JOHNS HOPKINS
COMMUNITY PHYSICIANS

Patient History Update

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

LABEL

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):

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:** _____

JOHNS HOPKINS
MEDICINE

OUTPATIENT AGREEMENT FORM

OUTPATIENT AGREEMENT FORM

Patient Identification Information

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, Suburban Hospital, Sibley Memorial Hospital, 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 acknowledge that Johns Hopkins and/or any physicians who render services to me may release all or part of my medical and billing records when required or permitted by state and/or federal law or regulation, including as necessary for treatment, payment, and operations.

Consent to be Contacted: 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 any number that is later acquired for me and to leave live or pre-recorded messages or text messages 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. Providing a 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. 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 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.*

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*.

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.

JOHNS HOPKINS
MEDICINE

OUTPATIENT AGREEMENT FORM

Patient Identification Information

Private Contract: I understand that under 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.

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.

Johns Hopkins Medicare Advantage MD Plans: I hereby irrevocably assign and transfer to Johns Hopkins, all rights, title and interest in the benefits payable under my Johns Hopkins Medicare Advantage Plan for the treatment rendered to me by Johns Hopkins during this outpatient visit. This irrevocable assignment and transfer shall be for the purpose of granting Johns Hopkins an independent right to recover under such Plan, including but not limited to appeals and/or requests for reconsideration, judicial review of a decision and any other appeal rights to deny benefits and Johns Hopkins agrees to waive any right to payment from the member other than plan-directed cost-sharing associated with the appeal and/or for non-covered charges.

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

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**

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.

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 Medicine Hospital Representative Signature_____

Print Johns Hopkins Medicine Representative Name_____

JOHNS HOPKINS NOTICES

The following notices are being given and are not negated if the patient or patient representative strikes through or crosses out any provision.

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.

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.

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).

JOHNS HOPKINS COMMUNITY PHYSICIANS

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

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)

WHO

I hereby authorize **Johns Hopkins Community Physicians** to take the following action.

ACTION REQUESTED (check one)

☐ Provide a copy of **My Health Information** to me ☐ Let me look at **My Health Information** (I am not requesting a copy)

☐ Release **My Health Information** to: ☐ Discuss **My Health Information** with: ☐ Obtain copies of **My Health Information** from:

_____
(name of other person or entity)

_____ _____
(street address) (city)

_____ _____ _____
(state) (zip code) (fax number)
(We cannot call before faxing.)

WHAT

For this Authorization, **"My Health Information"** means (check one or more):

☐ Abstract (discharge summary, operative notes, clinic notes, diagnostic testing)
☐ Billing Record
☐ Immunization Record
☐ Lab Reports
☐ OB/GYN Reports
☐ Physical
☐ Progress Notes
☐ Radiology Reports
☐ Other:_____

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

If I have initialed here (_____), this Authorization does NOT include records from other healthcare providers that are a part of my Johns Hopkins records included in this request. (If this blank is not initialed, those records ***will be*** included.)

For the date(s) of service from: _____ to _____ (records will be provided for all service dates if left blank)
(insert date(s) of service requested) (Note: Information from recent visits may not yet appear in the record.)

WHY

☐ At my request ☐ For my healthcare / treatment ☐ For legal purposes ☐ For payment / insurance purposes

Other: _____

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

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- ☐ **Court Appointed Personal Representative of Deceased**

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

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

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
COMMUNITY PHYSICIANS

Day of Appointment Checklist

☐ Insurance Card and Co-pay 

☐ Name & Number of your emergency contacts 

Bring the following medications in the Original Bottle or Packaging:

- ☐ Prescription Medications
- ☐ Over the Counter Medications
- ☐ All Vitamins and Minerals
- ☐ All Herbal Supplement

Discharge Papers from:

- ☐ Emergency Room Visit
- ☐ Hospital Admission

List of Specialist Seen

- ☐ X-Ray
- ☐ Orthopedics
- ☐ Cardiology

☐ Immunization Record