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.

SIBLEY MEMORIAL HOSPITAL

JOHNS HOPKINS MEDICINE

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**.

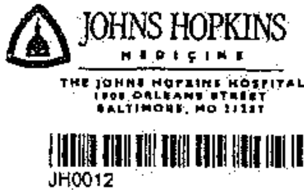
If your insurance company does not cover some or all of these charges, you will be billed directly for the balance indicated as "patient responsibility." Please **do not ask us to re-bill your insurance** by changing the procedure or diagnosis codes. We are unable to make a change once the insurance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



JH0012

OUTPATIENT AGREEMENT FORM

Patient Identification Information

This form applies to the following Johns Hopkins Health System Corporation ("Johns Hopkins") entities: Bayview Medical Center, Clinical Practices of the Johns Hopkins University School of Medicine, Howard County General Hospital, Johns Hopkins Community Physicians, Suburban Hospital Health System, and The Johns Hopkins Hospital, Healthcare and Surgery Centers.
This form is required to be completed for all new patients, and then at least annually or when the patient's insurance changes.

1) 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.

2) ELECTRONIC PRESCRIBING: I authorize Surescripts, an electronic prescribing network, to release my medication refill history to Johns Hopkins Medicine for the purpose of continued treatment.

3) 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 understand that I must pay any co-payment or other part of the bill that my health plan says I must pay. I know that I may need to pay this before I am treated.

I understand that I am entitled to a Prompt Payment hospital discount as follows: 2% if payment is made on or before the date of service or date of admission, or 1% if payment is made within 30 days of the date of the first bill or date of discharge, whichever is earlier.

I understand and agree that if my plan does not pay the hospital or doctor, I will have to do so. I further understand that interest will be added to unpaid amounts (doctor) that are more than 60 days past due. 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 of 10%, if judgment is entered). I know hospital rates are subject to change without notice during the course of my outpatient treatment.

I understand that under Maryland law Johns Hopkins will hold me responsible in any one of the following situations. I will 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.
(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.

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.

4) MY PERSONAL BELONGINGS: I understand that I am responsible for my personal belongings and valuables.

5) MEDIATION AGREEMENT: I understand that any claim that may arise out of the care provided from the doctors, nurses and other health care providers at Johns Hopkins Medicine 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.

6) THE JOHNS HOPKINS NOTICE OF PRIVACY PRACTICES: I received a copy of the Johns Hopkins Notice of Privacy Practices.

7) TELEPHONE CONSUMER PROTECTION ACT: I agree that by providing my landline or cell phone number(s), I am giving express consent for Johns Hopkins, its staff, employees, independent contractors, assignees, successors, and agents, to contact me at these numbers, or, at any number that is later acquired for me and to leave live or pre-recorded messages (including voicemail or text messages), regarding scheduling or scheduled appointments, my admission, my account or my bill related to any services I receive. For greater efficiency, calls or text messages may be delivered by an auto-dialer. I realize that as a consequence of providing this consent I will receive future calls or text messages that deliver prerecorded messages by or on behalf of Hopkins. Providing a telephone or cell phone number is not a condition of receiving services.

I agree to the items as defined in the above Johns Hopkins Outpatient Agreement:

My Signature: ______________________________ (SEAL) Date ____________

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

Representative's signature: ______________________________ (SEAL) Date ____________

Address: ______________________________ Phone #: ____________

____

15-200-0030N (9/04, 2/06, 11/06, 1/10, 7/13, 9/13, 10/13, 2/14, 8/14) Original - Medical Record

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)

JOHNS HOPKINS INSTITUTIONS

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION *TO* JOHNS HOPKINS

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

Patient Name: ____________________ (first) (m. initial) (last)

Birth Date: ____________________

Address: ____________________ (street address)

____________________ (city) (state) (zip code)

Phone #: ____________________

Medical Record #: ____________________ (if known)

For this authorization, "**My Health Information**" means:

____________________ (provide description of health information)

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

For the date(s) of service from: __________ to __________ (records should be provided for all service dates if left blank)
(insert date(s) of service requested)

I authorize ____________________ ("Health Care Provider") to provide **My**
(insert name of other health care provider)

Health Information to ____________________ for ____________________
(insert name of Johns Hopkins person or entity) (insert purpose for use or disclosure)

My Health Information should be faxed to ____________________ OR sent to:

____________________ (insert street address)

____________________ (insert city, state and zip code)

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 Health Care Provider identified above that provided health information to Johns Hopkins.
- 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).

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	☐	☐	☐
Beer, Wine, Liquor	☐	☐	☐
Drugs (cocaine, Marijuana, IV)	☐	☐	☐
Regular Exercise	☐	☐	☐
Sexually Active	☐	☐	☐

Do you have sex with men, women, or both? ____________

Highest Grade Completed ______________________

Job Description (if employed): ______________________

Past Exposure to Toxic Substances: ______________________

Marital Status: ______________________

Children (ages and health):

C0097N (8/04)

Patient Name: ________________________________

SEXUAL and EMOTIONAL HISTORY

Have you ever been treated for a sexually transmitted disease? Yes No ______________

Do you use condoms? Yes No ______________
What birth control method(s) do you use? ______________

Have you ever been a victim of abuse?

Physical	No	Yes	______________
Sexual	No	Yes	______________
Emotional	No	Yes	______________

OB-GYN HISTORY (WOMEN ONLY)

Are you pregnant NOW? Yes No Unsure
If YES, Due Date: ______________

NUMBER OF TIMES PREGNANT: ______________
FULL TERM PREGNANCIES: ______________
MISCARRIAGES or ABORTIONS: ______________
PREMATURE BIRTHS: ______________

DATE of LAST MENSTRUAL PERIOD: ______________
Was it normal: Yes No

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.

- ☐ Fever, chills, weight loss, sweats or don't feel well
- ☐ Eye or vision problem (glaucoma, change in vision, etc)
- ☐ Problem with nose or throat (allergies, smell, taste, throat, voice, swallowing)
- ☐ Heart problem (murmur, irregular beats, chest pain, heart attack)
- ☐ Lung problem (including asthma, emphysema, cough, shortness of breath)
- ☐ Bowel or stomach problems (change in bowel movement, indigestion, nausea)
- ☐ Genitourinary (difficulty with urination, blood in urine, kidney stones, infections)
- ☐ Muscle or joint aches, injuries, swelling
- ☐ Skin problems, rashes, concerning moles, breast problems
- ☐ Headaches, weakness, numbness, coordination problems
- ☐ Mood problems, depression, crying, forgetfulness, seeing things
- ☐ Heat or cold intolerance, change in color of skin, diabetes
- ☐ Bleeding problems, anemia, easy bruising
- ☐ Allergies, swollen glands,

PREVENTIVE HEALTH CARE UPDATE

Vaccinations: Please provide year of last vaccination

Tetanus	______________
Pneumonia:	______________
Influenza:	______________
Hepatitis B:	______________
Hepatitis A:	______________
MMR (Measles):	______________

PPD (Tuberculosis test) last done: ______________
Result: Positive Negative

Screening tests: Please provide the date of your last test.
Please circle any items that have been "abnormal" in the past.

Mammogram:	______________
PAP Test:	______________
Breast Examination:	______________
Rectal or Prostate Exam:	______________
Stool Sample for Occult Blood:	______________
Colonoscopy or Sigmoidoscopy:	______________
Bone Density (DEXA) scan:	______________

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!