or need and I agree to pay for my care myself.
- (4) When I receive services that are not covered under my health plan.

Assignment of Benefits: I assign to Johns Hopkins the right to submit a pre-service appeal to my health plan on my behalf.

Mediation Agreement (applicable to Maryland only): I understand that any claim that may arise out of the care provided from the doctors, nurses and other health care providers at any Johns Hopkins entity located in the state of Maryland are governed by the laws of the State of Maryland. I agree that before I file any lawsuit, I will try to resolve my claim through mediation. Mediation is a process through which a neutral third person assists the parties to help settle the claim. I do not give up my right to file a lawsuit if the mediation process fails to resolve my claim. I agree that any mediation or action in court must take place in Maryland. This agreement is binding on me and anyone who makes a claim for me.

The Johns Hopkins Notice of Privacy Practices: I received a copy of the Johns Hopkins Notice of Privacy Practices.

Consent for the Creation and Use of Photographs, Audio and Video Recordings (PAVR): I acknowledge that I have received the Johns Hopkins Photographs, Audio and Video Recording Patient Information Guide. I agree to allow for the creation and use of photographs, audio and video, recordings (PAVR), and other images and recordings of me, or the patient I represent, for the purposes of internal education and quality improvement.

Initial one: _____ I authorize _____ I do not authorize

Other Tests: In the event that a member of the hospital's work force sustains a bodily fluid exposure during the course of my treatment, I consent to HIV testing and authorize the hospital to release the result of this said test to me, the exposed healthcare employee, and my physician. I understand that I have the right to refuse testing without penalty. _____ I authorize _____ I do not authorize

Interpreter: If interpreter used, please complete the following: Remote In-person

Interpreter ID Number (if phone/video interpreter used): _____ Date: _____ Time: _____

Printed Name of Interpreter: _____

I AGREE TO THE ITEMS STATED ABOVE AND CERTIFY THAT ALL INFORMATION PROVIDED INCLUDING INSURANCE IS ACCURATE AND CORRECT TO THE BEST OF MY KNOWLEDGE. NO CHANGES TO THIS FORM WILL BE ACCEPTED.

Date: _____ Time: _____ Patient Signature: _____

For health care agent / guardian / surrogate / parent / spouse (circle one), I, _____ (print name), am the representative for the patient.

Date: _____ Time: _____ Representative's signature: _____

Relationship to Patient: _____ Date: _____ Time: _____

JOHNS HOPKINS NOTICES

Pathology: Johns Hopkins may dispose of any tissue or parts that are removed during a procedure; may retain, preserve, use, and share these tissues, parts or related information for internal educational and quality improvement purposes without my permission (even when these tissues, parts or related information identify me); and may use or share tissues, parts or related information that identifies me for research with my permission or with the approval of a review board governed by federal laws protecting these activities. If tissues, parts or related information do not identify me, Johns Hopkins may use them for scientific (research) purposes without my permission or action by a review board.

Pathology (Florida): I authorize Johns Hopkins to dispose of any tissue or parts that are removed during a procedure; to retain, preserve, use, and share these tissues, parts or related information, including any related DNA analysis, for internal education, research, quality improvement and other healthcare operations purposes, and as otherwise permitted by federal and state privacy laws, even when these tissues, parts or related information identify me.

Personal Belongings: Patients are responsible for their personal belongings and are encouraged to leave all money and valuables at home. Johns Hopkins shall not be responsible or liable for the loss of or damage to any personal property the patient brought into the facility including but not limited to money, dentures, glasses, hearing aids, personal electronic devices and documents.

Financial Assistance: I understand that Johns Hopkins has Financial Assistance Policies which provide financial assistance and payment plans to patients under certain circumstances. I understand that I can request information concerning Johns Hopkins Financial Assistance by contacting the Customer Service Department for Johns Hopkins at 443-997-3370 or 1-855-662-3017. I hereby authorize Johns Hopkins to run a credit report on me for use in determining whether I qualify for financial assistance or a payment plan. I also understand that I can obtain information by going online at: www.hopkinsmedicine.org/patient_care/pay_bill/payment_assistance.html

Physicians have their own financial assistance policies and the patient should contact the physician's office to inquire.

Advance Directives: An Advance Directive can mean any written or spoken statement of wishes regarding healthcare that is listed in the medical record. Advance Directives tell your health care providers who should speak for you and what medical decisions they should make if you become unable to speak for yourself. Examples include an appointment of a healthcare agent, healthcare instructions/treatment preferences (e.g., "Living will"), oral Advance Directive, and/or Advance Directive for Mental Health Services. If you have a written Advance Directive, please give a copy to the Registrar, your Nurse or Physician. If you would like to complete an Oral Advance Directive or revoke or revise an existing Advance Directive, please inform the Registrar, your Nurse or Physician.

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The Johns Hopkins Photographs, Audio and Video Recordings (PAVR) Patient Information Guide:

Internal Education and Quality Improvement

Please review this Information Guide before signing the Photographs, Audio and Video Recordings (PAVR) consent portion of The Johns Hopkins Inpatient or Outpatient Agreement form. Photographs, video, and audio recordings (PAVR) created and used at Johns Hopkins for the purposes of internal quality improvement and education are designed to improve patient care. Examples of how PAVR may be used include:

- **Quality Improvement Use- Video monitoring preparation the patient for surgery to prevent infection and ensure compliance with standards of care.**
- **Internal Education- The proper way to treat a wound, insert an IV or perform a procedure.**

Protecting your privacy: Johns Hopkins is grateful to patients who are willing to allow us to create and use PAVR so that we can improve the care we provide. At the same time, the privacy of patients, as well as the confidentiality of medical and related information, are among our highest priorities

- During the creation of PAVR, your privacy is protected as much as possible, and whenever possible the PAVR will be modified so that you are not recognizable.
- The Johns Hopkins staff will explain any intended use of the PAVR and answer any questions you may have.
- Use of your PAVR for purposes other than internal education and quality improvement shall require your additional consent and/or authorization.
- PAVR may include, but is not limited to photographs, drawings, video or audio recordings, digital or electronic images, motion pictures or other images

It is important that you **understand your rights** when PAVR is created or used. Your rights include:

- Consent for the creation and use of PAVR is voluntary. Your treatment will not be impacted, based on whether you sign the consent or not.
- Your consent will end only when the use of your information is no longer needed for the purposes of internal education and/or quality improvement.
- You may verbally request cessation of the creation of PAVR at any time while it is being made.
- You hereby release and waive all claims for compensation and rights to the images and recordings for which you consent.
- Following the creation of images and recordings you may revoke or withdraw your consent by mailing or faxing your written request to the care provider, clinic or department where your consent was made or given or to the Health Information Department. This withdrawal would affect only any new use of your PAVR by Johns Hopkins. If all identifiers have been removed from the PAVR this may not be feasible.

Please be sure to ask a Johns Hopkins staff member to clarify any questions you may have. We appreciate your assistance, and value your participation.



EP-00008

JOHNS HOPKINS INSTITUTIONS

STANDING AUTHORIZATION TO DISCUSS HEALTH INFORMATION WITH DESIGNATED PERSONS

. Complete all sections of this Authorization as appropriate to your request.

Patient Name: _____ **Birth Date:** _____
(first) (m. initial) (last)

Address: _____ **Phone #:** _____
(street address)

_____ **Medical Record #:** _____
(city) (state) (zip code) (if known)

For this Authorization, "**My Health Care Provider**" means _____
(name of health care provider)

For this Authorization, "**My Health Information**" means any and all information relating to my course of examination and treatment.

If I have initialed here (_____), "My Health Information" includes Substance Abuse Records/Information.

If I have initialed here (_____), "My Health Information" includes Mental Health Records/Information.

I authorize My Health Care Provider to discuss My Health Information with the person(s) or entity identified below for general information and inquiries, arranging appointments, identifying medications, discussing billing and payment and any other related matter.

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone #: _____ Phone #: _____

I understand that:

- This Authorization is voluntary. My treatment will not be impacted, no matter if I sign this Authorization or not.
- If I do not sign this Authorization, My Health Care Provider will not disclose My Health Information as requested.
- This Authorization is valid for one year from date signed, unless I revoke/withdraw this Authorization or unless an earlier date is specified here: _____. I may revoke/withdraw this Authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to the clinic or department where my Authorization was made or given.
- Once My Health Information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Signature of Patient Only: _____ **Date:** ____/____/____
(Required)

If you are NOT the patient but are signing on behalf of the patient, complete the following:

I, _____, am the (check which applies)
(print your name)

- Parent with Parental Rights** *(not sufficient for substance abuse records)*
- Registered Kinship Care Relative** *(not sufficient for substance abuse records)*
- Court Appointed Guardian**
- Legally Appointed Healthcare Agent** *(not sufficient for substance abuse records)*
- Medical Power of Attorney** *(not sufficient for substance abuse records)*
- Power of Attorney with Right to See Medical Records** *(not sufficient for substance abuse records)*
- Surrogate Decision Maker** *(not sufficient for substance abuse records or mental health records)*
- Court Appointed Personal Representative of Deceased**

Representative's Signature: _____ Date: ____/____/____
(Required)

Address: _____ Phone: _____

You MUST attach proof of your authority to act on behalf of the patient as checked above (other than parent).

FORMAT: I request that the copy be provided (where possible/available):

- on paper electronically on CD electronically on flash drive
- through a web portal, with notice provided to my email account at: _____
- by unencrypted e-mail to this email address: _____
- by other electronic means (if agreed upon by JH records department): _____

Important: I understand that the CD/disc or flash drive is not encrypted or password protected and that it is my responsibility to take extra precautions to protect the data on the device and not to lose or misplace the device. Additionally, I understand that unencrypted e-mail is not secure – that means it could be intercepted and seen by others; in addition, I understand that there are other risks with unencrypted e-mail including misaddressed/misdirected messages; e-mail accounts that are shared; messages forwarded to others; and messages stored on portable devices having no security. By choosing to receive **My Health Information** on a CD/disc, flash drive or by unencrypted e-mail, I am acknowledging and accepting these risks.

I understand there may be a fee for a copy of My Health Information. I understand that all fees will be in compliance with applicable law. I agree to pay this fee.

I understand that:

- This Authorization is voluntary. My treatment will not be impacted, no matter if I sign this Authorization or not.
- This Authorization is valid for one year from date signed, unless I revoke/withdraw this Authorization or unless an earlier date is specified here: _____. I may revoke/withdraw this Authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to the clinic or department where my Authorization was made or given.
- Once My Health Information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Signature of Patient Only: _____ **Date:** ____/____/____
(Required)

If you are NOT the patient but are signing on behalf of the patient, please complete below

I, _____, am the (check which applies)
(print your name)

- Parent with Parental Rights** (not sufficient for substance abuse records)
- Registered Kinship Care Relative** (not sufficient for substance abuse records)
- Court Appointed Guardian**
- Legally Appointed Healthcare Agent** (not sufficient for substance abuse records)
- Medical Power of Attorney** (not sufficient for substance abuse records)
- Power of Attorney with Right to See Medical Records** (not sufficient for substance abuse records)
- Surrogate Decision Maker** (not sufficient for substance abuse records or mental health records)
- Court Appointed Personal Representative of Deceased**

Representative's Signature: _____ **Date:** ____/____/____
(Required)

Address: _____ **Phone:** _____

You MUST attach proof of your authority to act on behalf of the patient as checked above (other than parent).



Patient History Update

Name _____
 History Number _____
 Date of Birth _____
 Date of Service _____

DIRECTIONS: PLEASE FILL IN THIS FORM AS WELL AS YOU CAN. SKIP OVER ANY QUESTIONS WHICH ARE DIFFICULT FOR YOU. YOUR PHYSICIAN, PRACTITIONER OR NURSE WILL HELP YOU WITH THEM.
 (PLEASE PRINT IN BLACK OR BLUE INK)

List current health problems (leave blank if none)

List Current Medications and doses:

ALLERGIES: Please list any medicines or substances to which you are allergic:

PAST MEDICAL HISTORY: Please list any operations, hospital admissions, or serious accidents/injuries you've had. If you've completed this form before, please provide us with an update with any problems in the last three years.

DIRECTIONS: Please list any operations, hospital admissions, or serious accidents/injuries you've had. If you've completed this form before, please provide us with an update with any problems in the last three years.

OPERATION, HOSPITALIZATION, or ACCIDENT	DATE (mo/yr)	HOSPITAL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

	Past	Present	Never	
Smoking/Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Highest Grade Completed: _____
Beer, Wine, Liquor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Job Description (if employed): _____
Drugs (cocaine, Marijuana, IV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Past Exposure to Toxic Substances: _____
Regular Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Marital Status: _____
Sexually Active:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Children (ages and health): _____
Do you have sex with men, women, or both? _____				

Patient Name: _____

SEXUAL and EMOTIONAL HISTORY	OB-GYN HISTORY (WOMEN ONLY)
<p><u>Have you ever been treated for a sexually transmitted disease?</u> Yes No _____</p> <p>Do you use condoms? Yes No _____ What birth control method(s) do you use? _____</p> <p><u>Have you ever been a victim of abuse?</u></p> <p>Physical No Yes _____ Sexual No Yes _____ Emotional No Yes _____</p>	<p>Are you pregnant NOW? Yes No Unsure If YES, Due Date: _____</p> <p>NUMBER OF TIMES PREGNANT: _____ FULL TERM PREGNANCIES: _____ MISCARRIAGES or ABORTIONS: _____ PREMATURE BIRTHS: _____</p> <p>DATE of LAST MENSTRUAL PERIOD: _____ Was it normal: Yes No</p>

FAMILY HISTORY			
			Relation
Breast Cancer	No	Yes	_____
Colon Cancer	No	Yes	_____
Prostate Cancer	No	Yes	_____
Ovarian Cancer	No	Yes	_____
Lung Cancer	No	Yes	_____
Skin Cancer	No	Yes	_____
Other Cancer:	No	Yes	_____
			Relation
Diabetes	No	Yes	_____
Hypertension	No	Yes	_____
Heart Disease	No	Yes	_____
Lung Problems:	No	Yes	_____
Other Health Problems:	No	Yes	_____
Alcoholism	No	Yes	_____
Drug Abuse	No	Yes	_____
Other:			_____

REVIEW of SYSTEMS	
Please check if you have any of the following problems and describe the problem in the space provided:	
<input type="checkbox"/> Fever, chills, weight loss, sweats or don't feel well	<input type="checkbox"/> Muscle or joint aches, injuries, swelling
<input type="checkbox"/> Eye or vision problem (glaucoma, change in vision, etc)	<input type="checkbox"/> Skin problems, rashes, concerning moles, breast problems
<input type="checkbox"/> Problem with nose or throat (allergies, smell, taste, throat, voice, swallowing)	<input type="checkbox"/> Headaches, weakness, numbness, coordination problems
<input type="checkbox"/> Heart problem (murmur, irregular beats, chest pain, heart attack)	<input type="checkbox"/> Mood problems, depression, crying, forgetfulness, seeing things
<input type="checkbox"/> Lung problem (including asthma, emphysema, cough, shortness of breath)	<input type="checkbox"/> Heat or cold intolerance, change in color of skin, diabetes
<input type="checkbox"/> Bowel or stomach problems (change in bowel movement, indigestion, nausea)	<input type="checkbox"/> Bleeding problems, anemia, easy bruising
<input type="checkbox"/> Genitourinary (difficulty with urination, blood in urine, kidney stones, infections)	<input type="checkbox"/> Allergies, swollen glands,

PREVENTIVE HEALTH CARE UPDATE	
Vaccinations: Please provide year of last vaccination	Screening tests: Please provide the date of your last test. Please circle any items that have been "abnormal" in the past.
Tetanus: _____	Mammogram: _____
Pneumonia: _____	PAP Test: _____
Influenza: _____	Breast Examination: _____
Hepatitis B: _____	Rectal or Prostate Exam: _____
Hepatitis A: _____	Stool Sample for Occult Blood: _____
MMR (Measles): _____	Colonoscopy or Sigmoidoscopy: _____
PPD (Tuberculosis test) last done: _____	Bone Density (DEXA) scan: _____
Result: Positive Negative	

Do you have an Advance Directive or Medical Power of Attorney? If yes, please list:
 No Yes: _____

Do you have any religious or spiritual beliefs you want your physician to know about?
 No Yes: _____

Your Name: _____ Date: _____ Provider: _____ Date: _____

Welcome to Sibley Primary Care!

Medical Record Information

We would like to provide you with the best care from the start!

On your first visit, it would be very helpful to your providers to have specific information about your health history.

You are welcome to send records from your previous doctor in advance of your appointment with us. Otherwise, kindly bring these records with you, as relevant:

1. Current medication list and/or medications in their original bottles
2. List of specialists
3. Preventive care
 - Immunizations record
 - Sexually transmitted infection screening
 - Recent lab testing
 - Colonoscopy or colon cancer screening report
 - Pap smear report
 - Mammogram report
 - Bone density screening (DEXA) report
4. Advance directives

If you are unable to obtain these records, please be prepared to provide information about where and when these were completed, so we can request the reports.

We look forward to meeting you, and to caring for you!