PHYSICIAN ASSOCIATES
FINANCIAL POLICY

6000 Executive Blvd #300
Rockville, MD 20852

1. It is our payment policy to collect the appropriate payment due at the time of service. This may include your co-payment, co-insurance, and/or deductible according to your health insurance benefit plan, or any previous balances due on your account.
2. We accept cash, check, all major credit cards, and Apple Pay. Additional payment options are available via *Pay My Doctor*.
3. You will be held responsible for any additional charges not covered under your policy. Should a credit balance occur, we will refund or apply to an outstanding balance any overpayment.
4. If Physician Associates does not participate with your insurance, you will be responsible for payment at the time of your visit.
5. There will be a charge for certain forms filled out, whether by the office staff or the physician.
6. Appointments must be canceled at least 24 hours prior to the appointment time to avoid additional charges to your account. If your appointment is scheduled for Monday, any cancellation must be made the preceding Friday.
7. Returned checks and accounts with balances more than 30 days old may be subject to additional fees, including a monthly late charge of 2%. Billing statements are sent out monthly. Physician Associates reserves the right to pursue legal remedies for accounts more than 90 days old.
8. Patients are responsible to provide Physician Associates with accurate insurance information to ensure that claims are processed expeditiously.

Notice to Medicare and HMO/PPO Patients

Certain services provided by this office are considered not covered under your insurance policy. You will be required to pay for any such services when rendered.

Our office does not mail or fax referrals to specialists' offices unless it is a medical emergency.

I understand and acknowledge the above financial policy.

_____________________________ _____________________________ _____________

Patient Name (please print) Patient Signature Date

Should you have any questions or concerns regarding these policies, please feel free to contact our billing staff for assistance.

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Patient Name: ________________________ DOB:__________________Date of Appt.:___________

List all Allergies	Allergic Reaction

Medication Name	Strength	Frequency

Health Maintenance

Date of Last Colonoscopy (patients over 50): _____________________________

Date of Last Mammogram (female patients over 40): ______________________________

Date of Last Papsmear (female patients): ___________________________________

Date of Last PSA Blood Test (male patients over 40): __________________________

Family History

Blood Relatives	Health Status	Age (if living)	Age at Death	Cause of Death	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					

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Immunization History

Vaccine	Date
Tetanus	
Pneumococcal	
Influenza	
MMR	
Polio	
Typhoid	
Gardasil	
Zostavax	
Hepatitis A	
Hepatitis B	
COVID-19	

Miscellaneous Information

Blood Type A+ B+ AB+ O+ A- B- AB- O-

Blood Transfusions
Number of Transfusions: ________________
Date(s):__________________________________
Reason(s): ____

Last Chest X-Ray
Date: ________________________
Normal _______ Abnormal ______

Last TB Skin Test
Date: ________________________
Positive_______ Negative ______

Date of Last EKG: _________________________

Date of Last Eye Exam: __________________________

Social/Prevention History

Alcohol Use	Yes	No	If yes, explain:
Caffeine Use	Yes	No	If yes, explain:
Exercise regularly Good sleep habits	Yes	No	If yes, explain:
Illegal drug use	Yes	No	If yes, explain:
Tobacco Use	Yes	No	If yes, explain:

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Do you wear seatbelts?	**Yes**	**No**	**If no, explain:**
Have you ever engaged in activity that puts you at risk of STDs/HIV?	**Yes**	**No**	**If yes, explain:**
Do you want to be tested for STDs/HIV?	**Yes**	**No**	
Are you in a relationship where you have been physically hurt/injured?	**Yes**	**No**	**If yes, explain:**
Do you ever feel afraid of your partner?	**Yes**	**No**	

List all previous illnesses, injuries, and surgeries	Date	Hospital and/or Physician

PHYSICIAN ASSOCIATES
Notice to HMO Members
6000 Executive Blvd #300
Rockville, MD 20852

Dear HMO Member:

Your insurance company has certain requirements that both you and this office must follow for you to receive the maximum benefits for which you pay and for us to receive payment for services provided.

1. Our contract with your insurance company designates your family and/or primary care physician and requires that all your medical care be coordinated and communicated through us.
2. If you have a medical problem, you must see one of the Physician Associate physicians or nurse practitioners who will treat you to the best of their abilities. If they feel they are unable to treat the problem, they will write you a referral to a participating specialist.
3. You must always have a referral from this office before you receive any health services from another provider. We cannot, under any circumstances, retroactively approve health services you received from another provider.
4. Any subsequent contacts with the specialist not provided for on your initial referral must be cleared by your primary physician. In other words, even if the specialist tells you to return to their office, you must first ascertain that the original referral provided for this service or you must be evaluated again by your primary physician.
5. There may be some services that your plan does not cover. Should you choose such a service you will be personally responsible for any charges incurred.
6. We are under the understanding that you have chosen Physician Associates as your primary care physician, however if you have not, you will be financially responsible for this visit. It is the patient's responsibility to contact the insurance company and change your PCP before the date of service. If this has not been completed before the date of service the insurance company may not pay for the visit. Therefore, it would become the patient's responsibility.

Failure to follow any of the above rules could result in expenses being denied by your health plan or worse, in cancelation of your contract. We ask your cooperation in following the above rules and suggest that your read your member handbook and/or call your health insurance company for any clarification.

We have attempted to contact your carrier to verify your coverage. Should we have been unable to do so, we will provide services that you requested but you will be responsible for the charges in full should the insurance company deny your coverage for any reason.

____ ____________________

Patient Signature Date

PHYSICIAN ASSOCIATES

6000 EXECUTIVE BLVD #300
ROCKVILLE, MD 20852
301-468-8999

REGISTRATION FORM

Today's Date ____ /____/____

PLEASE PRINT

PATIENT INFORMATION

PATIENT NAME (LAST,FIRST,MIDDLE)	DATE OF BIRTH ____/___/___	AGE	SEX ☐ M ☐ F

STREET ADDRESS	APT#	CITY	STATE	ZIP CODE

HOME PHONE	CELL PHONE	WORKPHONE	EMAIL ADDRESS

OCCUPATION	EMPLOYER	RETIRED ☐ YES ☐ NO	STUDENT ☐ YES ☐ NO FULLTIME? ____

MARITAL STATUS	LANGUAGE	RACE
☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED ☐ LIFE PARTNER	☐ ENGLISH ☐ CHINESE ☐ FRENCH ☐ KOREAN ☐ SPANISH ☐ VIETNAMESE ☐ OTHER ____________	☐ REFUSED TO REPORT ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN ☐ WHITE ☐ OTHER PACIFIC ISLANDER ☐ MORE THAN ONE RACE

EMERGENCY CONTACT

NAME	RELATIONSHIP	
ADDRESS	HOME PHONE	WORK PHONE

PREVIOUS OR REFERRING PHYSICIAN ________________________ **OFFICE PHONE** ____________
ADDRESS ____

INSURANCE INFORMATION

PRIMARY INSURANCE			SECONDARY INSURANCE		
INSURANCE COMPANY NAME			INSURANCE COMPANY NAME		
ID #	GROUP #		ID #	GROUP #	
SUBSCRIBER'S NAME	EMPLOYER		SUBSCRIBER'S NAME	EMPLOYER	
RELATIONSHIP TO PATIENT	SEX ☐ M ☐ F	DATE OF BIRTH ____/____/____	RELATIONSHIP TO PATIENT	SEX ☐ M ☐ F	DATE OF BIRTH ____/____/____

NAME OF PERSON RESPONSIBLE FOR BILL	RELATIONSHIP TO PATIENT		
STREET ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE		

Patient Authorization

I certify that the information that I have reported with regard to my insurance coverage is true and correct to the best of my knowledge. I authorize Physician Associates to apply for benefits on my behalf for covered services rendered. I release payment of all medical insurance benefits which are payable to me under the terms of my insurance policy or any third party payer, be made directly to Physician Associates. **I understand and agree that I am ultimately responsible for the balance on my account for any medical service rendered**. I further authorize the release of any necessary information, including medical information, needed for processing my insurance claim to my insurance carrier (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financial Administration). I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above named carrier at any time in writing. I request that payment of authorized Medigap benefits be made either to me or on my behalf to the above named provider for any services furnished me or physician/supplier. I authorize any holder of medical information about me to release to ________________ (medigap carrier).

Patient/Guardian Signature ______________________________________ **Date** __________

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The following signatures reflect that you have read the new patient packet and have agreed to the policies that are applicable to this practice. This signature page will be saved as part of your medical record. You may have a copy of the packet upon request.

Financial Policy

________________________________ ____________________________________ ______________
Print Name Signature Date

HMO Member (if applicable)

________________________________ ____________________________________ ______________
Print Name Signature Date

HIPPA
(Please check one)

_________ I do not want Physician Associates (Provider) to disclose any information concerning my care or treatment by Provider to individuals without my express written consent or legal authorization.

_________ I authorize Provider to disclose information related to my care and treatment to the following named individuals:

____

____

____

____

____

________________________________ ____________________________________ ______________
Print Name Signature Date