Carlden Health Family Clinic
198 Thomas Johnson Dr.
Suite#103
Frederick, MD 21702

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2023 Patient Demographics Form

Please provide the following demographic information for medical records at our office. Place answers above the line. Bold items are required.

_____ _____
NAME ***DATE OF BIRTH***

_____ _____
ADDRESS *APT #* *SOCIAL SECURITY NUMBER*

_____ _____
CITY ***STATE*** ***ZIP*** ***GENDER*** *Preferred Pronouns?*

_____ _____
PRIMARY PHONE ***Is this a Cell Phone?*** ***Yes*** ***No*** *SEXUAL ORIENTATION*

_____ _____
SECONDARY PHONE *Is this a Cell Phone?* *Yes* *No* *MARITAL STATUS*

_____ _____
EMAIL ADDRESS *ETHNICITY* *Country of Origin?*

_____ _____
INSURANCE PROVIDER *PRIMARY LANGUAGE* *Secondary Language?*

_____ _____
INSURANCE SUBSCRIBER ID # *(or provide card to receptionist)* *OCCUPATION* *Are you a student?* *Yes* *No*

_____ _____
EMERGENCY CONTACT NAME / RELATIONSHIP ***PRIMARY PHARMACY NAME***

_____ _____
EMERGENCY CONTACT PHONE ***PRIMARY PHARMACY ADDRESS / PHONE NUMBER***

I, the undersigned, certify that the information provided on this form is accurate and truthful. If I intend to claim insurance benefits for services rendered at Carlden Health, I certify that the insurance coverage I have provided is accurate and truthful. In exchange for providing and billing these services to my insurer, I assign directly to Carlden Health, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I, the Responsible Party named below, am financially responsible for all charges that have been duly processed through my insurance and still assigned to patient responsibility. I hereby authorize the doctor to release all information necessary to secure payment of my benefits. I authorize the use of this signature on all insurance submissions and claims for medical services provided by Carlden Health.

_____ _____
RESPONSIBLE PARTY SIGNATURE *RESPONSIBLE PARTY NAME, if you are not the patient*

_____ _____
TODAY'S DATE *If you are not the patient, what is your relationship to the patient?*

Complete Medical Record Information

Please fill in the circle for "Yes" or "No"

Have there been any updates to your **MEDICAL** history in the past 12 months? O Yes O No
If so, what has changed?

Have there been any updates to your **FAMILY** history in the past 12 months? O Yes O No

Question	**YES**	**NO**
Have you had alcohol in the past 12 months?	O	O
If yes, how often?	_____ Days per week	
If yes, how many drinks per week?	_____ Drinks per week	
In the last two weeks have you had little interest or pleasure in doing things you used to like to do?	O	O
In the last two weeks have you felt sad, depressed or hopeless?	O	O
Have you been sexually active in the last 12 months?	O	O
If yes, have you had: O Male Partner(s) O Female Partner(s) O Both?		
Do you have any history of Sexually Transmitted Disease (STD)?	O	O
Do you currently use tobacco in any form?	O	O
Are you a former smoker?	O	O
Are you able to pay for your medications?	O	O
Are you disabled?	O	O
Do you wear contacts or glasses?	O	O
Do you have a hearing impairment?	O	O
Do you use recreational/street drugs?	O	O
If yes, what? _____		
Do you have an Advance Directive or Living Will?	O	O
If no, would you like information on this today?	O	O

Please circle the most appropriate answer:

Race:	White	Black	Hispanic	Asian	Other: _____
Language:	English	Spanish	Italian	French	Other: _____
Ethnicity:	North American		Hispanic		Other: _____
Employment:	Full Time	Part Time	Retired	Temp	Other: _____
Student:	Full Time		Part Time		Other: _____

# of People in your Household: 1 2 3 4 5 6 7 8 9 10

_____
EMERGENCY CONTACT NAME

_____
EMERGENCY CONTACT PHONE

_____
EMERGENCY CONTACT'S RELATIONSHIP TO YOU

Optional. I allow my designated Emergency Contact the following privileges at Carlden Health:

☐ Access to my full medical record.

☐ May schedule and/or cancel my appointments.

☐ None. Emergency notifications only.

_____ _____ _____
SIGNATURE *NAME* *DATE*

HEALTH HISTORY
(Confidential)

NAME _____ **DATE** _____

DOB _____ **AGE** _____ **LAST AWV** _____

PRESCRIPTIONS
Please list any medications that are prescribed for you by a medical provider.

Drug: _____ *Dose:* _____ *# / Day:* _____ *Started:* _____

Drug: _____ *Dose:* _____ *# / Day:* _____ *Started:* _____

Drug: _____ *Dose:* _____ *# / Day:* _____ *Started:* _____

Drug: _____ *Dose:* _____ *# / Day:* _____ *Started:* _____

OTC MEDICATIONS
Please list any over-the-counter (OTC) medications you are currently taking.

Drug: _____ *Dose:* _____ *# / Day:* _____ *Started:* _____

Drug: _____ *Dose:* _____ *# / Day:* _____ *Started:* _____

ALLERGIES
Please describe any allergies you may have.

Drugs: _____ *Foods:* _____

Outdoors: _____ *Other:* _____

SYMPTOMS
Please check symptoms you currently have or have had in the past year.

General
- ☐ Depression
- ☐ Dizziness / Fainting
- ☐ Fever / Chills
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Muscle / Joint / Bone
Pain or numbness in:

- ☐ Arms / Hands
- ☐ Hips
- ☐ Back
- ☐ Legs / Feet
- ☐ Neck
- ☐ Shoulders

Genito-Urinary
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of Bladder Control
- ☐ Painful Urination

Gastro
- ☐ Appetite Poor
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

Cardiovascular
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure

Eye, Ear, Nose, & Throat
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache / Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Snoring
- ☐ Vision Flashes / Halos

Reproductive Health
- ☐ Abnormal Pap Smear
- ☐ Bleeding Between Periods
- ☐ Breast Lump
- ☐ Erection Difficulties
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Lump in Testicles
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Penis Discharge
- ☐ Sore on Penis
- ☐ Vaginal Discharge
- ☐ Other _____

Skin
- ☐ Bruise Easily
- ☐ Hives
- ☐ Rash / Itching
- ☐ Change in Moles
- ☐ Scars
- ☐ Sores That Won't Heal

SUBSTANCES
Please describe any substances you use and how much you use them.

Caffeine: _____ *Recreational Drugs:* _____

Tobacco: _____ *Other:* _____

HEALTH HISTORY
(Confidential)

SPECIALISTS

Please provide the month/year of your last specialist visits, as applicable.

Cardiology	_____	Gastro	_____	Oncology	_____	Pulmonary	_____
Dermatology	_____	Hematology	_____	Orthopedics	_____	Rheumatology	_____
Endocrinology	_____	Nephrology	_____	Physical Therapy	_____	Sleep Study	_____
ENT	_____	OBGYN	_____	Psychiatry	_____	Urology	_____

Have you had a DENTAL check-up in the past year? ☐ Yes ☐ No

Have you had a VISION check-up in the past year? ☐ Yes ☐ No

Have you had a MAMMOGRAM in the past year? ☐ Yes ☐ No

FAMILY HISTORY

Please list any relevant health information from your family, specifically:

Arthritis, Asthma, Cancer, Chemical Dependency, Diabetes, Gout, Heart Disease, High BP, Kidney Disease, or Tuberculosis.

Father *Age:* _____ *Health Problems:* _____

Mother *Age:* _____ *Health Problems:* _____

Sibling(s) *Age(s):* _____ *Health Problems:* _____

Other *Age(s):* _____ *Health Problems:* _____

CONDITIONS

Please check any conditions that you have ever had in your life.

☐ AIDS	☐ Chemical Dependency	☐ High Cholesterol	☐ Prostate Problems
☐ Alcoholism	☐ Chicken Pox	☐ HIV Positive	☐ Psychiatric Care
☐ Anemia	☐ Diabetes	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anorexia	☐ Emphysema	☐ Liver Disease	☐ Scarlet Fever
☐ Appendicitis	☐ Epilepsy	☐ Measles	☐ Stroke
☐ Arthritis	☐ Glaucoma	☐ Migraine Headaches	☐ Suicide Attempt
☐ Asthma	☐ Goiter	☐ Miscarriage	☐ Thyroid Problems
☐ Bleeding Disorders	☐ Gonorrhea	☐ Mononucleosis	☐ Tonsillitis
☐ Breast Lump	☐ Gout	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Bronchitis	☐ Heart Disease	☐ Mumps	☐ Typhoid Fever
☐ Bulimia	☐ Hepatitis	☐ Pacemaker	☐ Ulcers
☐ Cancer	☐ Hernia	☐ Pneumonia	☐ Vaginal Infections
☐ Cataracts	☐ Herpes	☐ Polio	☐ Venereal Disease

SERIOUS ILLNESS

Please describe any major health problems or events you have experienced.

Year _____ Reason _____

Year _____ Reason _____

Year _____ Reason _____

HOSPITAL HISTORY

Please describe and date any events that caused you to be hospitalized.

Year _____ Outcome _____

Year _____ Outcome _____

Year _____ Outcome _____

PREGNANCY HISTORY

Please describe and date events related to pregnancy.

Year _____ Gender _____ Complications, if any: _____

Year _____ Gender _____ Complications, if any: _____

Year _____ Gender _____ Complications, if any: _____

Carlden Health - Patient Policy 2020

We at Carlden Health strive to create a friendly and comfortable environment where your health is our primary concern. Please read this Patient Policy carefully so that you will understand our policies and avoid misunderstandings. All patients must fill out a "Patient Registration Form," HIPAA forms, and sign this Patient Policy before their first visit.

INSURANCE INFORMATION: Please bring a current insurance card with you to every appointment. Full payment for your service must be paid at the time of visit if you cannot provide the information needed to file your insurance claim. The patient and/or bearer of the insurance policy are ultimately responsible for payment for services not covered by their insurance plan.

PRIMARY INSURANCE CLAIMS: If Carlden Health has successfully filed your claim and not received finalization from your insurance company within 90 days, the remaining balance is the patient's responsibility and it is up to the patient to obtain payment from their insurance.

Carlden Health is not responsible for knowing the coverage and limitations of your insurance plan. Because of the great diversity in plans, we must require that the bearer of the insurance policy be responsible for knowing and understanding the limitations of their insurance coverage. It is your responsibility to understand the following:

- Whether or not preventive care or other services are covered by your plan.
- Whether or not Carlden Health is a part of your insurance provider network.
- The total and remaining amounts of your co-pay and your deductible. If the information is unknown, you will be responsible for payment in full at the time of service.
- Any other limitations in your coverage.

MEDICARE / SECONDARY INSURANCE CLAIMS: We do not file secondary insurance claims. If requested, you will be provided with the information and paperwork you will need to file a secondary claim through your insurance. We do file all Medicare claims; however, we do not accept assignment of Medicare claims. Payment must be made in full at the time of service for Medicare patients and payment from Medicare will be sent to you.

OUT-OF-NETWORK CLAIMS: If we are not contracted with your insurance company, we require full payment at the time of service. Patients with out-of-network insurance will be responsible for their bill in full at the time of checkout. It is the patient's responsibility to find out if we are in-network before being seen.

WORKER'S COMPENSATION / MOTOR VEHICLE ACCIDENTS: We do not process Workman's Compensation, or handle car accident cases where your benefits are not handled by your health insurance.

PATIENT UNDER AGE 18: The parents, guardian or adult accompanying the minor is responsible for payment. For unaccompanied minors, non-emergency treatment will be denied unless consent for treatment and charges have been pre-authorized by a parent or guardian.

VACCINATIONS: Adult and child vaccines are offered through our office. Most vaccines are covered by insurance, but some are not. Because of inconsistent insurance payment expectations, payment for certain vaccines is expected at the time of service. Patients are required to sign a waiver prior to receiving the vaccine.

VACCINE NON-COMPLIANCE: While we recognize and respect the individual's role as the ultimate decision maker for themselves and their child's healthcare, we believe strongly that we are obligated to deliver the best and safest healthcare possible for our patients and our community. Refusal of recommended vaccinations indicates a significant difference of philosophy of care and we feel professionally uncomfortable caring for patients who will not receive recommended vaccinations. We will not admit any individual who is more than six months behind the CDC's recommended schedule (http://bit.ly/CDCChildVax).

FORMS: There is a minimum of a *$10 charge for any forms* that take extensive completion time during a visit and for any forms that are brought in to be filled out outside of a scheduled appointment.

_____	_____	_____
SIGNATURE	*NAME*	*DATE*

PRESCRIPTION REFILL REQUESTS: *Please allow 2-3 days from the time of receipt for prescription refill requests.* Refill requests are primarily handled during an office visit. We do not fill controlled drugs over the phone or after office hours. We do not transmit controlled substances electronically, so a hard copy of all prescriptions for controlled substances must be picked up at our office. It is the patient's responsibility to have a list of the current medications that will need to be refilled prior to your follow up appointment. Failure to request a refill on a medication during an appointment may require the patient to return for another appointment.

CONTROLLED SUBSTANCE POLICY: Requests for controlled substance refills will not be given until prior records of usage has been obtained. Controlled substances will not be filled at your first appointment to our office. Controlled substances will only be refilled by the ordering provider and will not be filled after hours or on weekends. Patients requesting controlled prescriptions must pick up a paper prescription in the office; prescriptions will not be mailed to patient, faxed to pharmacy, or called in to pharmacy. Patients requesting such medication agree to random drug screening at the provider's request. Patients receiving controlled substances must arrive in-person for follow-up appointments a minimum of every three months.

LABORATORY CHARGES: Charges for blood collections will be filed with your insurance company and you may owe a balance for the charges. *For services rendered by Carlden Health employees, you are required to pay $10 at the time of your blood draw at our office to cover specimen handling fees.* The laboratory will bill your insurance for the individual tests will still be filed with your insurance company by our laboratory.

PHONE CONSULTATIONS: *All patient phone conversations with a medical provider may be billed as phone consultations.* If the patient has medical questions, concerns, or treatment options that are discussed and covered during the phone call by their provider, this appointment would be billed similarly to a regular office visit and any co-payments or deductibles owed by the patient may apply.

PAYMENTS: *Co-Pays and estimated Responsible Amounts must be paid at the time of service*. In the event you do not pay the proper amount at the time of checkout and owe a balance, the following billing process will apply for any amounts owed over $25 that were not paid at the time of service.

- If you owe for services rendered, your first billing statement will be sent via email. You will receive an explanation and a link to pay online via PayPal or Square.
- If unpaid after 30 days, a $1 fee will be added, and you will receive a paper billing statement in the mail.
- If unpaid after 90 days, a $10 fee will be added, and you will receive an email and a paper bill.
- If your bill remains unpaid after 180 days, your debt will be sent to Collections. Your credit will be reported as delinquent and your debt will be transferred to a third-party processor for payment.
- Accounts must be current to continue to receive care at our office. Patients may be refused care for non-emergency services if their account is 180+ days past due.

OVER-PAYMENTS: If you overpay for services, your account will be credited to use towards any expected expenses during your next appointment. You may also request a refund by mail at any time.

MISSED APPOINTMENTS: A $25 Missed Appointment charge will be added to your account if you:

- Do not show or arrive more than 10 minutes late for your appointment.
- Cancel any scheduled appointment within 6 hours of your appointment.
    - Any cancellations by email or through voice mail before 8:00am are acceptable.
- Carlden Health reserves the right to dismiss from the practice any patient who frequently misses scheduled appointments without prior notice. Patients who miss 3 consecutive scheduled appointments, or more than half of their appointments in a year, may be discharged at the discretion of Carlden Health.

I have read, understand, and agree to follow the above patient policy.
I acknowledge that failure to abide by these terms will result in my discharge from the practice.

_____	_____	_____
SIGNATURE	*NAME*	*DATE*

CONSENT TO USE OR DISCLOSE INFORMATION
FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

A. We have a legal duty to protect health information about you.
B. We may use and disclose Protected Health Information (PHI) about you without your authorization in the following circumstances.
    a. We may use and disclose PHI about you to provide health care treatment to you.
    b. We may use and disclose PHI about you to obtain payment for services.
    c. We may use and disclose PHI about you for health care operations.
    d. We may use and disclose PHI when required to do so because of the law.
    e. You can object to certain uses and disclosures.
    f. We may contact you to provide appointment reminders.
    g. We may contact you with information about treatment, services, products or health care providers.
C. You have several rights regarding PHI about you.
    a. You have the right to request restrictions on uses and disclosures of PHI about you.
    b. You have the right to request different ways to communicate with you.
    c. You have the right to see and copy PHI about you.
    d. You have the right to request amendment of PHI about you.
    e. You have the right to a listing of disclosures we have made.
    f. You have a right to a copy of this Notice.
D. You may file a complaint about our privacy practices to 1413 Carpenter Fletcher Rd, Durham, NC, 27713.
E. Effective date of this notice is April 14, 2003.
F. We participate in an Organized Health Care Arrangement with providers in the UNC Health Alliance. We may use your PHI for our own health care operations and for those of the Organized Health Care Arrangement in which we participate. (Effective 4/1/2017)

The Patient hereby consents to the use or disclosure or his/her individually identifiable health information ("protected health information") by Carlden Health in order to carry out treatment, payment, or health care operations. The Patient should review the Facility's Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

Facility reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If the Facility does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice by writing to 1413 Carpenter Fletcher Rd, Durham, NC 27713.

Patient retains the right to request that the Facility further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Facility is not required to agree to such requested restrictions; however, if the Facility does agree to Patient's requested restriction(s), such restrictions are then binding to the Facility.

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Facility in writing. The revocation shall be effective except to the extent that the Facility has already taken action in reliance on the Consent. Consent may be revoked upon written request to 1413 Carpenter Fletcher Rd, Durham, NC 27713.

The Facility may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that the Facility is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent, the Facility has the right to refuse to provide further treatment to Patient as of the time of revocation Form (except to the extent that the Facility is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

_____	_____	_____
SIGNATURE	*NAME*	*DATE*

2020 Patient Financial Agreement

Please review the following financial information at our office.

This document is a breakdown of Family Care's financial policies and an explanation of potential charges you could owe related to services at our office. Actual amounts vary depending on the type of service provided and your health insurance coverage at the time of service. This list is not comprehensive and may be updated without prior notice.

TYPE	DESCRIPTION	AMOUNT
Co-Payments / Co-Insurances	Amounts vary based on insurance coverage and must be made at the time of service.	Variable; based on plan benefits.
Deductibles	Patient is responsible for their health expenses prior to reaching their deductible. Amounts vary based on insurance coverage.	Variable; based on insurance coverage.
Phone Appointments	For medical care provided over the phone by a provider, in place of an in-person appointment.	Billed as an appointment.
Missed Appointments	Missed appointments, or appointments that are cancelled within 6 hours of the appointment.	$25
Blood Draws	Payment for Morning blood draws performed by a Quest employee are drawn at no charge. If a blood draw is performed by a Carlden Health employee in the Afternoon, there is a $10 fee.	No Charge, or $10
Completed Forms	Charge for form completion outside of a regular office visit or appointment.	$10
Returned Checks	A fee for a check that is returned by the bank for insufficient funds or any other reason that causes a check to be invalid.	$30
Late Fees	Non-payment of total balance in full at the time of service without prior approval from Carlden Health.	$1 initially + $10 after non-payment.
Records Requests	Printed or electronic copies of patient's medical records.	Variable; based on quantity.
Vaccinations	Vaccine administration.	Variable; based on vaccine.
Laboratory Fees	Billed directly from our contracted laboratories.	Variable; based on service.

I have read, understand, and agree with the above financial policy.
I understand that my first bill for services will arrive by email, or through my patient portal account.
I acknowledge that unpaid balances past 180 days may result in discharge from the practice.

_____ _____ _____

SIGNATURE *NAME* *DATE*