



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.

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.



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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*.

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.



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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

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.



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- 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 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. This Consent form is valid for one (1) year from the date noted on the form.



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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:



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

- I have read and understand the GBMC Spokesperson information.

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: _____

- I do NOT want my information released to any Spokesperson

4. Release of information with third party healthcare partners

- I have read and understand that GBMC may share my contact information with partners to connect me with proper care
- I decline to have my information shared.

5. 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.

Signature of Patient or Guardian

Relationship to Patient

Printed Name of Patient or Guardian

Date