

Prohealth Primary Care, LLC.

115 W. Bel Air Ave. Aberdeen, MD 21001
Fax: 410-273-1479

Patient's
Last name : _____ First name : _____ MI : _____
Address : _____
City : _____ State code : _____ Zipcode : _____
Referral Dr : _____ Marital : _____
Phone # : _____ Sex (M/F) : _____ Status : _____ S M D W
Birthday : _____ / _____ / _____ Social sec : _____ / _____ / _____
Home Phone : (_____) _____ Work Phone : (_____) _____
Emergency : _____ Emer Phone : (_____) _____
Email : _____ Cell Phone : (_____) _____

== Primary Insurance Coverage ====== **== Secondary Insurance Coverage ======**

Company : _____ Company : _____
Insured name : _____ Insured name : _____
Relationship : _____ DOB: _____ Relationship : _____ DOB: _____
Co-pay amount : _____ Co-pay amount : _____
Policy number : _____ Policy number : _____
Group number : _____ Group number : _____
Employer : _____ Employer : _____

== Guarantor Information ======

Guarantor : _____
Address : _____
City : _____ State code : _____ Zipcode : _____
Telephone # : (_____) _____ Miscellaneous : _____

Patient's Authorization

I authorize PROHEALTH PRIMARY CARE, LLC. to apply for benefits on my behalf for services rendered by PROHEALTH PRIMARY CARE, LLC.. I request payment from my insurance company be made directly to PROHEALTH PRIMARY CARE, LLC.. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

Singature of Subscriber or Beneficiary

Date

Maryland Healthy Kids Program

Medical/Family History Questionnaire

Patient Name:		Date of Birth:	Sex: (circle) Male Female
Form Completed By:	Today's Date	Relationship:	
PREGNANCY AND BIRTH HISTORY		PSYCHOSOCIAL HISTORY	
Name of Hospital: _____ Illnesses during pregnancy? No <input type="checkbox"/> Yes <input type="checkbox"/> Medications during pregnancy? No <input type="checkbox"/> Yes <input type="checkbox"/> Alcohol/Drug Abuse? No <input type="checkbox"/> Yes <input type="checkbox"/> Problems at birth? No <input type="checkbox"/> Yes <input type="checkbox"/> Describe: _____ Type of delivery? <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section Birth Weight _____ Discharge Weight _____ Did baby receive Hepatitis B vaccine? No <input type="checkbox"/> Yes <input type="checkbox"/> Date of Hepatitis B immunization: _____ Newborn Hearing Screen? No <input type="checkbox"/> Yes <input type="checkbox"/>		Who lives in household? _____ How many? _____ <input type="checkbox"/> Rent? <input type="checkbox"/> Own? <input type="checkbox"/> Shelter? Who cares for child? _____ Date of Birth? Mother _____ Father _____ Are parents working? Mother No <input type="checkbox"/> Yes <input type="checkbox"/> Father No <input type="checkbox"/> Yes <input type="checkbox"/> Foster Care? _____ Dates: _____ Other Languages? _____	
FAMILY HISTORY		MEDICAL HISTORY	
Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had: Allergies (List) _____ Who? No <input type="checkbox"/> Yes <input type="checkbox"/> Asthma _____ No <input type="checkbox"/> Yes <input type="checkbox"/> TB/Lung Disease _____ No <input type="checkbox"/> Yes <input type="checkbox"/> HIV/AIDS _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Suicide Attempts _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Heart Disease _____ No <input type="checkbox"/> Yes <input type="checkbox"/> High Blood Pressure/Stroke _____ No <input type="checkbox"/> Yes <input type="checkbox"/> High Cholesterol _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Blood Disorders/Sickle Cell _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Diabetes _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Seizures _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Mental Illness _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Cancer _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Birth Defects _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Hearing Loss _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Speech Problems _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Kidney Disease _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Alcohol/Drug Abuse _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Hepatitis/Liver Disease _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Thyroid Disease _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Learning Problems/Attention Deficit Disorder _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Family Violence _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Other: _____ _____		Has your child ever had: Allergies (List) _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Asthma _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Chicken Pox (Year) _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Frequent Ear Infections _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Vision/Hearing Problems _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Skin Problems/Eczema _____ No <input type="checkbox"/> Yes <input type="checkbox"/> TB/Lung Disease _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Seizures/Epilepsy _____ No <input type="checkbox"/> Yes <input type="checkbox"/> High Blood Pressure _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Heart Defects/Disease _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Liver Disease/Hepatitis _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Diabetes _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Kidney Disease/Bladder Infections _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Physical or Learning Disabilities _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Bleeding Disorders/Hemophilia _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Sexually Transmitted Diseases _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Emotional or Behavioral Problems _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Depression/Suicidal Thoughts _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Hospitalizations/Surgeries _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Physical/Emotional/ Sexual Abuse _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Bone or Joint Injuries _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Obesity/Eating Disorders _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Other: _____ _____	
Reviewed by:		Date of Review:	

Vaccine Administration Record

Patient Name: _____

Birthdate: ____ / ____ / ____

Parent/Guardian Signature: _____
(optional)

Provider/Clinic Name & Address:

Prohealth Primary Care, LLC.

115 West Bel Air Avenue
Aberdeen, MD 21001

VACCINE* (Please Circle Appropriate Vaccine)	Date Administered	Vaccine Manufacturer	Vaccine Lot Number	Name and Title of Vaccine Administrator	Date Vaccine Information Statements Given	Publication Date of Vaccine Information Statements
DTaP 1 or DT 1						05/17/07
DTaP 2 or DT 2						05/17/07
DTaP 3 or DT 3						05/17/07
DTaP 4 or DT 4						05/17/07
DTaP 5 or DT 5						05/17/07
IPV 1						01/01/00
IPV 2						01/01/00
IPV 3						01/01/00
IPV 4						01/01/00
Hib 1						12/16/98
Hib 2						12/16/98
Hib 3						12/16/98
Hib 4						12/16/98
PCV 1						04/16/10
PCV 2						04/16/10
PCV 3						04/16/10
PCV 4						04/16/10
MMR 1						03/13/08
MMR 2						03/13/08
Varicella 1						03/13/08
Varicella 2						03/13/08
History of Varicella Disease: Date-						
Hepatitis B 1						07/18/07
Hepatitis B 2						07/18/07
Hepatitis B 3						07/18/07
Influenza 1						
Influenza 2						
Tdap						11/18/08
Td						11/18/08
Td						11/18/08
MCV4						01/28/08
Hepatitis A 1						03/21/06
Hepatitis A 2						03/21/06
Rotavirus 1						05/14/10
Rotavirus 2						05/14/10
Rotavirus 3						05/14/10
HPV 1						03/30/10
HPV 2						03/30/10
HPV 3						03/30/10

* - When combination vaccines are given, enter the vaccine information in each separate vaccine row.

Nathaniel M. Sumilang, M.D.
410-272-3377

Gwenneth Cancino, M.D.
410-272-1692

Prohealth Primary Care, LLC.

115 W. Bel Air Ave. Aberdeen, MD 21001

SECTION ONE

Acknowledgement of Receipt of Notice of Privacy Policies

Version Effective 04/09/03

I, _____ have received a copy of Pro Health Primary Care, LLC's Notice of Privacy Policies with an effective date of 04/09/03. By signing this form, I am consenting to Pro Health Primary Care, LLC's use and disclosure of my Health information to carry out treatment, payment and healthcare operations.

Patient Name: _____

Date of Birth: _____

Signature: _____
(Patient or Appropriate Representative) _____ (Relationship)

Date: _____

SECTION TWO

Patient Authorization for Release of Protected Health Information

Before Pro Health Primary Care, LLC can permit a family member or other designated person to have access of your PHI (Protected Health Information), we must first obtain your authorization. You understand that if someone requests access to your PHI and we do not have your authorization, we may refuse to provide access to this information.

The following have my permission to receive PHI for treatment, payment, or telephone contact.

*(Consent is for an adult to be in exam room with you, or speak with doctor concerning your care.)

The following have my permission to consent to treatment for examination, shots and blood work.

*(Consent is for a minor patient to be brought to appointments by adult other than parent.)

Name: _____
Relationship to Patient: _____

Signature: _____
(Patient or Appropriate Representative) _____ (Relationship)
Date: _____

This authorization shall expire one year from today unless revoked by patient/representative prior to that date. Revocations of this authorization will be accepted by Certified mail or Facsimile to this office.

FOR OFFICE USE ONLY

Consent received by _____ on _____
 Consent added to the patient's medical record on _____
 Consent refused by patient, and treatment refused as permitted.

Please read and initial each paragraph below:

CURRENT INSURANCE CARDS

This must be presented at each office visit so we can bill your insurance.

If you don't have your card, you have the option to reschedule your appointment or pay your visit in full.

INSURANCE INFORMATION

Insurance guidelines and information are your responsibility. You are responsible for co-pay, deductible and coinsurance. You are responsible for whatever your insurance company does not cover.

CO-PAYS COLLECTION

All co-pays must be paid at the time of services. There is a \$10.00 service charge/fee for all billed co-pays.

There is \$35.00 fee for all checks returned by your bank.

OFFICE VISIT FEES

If we do not participate with your insurance, or you don't have active insurance, all fees are collected at time of service.

CANCELLED OR MISSED APPOINTMENTS

We require at least 24 hour notice if you cannot keep your appointment. If you miss 3 appointments (no show), you may be notified and advised to find another doctor. There is a \$35.00 charge for all missed appointments or cancelled with less than 24 hour notice.

ADDITIONAL CHARGES

There are late payment fees. Payment is due upon receipt of bill. If your insurance company is billed and does not cover the entire cost of the visit, you may receive a bill. Please pay this promptly as we do charge a \$10.00 per month fee if the bill is not paid. We make every attempt to work with patients who are having difficulties paying their bills.

If you are unable to afford your bill, please call us so that we may work out a payment plan.

LATE FOR APPOINTMENT

If, for any reason, you are more than 15 minutes late for an appointment, we reserve the right to reschedule your appointment.

PRESCRIPTION REQUEST

Schedule follow-up appointment for prescription refill. Request your refill on the day of your visit. We do not participate with pharmacy automatic refill.

REFERRAL AND FORM COMPLETION

Allow 7 days to process form completion and referral. You'll only be notified if there's any problem. We do not fax/mail (unless with self-stamped envelope) referral. Do not schedule appointment until you have the referral. It is your responsibility that the specialist chosen participates with your insurance.

CHILDREN UNDER 18

Children must be accompanied to the office by an adult on the HIPPA form. We can not treat the child without the company of an adult on the HIPPA form.

MEDICAL RECORDS

If medical records are requested to be copied, you'll be billed at the following rate in accordance with Maryland State Law. A health care provider may require an authorizing person, who requests a copy of medical record, to pay the cost of copying. \$0.76 per page as well as a \$22.88 preparation fee and the postage will be the required payment for medical record copying.

FORM FEE

There are separate fee (\$10-\$25) for forms completion.

CELL PHONES

Turn off cell phones when you come to our office and exam room. Go outside the office if you need to use your cell phone.

FOOD/DRINK

No food/drink allowed inside the office/exam room. Please finish your food/drink before entering the office.

WEATHER CLOSING

There may be occasional changes of schedule due to holidays, weather and other unforeseen events.

For closing due to weather, we may follow the Harford County government.

OFFICE HOURS

For referral, routine appointment, non-urgent question, please call during office hours.

ProHealth Primary Care office hours are 7:00 AM - 5:00 PM.

Phones are off for lunch between 12:00 PM - 1:00 PM (Office remains open).

Phones are turned off for the day at 4:30 PM. Office open until 5:00 PM

AFTER HOURS

For sick/urgent concern, you can reach Dr. Sumilang at 410-652-2685, and Dr. Cancino at 410-652-0074.

We are dedicated to serving you courteously, Thank you.

Patient name: _____

Patient signature: _____

Date: _____

ProHealth Primary Care Office and Financial Policies

PRIVACY NOTICE TO PATIENTS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED
AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Please Review It Carefully.

- I) The General Authorization for Release of Medical Records that you sign authorizes your medical care provider, PROHEALTH PRIMARY CARE, LLC., to disclose the information in your medical records to the extent needed for the following purposes:
- A) For the purpose of the provider treatment to you. This would include, for example sharing information with employee and contractors of Provider, or with other health care providers who are treating you or consulting in your care.
 - B) For the purpose of arranging payment for your care. This would include, for example, your insurer or other third party payor who is responsible for paying all or part of your care.
 - C) For the purpose of Provider's "health care operations." This would include such things as internal quality assessment activities, contacting other health care provider regarding treatment alternatives, evaluating provider performance, training providers of care, legal and medical review of care provided, business planning and management, customer service, resolutions of internal grievances and the provision of legal and auditing services.
 - D) For the purpose of other health care providers' "health care operations", to the extent that they have a treatment relationship with you.
- II) A Specific Authorization for Release of Medical Records that you may sign authorizes Provider to make a specific disclosure that is not covered under section 'A', above. A Specific Authorization will name the party to whom you are authorizing disclosure, and will contain any limitations on the authority to disclose your records.
- III) You may revoke any authorization provided to Provider by giving Provider a written notice of revocation. Provider may refuse to treat you if you revoke the General Authorization.
- IV) Provider may be required by law, in some cases, to make disclosures of your record that you have not authorized, Example are subpoenas in criminal or civil litigation, or request/surveys by licensure agencies of the U.S. Department of Health and Services.
- V) Provider may contact you to provide appointments reminder of information about treatment alternatives of other health-related benefits and services that may be of interest of you.
- VI) You have the following rights with respect to your medical records/information.
- A) You have the right to request restrictions on the use and disclosure of your medical records/information, however Provider is not required to agree to restrictions not guaranteed by law. You will be informed if Provider will not agree to request restriction.
 - B) You have the right to receive confidential communications of your health information and to direct the place and matter of communications.
 - C) You have the right to inspect and copy of your medical records. (Provider is entitled to charge you reasonable fee related to the cost of copying your records.)
 - D) You have the right to seek to amend your records, and if Provider does not agree with your request to, note your objection in your medical records.
 - E) You have the right to receive an accounting (list) of disclosures of your medical records/information made by Provider. (Except for those disclosures that are made to you with your specific authorization, that fall within the scope of Provider's "health care operations" or disclosures made for payments or treatment purposes.)
 - F) You have the right to receive a paper copy of this notice.
- VII) Provider is required by law to maintain the privacy of protected health information, and to provide patients with this notice. Patients will be provided with revised notices, as appropriate.
- VIII) If a patient believes that his or her privacy rights have been violated, the patient may complain to Provider, or to the Secretary of U.S. Department of Health and Human Services. To complain to Provider, please write or call us with the details. Provider will not retaliate in any way against a patient for making a complaint.
- IX) If you as a patient or guardian believe that your privacy have been violated, and wish to notify our practice, please call our office at (410)272-3377 and ask to speak with our Privacy Complaint Person: Nancy Thomas.
- X) Provider reserves the right to change its privacy practices, and to make its new policies effective for all protected health information that provider maintains. If such changes are made, Provider will post an updated "Privacy Notice to Patients" in our office.

For more information please call: Nancy Thomas 410-272-3377