



Name: _____

Date of Birth: _____

Welcome to Our Practice

Greater Baltimore Medical Center (GBMC) welcomes you to our practice. We are dedicated to providing you with the kind of care that we would want for our own loved ones.

This **Information Package** is designed to help you understand the options for improved quality care that are available to you, as well as some expectations we have for you to assist us in your care.

We look forward to seeing you at your scheduled appointment. To save time on the day of the appointment, please read this **Information Package**, check and sign the consent document, and complete the enclosed registration forms. Please bring the forms and consent document with you to your visit. If you are unable to complete these forms before your visit, please plan to arrive 15-20 minutes before your scheduled time, so that we may answer any questions and complete the forms.

Medications

When you come for an appointment we will always need to know all of the medications that you are currently taking. You may complete the enclosed **Medication List** or, if it is easier, you may put all of your medications into a bag and bring them with you to your appointment.

Insurance

We participate with most insurance plans. Please bring a photo ID and your insurance card(s) to each appointment.

HMO/Managed Care plans

If your insurance is an HMO or Managed Care plan,

- And you are seeing a GBMC primary care provider; you must have a GBMC provider listed as the Primary Care Provider (PCP) on your insurance card in order to be seen.
- If you are seeing a specialist, you may need a referral or pre-authorization.

Under the terms of your plan, the provider may not be able to see you without the proper PCP listing and/or the necessary referral or authorization, unless you are willing to sign a *Voluntary Waiver of Insurance Benefits* and agree to payment at the time of service.

Appointments

Please be on time for your appointment. We will do our best to see you at the appointed time and/or advise you of any delays. If you need to cancel or reschedule an appointment, please call the office and give us at least 24 hours notice, so that we may put someone else who needs to be seen in your place.

Surveys

Periodically, you may receive surveys online or through the mail asking you to give us feedback about how well we are meeting your needs. We would greatly appreciate your input, as that helps us to improve our service.



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Screenings

Your provider may provide clinically appropriate screenings based on US Preventive Task Force guidelines which will be billed to your insurance. If you do not wish to be screened, please let your physician know.

Financial Policy

GBMC is committed to providing you with quality and affordable health care. We participate with most insurance plans. We also recognize our obligation to the community to provide appropriate medical care, regardless of ability to pay. We will assist you, if needed, through negotiated payment plans and our Charity Care policy. **Please contact our Central Billing Office at 443-394-6110 if you have questions about your bill. If you are in need of financial assistance, please call 443-204-8254.**

Definitions

CO-PAYMENT is a fixed amount set by the insurer that the patient is responsible for paying at the time of service. The co-payment may vary by the type of service, the provider rendering the service, and/or the place in which the service is rendered.

CO-INSURANCE is the patient's cost share, usually calculated as a percentage of the cost of the service. The co-insurance may not be subject to a deductible amount.

DEDUCTIBLE is the amount the patient is responsible for before the insurance plan starts paying for services. The deductible may not apply to all services.

Uninsured Patients

If you are uninsured, payment is expected on the day of your visit. If you need elective surgery, payment is expected prior to scheduling your procedure. You will be eligible for a 30% prompt pay discount, if you pay in full at the time of your visit or prior to surgical scheduling.

Insurance Coverage

It is your responsibility to know and understand the terms of your insurance coverage. Your insurance plan is a contract between you and your carrier. It is your responsibility to know whether your insurance carrier requires a referral and to bring it with you at the time of service. Please contact your insurance carrier with any questions regarding your coverage.

Co-Pays, Deductibles, and Coinsurance

All co-pays are due at the time of service. Contractually, your insurance company requires us to collect the portion for which you are responsible at the time services are rendered. Deductibles and coinsurance amounts are due once notification by your insurance company has been received, either in an Explanation of Benefits (EOB) or a statement from GBMC.

Acceptable Forms of Payment:

We accept the following forms of payment: Cash, Check, money order, Visa, MasterCard, Discover and American Express. A fee of \$25 will be assessed for each personal check returned by your bank as *non-sufficient funds*.



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Medicare

If we believe you are receiving a service that Medicare does not consider reasonable or necessary for your condition and for which payment is expected to be denied, you will be notified in writing with the Advance Beneficiary Notice of Non-Coverage (ABN) form prior to receiving the service. This will provide you with the opportunity to decide if you will proceed with the service ordered. This process is required by Medicare and preserves your right to appeal their decision.

Non-payment / Delinquent Accounts

You will receive a statement of your account each month either via mail or electronically through MyChart and may receive a phone call about unpaid balances. If you are interested in receiving your statement electronically, you must opt in through your MyChart account. If a balance remains unpaid for more than 90 days, the message on your third statement will state that your account is being reviewed for placement with a collection agency. Your account may be assessed a 30% surcharge to cover agency fees. You will be allowed 10 days to send the payment in full. Partial payments or extended payments will not be accepted unless otherwise negotiated with the Central Business Office at 443-394-6110.

Missed Appointments

We reserve the right to charge for missed appointments and appointments that are canceled within 24 hours of your visit. These charges will be your responsibility and will be billed directly to you. If you have missed or canceled a total of 4 appointments with less than 24 hours prior to your appointment time within a year, you may be discharged from our practice under our missed appointment policy.

Medical Records

Your medical records will be provided to you, other providers and your insurance carrier at no charge. If medical records are requested by other parties, such as attorneys, there will be a service charge for printing and/or copying and mailing. If records are requested in electronic format, there is no extra charge.

Forms Completion

We reserve the right to charge a fee for completion of forms (disability, FMLA, MVA, school, camp, etc.). The fees are as follows: Simple/single page forms: \$10 (each form) -Complex/multi-page forms: \$25 (each form).

MyChart at GBMC

MyChart at GBMC is an internet application that allows patients to view their medical record, receive certain laboratory and imaging results, request prescriptions, pay bills, communicate with their GBMC healthcare providers on non-urgent matters and arrange for clinical services/appointments. To learn more about GBMC MyChart and sign-up for an account, please visit www.gbmc.org/MyChart.

Payments and Correspondence

All payments or correspondence should be submitted through MyChart or mailed to:

GBMC Physician Self Pay

PO Box 418034

Boston, MA 02241-8034

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 requires that GBMC provide you with information about how we may use your Protected Health Information (PHI). All of that information is



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contained in GBMC's *Notice of Privacy Practices* which you will receive in a separate pamphlet. The Notice will tell you:

- How GBMC may use and disclose your protected health information.
- Your rights with respect to the information and how you may exercise these rights.
- GBMC's legal duties with respect to the information.
- Whom you can contact for further information about GBMC's privacy policies.

Designated Spokesperson

Because of HIPAA Privacy Rules, providers may not release your health information to anyone without your permission. This includes family members or friends that you may want the provider to keep informed. You may give us authorization to share information with specific individuals that you designate as your **Spokesperson(s)**. If you provide this authorization, here are some things of which you should be aware:

- We will share information about the services rendered by GBMC Physicians only (x-rays, laboratory and other test findings, diagnosis, prognosis and treatment plan) either in person or over the telephone.
- Once this information is released to the spokesperson, it may no longer be protected by the federal privacy regulations.
- The designated spokesperson(s), Medical Power of Attorney, Health Care Agent or other individual allowed by law will be the only individual(s) who may obtain information about you.
- Your spokesperson does not have decision-making abilities unless he/she is legally able to do that under the law.
- The authorization will expire one year after the date on the *Patient Consent Signature* form.
- You may withdraw this authorization at any time by notifying the GBMC Privacy Officer in writing. If you do withdraw the authorization, it will not have any effect on actions taken by GBMC prior to receiving the written request.
- You may refuse to sign this authorization. Your treatment will not be affected in any way by your choice to grant or not grant spokesperson authorization.

Release of Information to third party healthcare partners

Occasionally, we may share your contact information including phone number, address or email, with our healthcare partners, so that they can assist in providing you care as directed by your care team. They may use this information to correspond with you to support our office's effort to connect you with the proper care. Healthcare partners will not use this information to proactively contact you for an appointment if you have not initiated contact. This information is not to be used for other purposes. You may opt out of having your information shared by indicating on the *Patient Consent Signature* form or at any time by contacting the office.

E-Prescribing Consent

E-Prescribing is your physician's ability to electronically send an accurate, error-free and understandable prescription directly to your pharmacy from his/her office. The ability to electronically



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send prescriptions is an important element in improving the quality of your care. E-Prescribing greatly reduces medication errors and enhances patient safety. This consent allows GBMC to enroll you in the E-Prescribe program.

The Medicare Modernization Act of 2003 (MMA) listed standards that must be included in any E-Prescribing program. These include:

- **Formulary and Benefit Transactions** which provide your physician with information about which drugs are covered by your benefit plan.
- **Medication History Transactions** which provide your physician information about medications that you are already taking from other healthcare providers to minimize the possibility of unwanted drug interactions.
- **Fill Status Notifications** which provide information to your physician about whether your prescription has been filled, partially filled, and picked-up at the pharmacy.

Patient Consent Form

Please ask for clarification of anything that you don't understand or may have a concern about before you sign the Patient Consent form. Then please check the items that you consent to and sign and date the form.

Patient Consent to Treat and Financial Agreement

Name of patient: _____ **Date of Birth:** _____

Consent to Treat: I authorize Greater Baltimore Medical Center, Inc., GBMC Physicians, LLC, and their successors and assigns, ("GBMC") through their physicians and clinical staff, to provide medical treatment for me/the patient named on this consent form. I understand GBMC is partnering with Sheppard Pratt Physicians, P.A. ("Sheppard Pratt," a provider of mental health treatment), Mosaic Community Services, Inc. ("Mosaic," a provider of mental health and substance use disorder treatment), and KOLMAC Clinic, Inc. ("KOLMAC," a provider of substance use disorder treatment), collectively "Treating Partners." When medically appropriate in the GBMC treating physician's opinion, GBMC may, with my below authorization, refer me/the patient to the Treating Partners.

- I agree that GBMC may share contact information with the Treating Partners and consent to treatment at GBMC by the Treating Partners when recommended by the GBMC treating physician.
- I decline to have information shared and decline treatment by Treating Partners.

I understand and agree that, if I am treated by Sheppard Pratt at GBMC, Sheppard Pratt will document treatment provided in the GBMC medical record and GBMC is the custodian of that record. Access to the medical record is explained in the GBMC Notice of Privacy Practices (NOPP). Mosaic and KOLMAC will document in their own medical records, and should be contacted directly for access to those records.

Welcome Packet: I have received a copy of the *GBMC Welcome to Our Practice Packet* as well as an explanation of the treatment process and discharge procedure.

Authorization for Release of Protected Health Information to a Spokesperson: I have read the Welcome to Our Practice packet and understand the role of and my rights regarding a Spokesperson(s). This confirms that I authorize GBMC to tell the Spokesperson(s) about care provided by GBMC, including x-rays, laboratory results, test findings, diagnosis, prognosis and treatment plans either in person or by telephone.

Spokesperson(s) Information: (please print clearly)

Name: _____ Relationship to Patient: _____ Phone: _____
 Name: _____ Relationship to Patient: _____ Phone: _____

- I do NOT want my information released to any Spokesperson

Consent to E-Prescribe (please check all boxes that apply): I have read the Welcome to Our Practice packet and understand the E-Prescribing program. I certify that I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

- I hereby provide informed consent to GBMC to enroll me/the patient in the E-Prescribe Program.
- I decline to participate with the E-Prescribe Program.

Financial Agreement:

This Agreement covers all billable services that are rendered by GBMC and, if authorized herein, Treating Partners (collectively "Provider(s)") beginning _____ and continuing for as long as the I/the patient receives care.

Release of Information and Authorization to Pay Insurance Benefits: I authorize the Provider(s) to release medical information related to the care and treatment of me/the patient to third-party payors and their review agents which may be necessary to obtain benefits payable under any medical insurance plan for services rendered by the Provider(s). I understand that any benefit quotes or coverage information given to

Name of patient: _____ Date of Birth: _____

me by any member of the staff, faculty or representative of the Provider(s) is not guaranteed and is only what the Provider has been told by my/the patient's insurer, review agencies, and/or third-party payors. I assign to the Provider(s) all benefits due to the Provider(s) for services rendered to me/the patient from insurers, health management agencies, and/or other third-party payors. I further authorize the Provider(s) to discuss financial information with third parties for the limited purpose of collecting payments for services rendered.

Responsibility for Payment: Unless I check below that I am a health care agent only, I guarantee payment to the Provider(s) for billable services rendered to me/the patient. If I notify the Provider(s) that the I/the patient is an enrollee or subscriber of a Health Maintenance Organization ("HMO") or other third-party payor, I understand that, for services covered and authorized, I/the patient will be responsible for co-payments, co-insurance payments and deductibles. I understand that it is my responsibility to contact my insurance company for pre-certification/authorization of medical services as required by my insurer. If a billable service is not paid by the third-party payor, I/the patient agree to pay the full invoiced amount for the service rendered.

Medicare Assignment and Authorization: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize medical or other information related to this arrangement to be released to the Social Security Administration or its intermediaries or carriers if needed for a related Medicare claim. I request that payment of authorized benefits be made to the Provider(s) for any services furnished by the Provider(s) to me/the patient. I assign the benefits payable for Provider services to the Provider furnishing the services and authorize such Provider to submit a claim to Medicare for payment. I understand that I am responsible for any health insurance deductible and co-insurance.

Medicare Secondary Payor (MSP) Questionnaire: If the I/the patient receives Medicare, I have reviewed, completed and returned the MSP Questionnaire to the designated entity.

Missed Visit Policy: I understand the patient or parent(s)/legal guardian and/or guarantor will be responsible for paying a fee determined by Provider for any missed appointments unless patient/parent/legal guardian cancels twenty-four (24) or more hours before the scheduled appointment time. The twenty-four (24) hour cancellation requirement may be waived if there is a genuine emergency, as is determined by the Provider. Fees for missed visits are not covered by insurance.

- I am executing this Patient Consent only in my capacity as health care agent named in accordance with Maryland law. I am not the patient, parent, guardian or guarantor and I will not be responsible for payment.

I certify that I have read, understood, and agree to the above terms.

Patient/Parent/Guardian/Healthcare Agent:

Person Responsible for Payment:

Name

Name

(SEAL)
Signature and Date

(SEAL)
Signature and Date

Relationship to Patient

Relationship to Patient





Name: _____

Date of Birth: _____

MEDICATION LIST

Home medications for reconciliation for present office visit.

Please complete this medication list form. If you are taking more than 10 medications, continue on the next page. Bring this medication list to your appointment.

Patient Name: _____, _____
(Last Name) (First Name) (Middle Initial)

Date of Birth: _____ Date List Completed: _____

Person Completing List: _____, _____
(If other than patient) (Last Name) (First Name) (Middle Initial)

Medication	Dose	Frequency	Reason for Medication	Route (for example- by mouth, eye drops, or by injection)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Over-the-Counter Medications (Drugs), Vitamins, and Herbal Preparations:



Patient Name: ___ Mr. ___ Ms. ___ Mrs. (Last) (First) (Middle Initial) (Previous Name)

Address Line 1: _____ Address Line 2: _____

City _____ State _____ Zip Code _____

Home Phone#: _____ Cell Phone#: _____ Work#: _____

PCP: _____ Referring Provider: _____

Preferred Pharmacy: _____ Pharmacy Phone: _____ Pharmacy Address: _____

Date of Birth: _____ [] Male [] Female SS# _____

Email Address: _____ Preferred Language: _____

Marital Status:	Race:	Ethnicity:	Preferred Method of Communication:	Employment Status:	Student Status:
___ Single	___ American Indian or Alaska Native	___ Hispanic	___ Home #	___ Full time	___ Full time
___ Married	___ Asian	___ Non Hispanic	___ Cell #	___ Part time	___ Part time
___ Divorced	___ Native Hawaiian	___ Refused to Report	___ Work #	___ Not employed	___ Not a student
___ Widowed	___ Black or African Am.		___ Mail	___ Self employed	
___ Legally Sep	___ White		___ Email	___ Retired	
___ Unknown	___ Hispanic			___ Active Duty	
___ Partner	___ Other Race			___ Military	

Employer Name: _____ Phone # _____ Dept/Ext: _____

Employer Address: _____

Emergency Contact Name: _____ Relationship: _____

Phone # _____ Cell# _____ Work# _____

Address: _____ Zip Code: _____

<u>PRIMARY INSURANCE INFORMATION</u>					
Insurance Company _____					
Claims Address: _____					
City _____		State _____		Zip _____ Phone _____	
ID# _____			Group # _____		
Subscriber _____		DOB: _____		Relationship to Patient _____ [] Male [] Female	
Subscriber's Employer _____					
Subscriber's Employer's Phone # _____			Policy Effective Date _____		

SECONDARY INSURANCE INFORMATION

Insurance Company _____
Claims Address: _____
City _____ State _____ Zip _____ Phone _____
ID# _____ Group # _____
Subscriber _____ **DOB:** _____ **Relationship to Patient** _____ [] Male [] Female
Subscriber's Employer _____
Subscriber's Employer's Phone # _____ Policy Effective Date _____

Other Insurance Information:

Do you have any other insurance? If yes, please list: _____

Are you here for a Workers Comp Accident [] yes [] no Personal Injury [] yes [] no
Are you here for an injury from a motor vehicle accident? [] yes [] no Other injury? [] yes [] no
If yes to either of these questions: **What was your date of injury or accident? _____
How did your injury occur? _____
What is your injury or accident claim number? _____
What is the name/address of your attorney or insurance company for this claim? _____
_____ Phone #: _____

I certify that the demographic and insurance information on this form is current and accurate to the best of my knowledge.

X _____
Signature of Patient and/or Financially Responsible Party Relationship (If 17 yrs or younger) Date

Please complete ONLY FOR PEDIATRIC PATIENTS If you are not a pediatric patient STOP here:

Siblings (list all) **Children live with:** Parents Mother Father Other
Name _____ DOB _____ Social Security # _____
Name _____ DOB _____ Social Security # _____
Name _____ DOB _____ Social Security # _____
Name _____ DOB _____ Social Security # _____

Father's Name _____
Address _____
City _____
State _____ Zip Code _____
Home Phone _____
Social Security # _____ DOB _____
Employer _____
Work Phone _____
Occupation _____

Mother's Name _____
Address _____
City _____
State _____ Zip Code _____
Home Phone _____
Social Security # _____ DOB _____
Employer _____
Work Phone _____
Occupation _____

****Note:** The parent who brings a child to the office for medical services is responsible AT THE TIME OF SERVICE for co-payments, deductibles, balances, or for payment in full, in the event the provider of service is non-participating with your insurance carrier.
9/1/2014