



Welcome to Our Practice

Greater Baltimore Medical Center (GBMC) and Greater Baltimore Medical Associates (GBMA) are pleased to welcome you to our practice and let you know that 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 some of the options for improved quality care that are available to you, as well as some of the things that we expect from 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 that you may have about completing 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.

Payment for Services

Co-payments are due at the time of your appointment. If you do not have insurance, we will give you a 30% discount if you pay in full at the time of service. We accept cash, check, VISA, MasterCard, Discover, and American Express. If you are unable to pay at the time of service, please refer to the **Financial Policy** in this package for options available to you.

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, so that we can improve our service.

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. In the event that you present without a referral when one is required, we will ask you to sign a *Voluntary Waiver of Insurance Benefits* if you want to receive services that day. You will be responsible for the bill. 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 liable 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*.



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. 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 and may receive a phone call about unpaid balances. If a balance remains unpaid for more than 90 days, the message on your third statement will say 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. Our fee is \$50. These charges will be your responsibility and will be billed directly to you. If you have missed or canceled 3 appointments in a row, you will not be allowed to schedule another appointment until payment of the missed appointment fees has been received.

Medical Records

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

Forms Completion

We reserve the right to charge a fee for completion of forms (disability, FMLA, MVA, etc.). The fees are as follows: Simple/single page forms: \$10 (each form) -Complex/multi-page forms: \$25 (each form). These fees must be paid in full at the time the forms are submitted at the practice.

All payments or correspondence should be 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 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 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 that you should be aware of:

- 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 able to do that as set forth in 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.

Consent to Photograph

GBMC would like to photograph you for identification purposes while you are under our care. The photographic image will be stored in your electronic medical record. GBMC will not use this photograph for any other purpose.

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 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.



Web Portal Participation

Greater Baltimore Medical Associates is pleased to offer you the chance to communicate with your doctor using **MY GBMC**, our new web portal. **MY GBMC** is a safe and secure way for your physician to communicate with you and for you to communicate with your physician. There is no charge for using **MY GBMC**.

You can use **MY GBMC** to:

- Look at summaries of your medical visits
- Ask a question of your Physician,
- See your recent laboratory test results
- Check on upcoming appointments
- Request prescription refills
- Request renewals of insurance-required referrals

We can use **MY GBMC** to:

- Remind you about your appointments
- Tell you about your lab results
- Answer your questions without playing “telephone tag”
- Let you know when you are overdue for preventive services

How **MY GBMC** works

We will give you a user name and a password to the portal. Once you sign on, you must change the password to something that has meaning for you. Security depends on the secrecy of your password. Choose a good password that isn't easy to guess. Keep it secret, so that only you or someone that you trust knows it.

We will use the e-mail address that you give us to send you an e-mail that a message is waiting for you on **MY GBMC**. No medical information will be in the e-mail that we send you. When you receive it, you will go to the portal to retrieve the secure message that we left for you. It is as easy as that!

It is up to you to make sure that your e-mail is working, and that our e-mail doesn't end up in your “junk mail” folder. If you stop using e-mail or change your e-mail address, you need to call the practice and let us know right away.

When you use **MY GBMC** to send a message to us, someone will answer by the next business day.

Do not use MY GBMC to communicate urgent matters!

If you have a problem that needs immediate attention, or you are not certain whether it can wait, call the office.

IN AN EMERGENCY, ALWAYS DIAL 911 FIRST.

By participating in the Web Portal, you agree to abide by the policies listed above and those that appear on the *Log In* screen.

Patient Consent Form

Please be sure to 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 on page 2. This Consent form is valid for one year from the date noted on the form. We will ask you to sign a new consent form annually.



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



Patient Consent Form

Instructions: Please carefully read the information contained in the *Patient Information* package. Be sure to ask for clarification of anything that you don't understand or may have a concern about. Then please, check the items you consent to and sign and date this form at the bottom.

1. Authorization for Treatment:

- I authorize my GBMC physician to provide medical treatment to the patient named on this consent form.

2. Financial Policy

- I have read and understand the information provided on the GBMC Financial Policy.
- I understand that I am responsible for any deductibles, co-insurance or co-payments associated with my insurance policy and for payment of services not covered by my insurance policy.
- By signing this form, I authorize payment of insurance benefits otherwise payable to me, to be paid directly to GBMC.
- I understand that it is my responsibility to contact my insurance company for pre-certification of medical services as required by my insurer.

3. Notice of Privacy Practices

- I certify that I received the GBMC Notice of Privacy Practices.
- I authorize my GBMC physicians to disclose any health information (including information related to psychiatry, drug abuse, alcoholism or HIV testing) for my treatment, for payment for services and associated care, and in routine health system operations.

4. Authorization for Release of Protected Health Information to a Spokesperson

- I have read and understand the GBMC Spokesperson information.
- I do NOT want my information released to any Spokesperson
- I authorize GBMC to tell the spokesperson(s) named below about my x-ray, laboratory, test findings, diagnosis, prognosis and treatment plans either in person or by telephone.

Spokesperson Information: (please print clearly)

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

5. Consent to Photograph (please select one option)

- I authorize GBMC to photograph, or permit other persons in the employ of this facility to photograph, the person named on this form for identification purposes only.
- I decline to be photographed.

New Patient Consent Signature Form

6. Consent to E-Prescribe (please check all boxes that apply)

- I have read and understand the information detailed under E-Prescribing Consent.
- 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 in the E-Prescribe Program
- I decline to participate with the E-Prescribe Program.

7. Web Portal Participation Agreement for MyGBMC

- I acknowledge that I have read and fully understand the Web Portal Participation information and the policies regarding the patient portal.
- I understand the risks associated with online communications between my physician and me, and I consent to the conditions outlined under Web Portal Participation.
- I agree to follow the instructions, policies and procedures set forth in the log in screen as well as any other instructions that my physician may impose to communicate with me online.
- I understand that it is my responsibility to keep my password secure and email address up- to- date.
- I agree not to use *MyGBMC* for urgent matters.

Signature of Patient or Guardian

Relationship to Patient

Printed Name of Patient or Guardian

Date

Please list any operations or hospitalizations you have had:

Year	Operation	Year	Hospitalizations

When was your last exam?

Eye exam:	Mammogram:	Cholesterol check:
Hearing exam:	Pap smear:	Stool check for blood:
Dental exam:	Bone Density Test:	Colonoscopy:
PSA Test:		

Family Medical History: Please list any serious medical conditions

Mother: _____ Maternal Grandparents _____
 Father _____ Paternal Grandparents _____
 Siblings: _____

Prevention History

Yes No

Yes No

Do you wish to be tested for Aids?			Do you wear sunscreen?		
Do you use drugs?			Do you wear a seatbelt?		
Do you work with harmful substances?			Do you wear a helmet?		
Are you in a relationship where you feel hurt/afraid?			Do you have a living will or advanced directives?		
Do you drink alcohol? How much?			Do you exercise? How much?		
Are you pregnant or lactating?			Do you follow a healthy diet?		
			Do you get adequate calcium?		

Vaccination History

Are you up to date with your childhood immunizations?

- Yes (if yes, please provide)
- No

When was your last:

Tetanus shot?	Hepatitis A ?	Flu shot?
Chickenpox as a child? Yes/ No	Hepatitis B?	PPD or Tuberculosis Test?
Pneumonia shot?		

Patient signature _____ Date _____

Physician signature _____ Date _____