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.
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, we 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
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.”
OUTPATIENT AGREEMENT FORM

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.
OUTPATIENT AGREEMENT FORM

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.

15-200-0030N (5/19)
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: ________________________________________________________

(First) (m. initial) (last)

Birth Date: ________________

Address: _____________________________________________________________

(street address)

Phone #: ______________________

(city) (state) (zip code) (if known)

Medical Record #: _________

Signature of Patient Only: _____________________________________________ Date: ___/___/____

(Required)

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.

A.2.1.u
Copy – Medical Records Copy – Patient / Representative Effec. Date 12/1/12

Standard Register HIPAA-35N
Page 1 of 2
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: ___/___/____

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: _______________
(address) (first) (m. initial) (last)

Address: ____________________________________________ Phone #: _________________________
(street address) (city) (state) (zip code)

Medical Record #: ___________________________ (if known)

WHO

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

ACTIONS 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)

___________________________  ________________________   ___
(street address) (city) (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)
☐ Lab Reports  ☐ Radiology Reports
☐ OB/GYN Reports  ☐ Other:____________________________
☐ Billing Record  ☐ Physical
☐ Immunization Record  ☐ Progress Notes

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.
- 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)
☐ 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 or mental health 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

**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)
- 
- 
- 
- 
- 
- 
- 
- 
- 
- 
- 
- 

**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.

<table>
<thead>
<tr>
<th>OPERATION, HOSPITALIZATION, or ACCIDENT</th>
<th>DATE (mo/yr)</th>
<th>HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

### SOCIAL HISTORY

<table>
<thead>
<tr>
<th>Smoking/Tobacco</th>
<th>Past</th>
<th>Present</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beer, Wine, Liquor</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Drugs (cocaine, Marijuana, IV)</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Regular Exercise</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Sexually Active</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

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): ____________

©2007-4 (E04)
**SEXUAL and EMOTIONAL HISTORY**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever been treated for a sexually transmitted disease?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Do you use condoms? Yes No</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What birth control method(s) do you use?</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever been a victim of abuse?</td>
<td>Physical No Yes</td>
<td>Sexual No Yes</td>
<td>Emotional No Yes</td>
</tr>
</tbody>
</table>

**OB-GYN HISTORY (WOMEN ONLY)**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you pregnant NOW?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>If YES, Due Date:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NUMBER OF TIMES PREGNANT:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FULL TERM PREGNANCIES:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MISCARRIAGES or ABORTIONS:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PREMATURE BIRTHS:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DATE OF LAST MENSTRUAL PERIOD:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was it normal: Yes No</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FAMILY HISTORY**

<table>
<thead>
<tr>
<th>Relation</th>
<th>Breast Cancer</th>
<th>Colon Cancer</th>
<th>Prostate Cancer</th>
<th>Ovarian Cancer</th>
<th>Lung Cancer</th>
<th>Skin Cancer</th>
<th>Other Cancer:</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>No Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>No Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td>No Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung Problems:</td>
<td>No Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Health Problems:</td>
<td>No Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcoholism</td>
<td>No Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug Abuse</td>
<td>No Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus</td>
<td></td>
</tr>
<tr>
<td>Pneumonia</td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B:</td>
<td></td>
</tr>
<tr>
<td>Hepatitis A:</td>
<td></td>
</tr>
<tr>
<td>MMR (Measles):</td>
<td></td>
</tr>
</tbody>
</table>

PPD (Tuberculosis test) last done: ________________________________

Result: Positive Negative

Streaming tests: Please provide the date of your last test.

<table>
<thead>
<tr>
<th>Test</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammogram</td>
<td></td>
</tr>
<tr>
<td>Pap Test</td>
<td></td>
</tr>
<tr>
<td>Breast Examination:</td>
<td></td>
</tr>
<tr>
<td>Rectal or Prostate Exam:</td>
<td></td>
</tr>
<tr>
<td>Stool Sample for Occult Blood:</td>
<td></td>
</tr>
<tr>
<td>Colonoscopy or Sigmoidoscopy:</td>
<td></td>
</tr>
<tr>
<td>Bone Density (DEXA) scan:</td>
<td></td>
</tr>
</tbody>
</table>

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!