MELISSA LOUGHNEY,M.D., LLC
COMPREHENSIVE MEDICAL HISTORY

DATE _____

NAME_____**DOB** _____

MALE ☐ **FEMALE** ☐ **HEIGHT**_____**WEIGHT**_____

PLEASE CHECK ALL THAT APPLY

RACE ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White

ETHNIC CATEGORY: ☐ Hispanic or Latino ☐ Not-Hispanic or Latino

PREFERRED LANGUAGE _____

OCCUPATION_____

REFERRING PHYSICIAN_____

ALLERGIES_____

CHIEF COMPLAINT_____

SMOKING STATUS: SMOKER: ☐ YES ☐ NO

☐ CURRENT DAILY SMOKER ☐ OCCASIONAL SMOKER ☐ FORMER SMOKER
☐ NEVER SMOKED

OTHER TOBACCO PRODUCTS USED _____

ALCOHOL ☐ YES ☐ NO FREQUENCY: _____

DRUG USE ☐ YES ☐ NO _____

CAFFEINE ☐ YES ☐ NO DAILY INTAKE:_____

SURGICAL HISTORY & DATE		MEDICAL HISTORY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY
Thyroid_____
...Diabetes_____
...High Blood Pressure_____
...Stroke_____
...Heart Attack_____
...Cancer_____
...Asthma_____

PREVIOUS HOSPITALIZATIONS

REASON_____DATE_____HOSPITAL_____
REASON_____DATE_____HOSPITAL_____
REASON_____DATE_____HOSPITAL_____

CURRENT MEDICATIONS (Including Vitamins, Aspirin, etc.)

MEDICATION	DSG	MEDICATION	DSG	MEDICATION	DSG

PHARMACY_____LOCATION_____PHONE_____

CONSENT FOR RELEASE OF INFORMATION

I have read the NOTICE OF PRIVACY PRACTICES. I am aware the my "Protected Health Information" (PHI) will be disclosed to those physicians involved in my care, my insurance company(ies), business associates of the Practice, for the purpose of carrying out treatment, payment or health care operations. In addition, I have specified my references for routine uses and disclosures as indicated below:

Name_____DOB_____

Please indicate any and all of the following methods that would be appropriate for Melissa Loughney, LLC to contact you, should it be necessary:

☐ ADDRESS_____ ☐ EMAIL_____

☐ HOME #_____WORK #_____

☐ OTHER/CELL #_____FAX #_____

In the occasion that we do not contact you, it is suitable to leave a message (check all that apply)

☐ on answering machine ☐ with adult household member ☐ exclusively with patient

Who is authorized to receive patient medical/billing information? (check all that apply)

☐ patient only ☐ spouse ☐ family member (name)_____

☐ other (please specify)_____

I understand that further authorization (s) may be necessary as required by law should any additional disclosures of PHI be requested.

_____ _____

Signature of patient or personal representative (revised annually) Date

_____ _____

Printed name of patient or personal representative Description of personal representative's authority

_____

Revised Signature (Date) Revised Signature (Date) Revised Signature (Date)

MELISSA LOUGHNEY,M.D., LLC

ENDOCRINOLOGY

MELISSA LOUGHNEY, MD

PATIENT REGISTRATION FORM

Patient Name: _____
First Middle Last

Home Address:

No. Street: _____

City: _____

State/Zip: _____

Sex: ☐ Male ☐ Female

Home Phone #: _____ _____ _____
Area Code

Work Phone #:
_____ _____ _____
Area Code

Date of Birth: _____
Month Day Year

Soc. Sec.# _____

Referring Physician: _____

Phone# for Referring Physician _____

Marital Status: ☐ Single ☐ Married ☐ Other _____

Employment Status: ☐ Employed
☐ Full-Time Student
☐ Part-Time Student
☐ Retired
☐ Not Employed
☐ Other: _____

Employer / School Name: _____

Employer / School Address: _____

No. Street: _____

City: _____

State/Zip: _____

Occupation/ Position: _____

EMERGENCY CONTACT:

Name: _____

Relationship: _____

Daytime Phone #: _____ _____ _____
Area Code

Evening Phone #: _____ _____ _____
Area Code

BILLING INFORMATION:

Preferred Method of Payment:
☐ Personal Check
☐ Cash
☐ Credit Card (MC, VISA, AMEX)

Do you have health insurance coverage? ☐ YES ☐ NO
If yes, please present insurance card to registrar and complete below.

PRIMARY Insurance Plan/Program Name:
☐ MEDICARE
☐ Blue Cross/Blue Shield of the National Capital Area

☐ OTHER: _____

Insured Name _____

*Insured's ID Number:

*Policy Group Name/Number: _____

Insured's Address: (If different from patient's address.)

Insured's work number: _____

Insured's Date of Birth: _____

Relationship to Patient: ☐ Self ☐ Other: _____

Is Insurance Related to Employment? ☐ YES ☐ NO

IS THERE ANOTHER HEALTH PLAN? ☐ YES ☐ NO
(If yes, complete secondary insurance information).

SECONDARY Insurance Plan/Program Name:
☐ MEDICARE
☐ Blue Cross/Blue Shield of the National Capital Area
☐ OTHER: _____

Address:

Insured's Name: _____

*Insured's ID Number: _____

*Policy Group Name/Number: _____

Insured's Address:

Insured's work number: _____

Insured's Date of Birth: _____
Relationship to Patient: ☐ Self ☐ Other
Is Insurance Related to Employment? ☐ YES ☐ NO

Read back of form before signing this form.

I certify that the information I have reported above is correct. I authorize payment of medical benefits to the above listed physicians for services rendered to me. The undersigned agrees to promptly pay all charges when billed for medical services. I have read, understand and agree to the Financial Policy (see reverse side).

I authorize the release of any medical or other information necessary to the above billing agent, to the referring physician, and/or to any other physician(s) to whom I am referred to for medical care. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at anytime in writing.

_____ _____
Signature of Patient or Authorized Person Date

6400 GOLDSBORO ROAD • SUITE 330 • BETHESDA, MD 20817 • OFFICE: (301) 320-3365 • FAX: (301) 320-0171

Melissa Loughney, LLC

Endocrinolgy

Our Financial Policy

The following clarifies our Financial Policy. We ask that you read the information carefully and sign to acknowledge that you are aware of these policies. Also, please complete the Registration Form on the reverse side. Thank you so much for taking the time to review this information.

Insurance: Melissa Loughney, LLC participates with Medicare Part B, Blue Cross/Blue Shield NCA and many other managed care plans. We advise you to verify our participation with your insurance carrier as these contracts do change from time to time. Please present your insurance card(s) so that we will have accurate information to file the claims for you.

Referrals: It is imperative that you know the rules and regulations of your insurance company. For your own financial protection, verify your need for a referral with your insurance company before seeing our physicians. If you do not have a required referral, our front desk staff will either have you sign a form accepting full financial responsibility for the office services, ask you to call your primary care physician for a faxed referral or cancel your appointment with our physician. *Not having a required referral can be very costly to you.*

Payments at Time of Service: Your insurance plan has instructed us to collect your co-payment at the time of service. Some patients will be expected to also pay their deductible and/or co-insurance. Patients who are self-pay will be expected to pay the full amount of the fees charged at the time of service. Please be aware that some services provided may be non-covered services and therefore not paid by your insurance. Some services are deem d not reasonable or not necessary under the Medicare Program and/or other insurance and become your financial responsibility. We accept personal checks, cash, money orders, MasterCard/Visa, and American Express credit cards.

Billing Statements: Billing statements are mailed monthly to our patients who owe a balance. These statements are itemized using standard international procedure codes, the dates services are provided, the service, the charge and any payments made by the insurance company and the patient. Additionally, our Business Office will mail the patient/guarantor a notice of incomplete insurance payments due to patient-owed deductible or other reason as soon as we are notified by the insurance company. Any non-covered service or charges going toward the patient's deductible are the responsibility of the patient/guarantor. Non-payment by insurance company due to incomplete or inaccurate information provided to our Business Office becomes the responsibility of the patient/guarantor.

Collections: Please contact our Business Office immediately if you need to make arrangements for a payment plan. If you do not contact us and do not pay your balance, we may proceed swiftly to tum your account over to one of our collection agencies after alerting you with a series of letters. Please do not let your credit be compromised; call us if you do not understand your bill or any charges. Our Business Office can be reached at 301-320-4383 'We do have voice mail in case you call after hours. We will return your call within 48 hours. Our staff is very knowledgeable and helpful.

Important Points:

- Provide us with accurate, up to date insurance information.
- Verify our participation with your health insurance company.
- Obtain required referrals and bring them to your appointment.
- We require payment at the time of service for co-pays, co-insurance and self-pay.
- Call the Business Office for questions at 301-320-4383
- We will charge your account $25 for a returned check.
- We will charge your account $25 for no-show appointments.

I have reviewed the above information: _____ Date:_____

Relationship to patient: _____

MELISSA LOUGHNEY, M.D., LLC

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

For Office Use only:
Patient Name: _____
Medical Record #: _____
Date of Admission: _____

By signing this form, you acknowledge that Drs. Kane and Davis Associates', LLC has provided you access to a copy of its Privacy Notice, which explains how your health information will be handled in various situations. By law, we are required to have you sign this form on your first date of service with us.

If your first date of service with us was due to an emergency, we must try to provide you access to this notice and have you sign this form as soon as we can after the emergency

Check all that are true:

[ ] I have reviewed the Privacy Notice for Melissa Loughney, LLC

_____
Patient's Signature

.....

Melissa Loughney, LLC staff should complete is Acknowledgement Form is not signed:

1. Does patient have a copy of the Privacy Notice?

   [ ] Yes [ ]No

2. Please explain why the patient was unable to sign an acknowledgement form and staff efforts in trying to obtain the patient's signature:

Melissa Loughney, M.D., LLC
6400 Goldsboro Rd Ste 330
Bethesda, MD 20817
(301)320-3365: *office*/(301)320-0171: *fax*

NOTICE OF PRIVACY PRACTICES

(Effective Date 09/24/2015)

This notice describes how medical information about you may be used and disclosed and how you may get access to this information. Please review it carefully. If you have any questions about this notice, please contact our Privacy Officer at the address/phone listed above.

Each time you visit Melissa Loughney, M.D., LLC, your medical record is updated to document your symptoms, exam and test results, diagnosis, treatment and recommendations for future treatment. We are required by law to ensure that your medical information is kept private; give you this Notice of Privacy Practices; and follow the terms of the notice that are currently in effect. We may change the terms of our notice, at any time. You may request a revised copy of this notice by asking for it at your next scheduled appointment or contacting our Privacy Officer.

HOW Melissa Loughney, M.D., LLC MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following examples provide different ways that Melissa Loughney, M.D., LLC may use and disclose medical information about you. Your protected health information may be used and disclosed by your physician, Melissa Loughney, M.D., LLC staff, and others outside of Melissa Loughney, M.D., LLC involved in providing health care services to you.

Each category below gives examples as to how Melissa Loughney, M.D., LLC may use and disclose your protected health information.

Treatment. Melissa Loughney, M.D., LLC may use medical information about you to provide, coordinate or manage your medical treatment or services. For example, information obtained by your nurse or physician will be recorded and used to determine the best course of treatment for you. This information may be shared with other healthcare providers involved in your healthcare diagnosis or treatment.

Payment. Melissa Loughney, M.D., LLC may use and disclose medical information about you to receive payment for your healthcare services. For example, we may send a bill to you, an insurance company, or a third party. The information on the bill may include information that identifies you and the health care services you received. We may also communicate with your health insurance carrier to get prior approval for a treatment or to determine if a treatment is covered under your plan. In addition, we may contact you by phone to discuss your account.

Health Care Operations. Melissa Loughney, M.D., LLC may use and disclose medical information about you in order to support the business activities of the practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students and conducting or arranging for other business activities.

In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate which physician you are seeing. We may also call you by name in the waiting room when your physician is ready to see you.

Business Associates: Melissa Loughney, M.D., LLC may use a third party or business associate to perform various functions necessary to the practice (e.g., billing and transcription). Melissa Loughney, M.D., LLC requires that all business associates sign contracts stating they will protect your information.

Appointment Reminders. We may use and disclose medical information when we contact you by phone or mail to remind you of an appointment.

As Required By Law. Melissa Loughney, M.D., LLC will disclose medical information when required to do so by federal, state or local law, in response to a court order, valid subpoena, warrant, summons or similar process.

Military and Veterans. Melissa Loughney, M.D., LLC may release medical information of patients in the armed forces as required by military command authorities.

Workers' Compensation. Melissa Loughney, M.D., LLC may release medical information about you to comply with workers' compensation laws.

Public Health. Melissa Loughney, M.D., LLC may disclose medical information about you for public health reasons. Some common reasons for disclosure are to:

- Prevent or control disease, injury or disability;
- Report births and deaths;
- Report child neglect or abuse;
- Report reactions to medications and/or problems with products (i.e. FDA reporting);
- Notify people of recalls of products they may be using;
- Notify a person who is at risk for exposure to a disease or may be at risk for contracting or spreading a disease or condition; or
- Notify the appropriate government authority if we think a patient has been the victim of neglect, abuse, or domestic violence. We will only make this disclosure if you agree or when we are required or authorized by law.

Law Enforcement. When legal requirements are met, Melissa Loughney, M.D., LLC may release medical information about you if asked to do so by a law enforcement official:

- For legal processes that are required by law;
- Concerning victim(s) of a crime;
- Regarding a death we believe may have occurred as a result of a crime;
- If a crime occur on the premises of Drs. Kane and Davis Associates, PLLC; or
- During a medical emergency when it is likely that a crime has occurred.

Coroners, Medical Examiners and Funeral Directors. Medical information may be released to a coroner or medical examiner for identification purposes or to determine the cause of death. As authorized by law, Melissa Loughney, M.D., LLC may release medical information to funeral directors to permit the funeral director to carry out his or her duties.

Inmates: If you are an inmate of a correctional institution or in the custody of a law enforcement official, Melissa Loughney, M.D., LLC may release medical information about you to the correctional institution or law enforcement official.

SPECIAL SITUATIONS

Emergencies/Communication Barriers: Melissa Loughney, M.D., LLC may disclose your health information in the event of an emergency health situation or if significant communication barriers exist and the physician determines, using professional judgment that you intend to consent to use or disclosure under the circumstances. Your physician will attempt to obtain your consent as soon as possible after the delivery of treatment. If your physician is required by law to treat you, he or she may disclose your health information with or without your consent.

Family and Others Involved in your Care or Payment for your Care: Using our best judgment, Melissa Loughney, M.D., LLC may disclose health information about you to a family member, relative or friend involved in your medical care or the payment of your care.

Organ and Tissue Donation: If you are an organ donor, Melissa Loughney, M.D., LLC may release medical information to organizations engaged in the procurement, banking or transplantation of organs in order to aid in the organ or tissue donation and transplantation.

Research: Melissa Loughney, M.D., LLC may disclose medical information to researchers if an institutional review board has approved the research proposal and protocols are in place to ensure the privacy of your medical information.

YOUR MEDICAL INFORMATION AND YOUR RIGHTS

Your health record is the physical property of your healthcare provider. The information, however, belongs to you. You have the following rights:

Right to Inspect and Copy: You have the right to inspect and obtain a copy of your medical record. This typically includes medical and billing records.

If you would like to inspect your medical information, please submit your written request to our Privacy Officer.

If you would like to request a copy of your medical information, please submit your written request to the practice. You will be charged a fee for the cost of copying, mailing and other costs associated with your request.

Right to Request a Restriction: You have the right to request restrictions on use and disclosure of your medical information. You may request that any or part of your health information be restricted for the purpose of treatment, payment, healthcare operations, or disclosure to family or friends. Melissa Loughney, M.D., LLC is not required to agree to your request. If your physician determines that it is in your best interest to use and disclose this information, your request will be denied. If your physician approves your request, V will not use or disclose your health information unless it is needed to provide emergency treatment or required by law.

To request a restriction, please submit your written request to our Privacy Officer. Your request must include:

- The information you wish to restrict

- If you want to limit Melissa Loughney, M.D., LLC's use, disclosure, or both;
- To whom the limits to apply.

Right to Obtain an Accounting of Disclosures: You have the right to request an accounting of certain disclosures we have made (if any) of your health information, which do not fall under the routine disclosures stipulated for payment, treatment and/or healthcare operations or for which you have not additionally authorized in writing. To request an accounting of such disclosures, please submit your written request to our Privacy Officer. Your request must include a time period of not longer than six years. Please indicate in your request how you would like this information provided to you, for example, on paper, electronically, etc. Melissa Loughney, M.D., LLC will provide you one free accounting per 12 month period. You will be charged for any additional accountings. Melissa Loughney, M.D., LLC will notify you of the cost involved with additional requests. At that time, you may choose to withdraw or modify your request before any costs are incurred.

Right to Confidential Communications from Melissa Loughney, M.D., LLC. Melissa Loughney, M.D., LLC will accommodate reasonable requests for confidential communications. We reserve the right to condition your request based on information you provide regarding your management of payment and our ability to reach you at an alternative address or other method of contact.

To request confidential communications, please send your written request to our Privacy Officer and specify how or where you wish to be contacted.

Right to Have your Physician Amend your Protected Health Information: This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases we may deny your request for an amendment. If we do so, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer to determine if you have questions about amending your medical record.

Right to Obtain a Paper Copy of This Notice Upon request, and at any time, Melissa Loughney, M.D., LLC will provide you with a paper copy of this Notice. To request a paper copy of this notice, please contact our Privacy Officer.

COMPLAINTS

If you believe your privacy rights have been violated, you may contact our Privacy Officer at the address/phone number listed above, without fear of retribution. All complaints must be submitted in writing and will be handled confidentially. The Privacy Officer will contact you within 10 business days of receipt of your complaint.

Should you feel further assistance is warranted, you may contact the Office for Civil Rights/U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Rm 509F HHH Building, Washington, D.C. 20201 or call the Office of Civil Rights (OCR) Hotline at 1-866-627-7748.