

<b>Patients Name:</b>		<b>Date of Birth:</b>	<b>Sex: F / M</b>	<b>Today's date:</b>
Street		Apartment/Unit		Social Security number
City		State		Zip Code
Home Phone	Cell Phone		Work Phone	
Employer			Your Email Address	
Employer address			Occupation/Job title	

<b>Responsible Party Name:</b>		<b>Date of Birth:</b>	<b>Sex: F / M</b>
Street		Apartment	
City		State	
Best contact number		Relationship	
		Zip Code	

<b>Emergency Contact Name:</b>	
Contact number	Relationship to patient

**INSURANCE INFORMATION**

Primary insurance name	Secondary insurance name
ID/Policy number	ID/Policy number
Group number	Group number

<b>Pharmacy Name:</b>	
Pharmacy address	Phone Number

**-AUTHORIZATION-**

I, \_\_\_\_\_, hereby authorize Rochelle S. Hardy, M.D., to apply or benefits on my behalf for services rendered to me (or my minor child) and request that payment be made and sent directly to Rochelle S. Hardy, M.D.

I understand that this in no way relieves me of my primary responsibility to pay for services rendered to me (or my minor child). I understand and agree that should my insurance deny my claim for any reason, I will pay such balance up demand. If my account is turned over for collection, I agree to pay reasonable collections and/or legal fees incurred as a result the undersigned agrees that should suit be filed, venue (location of suit) shall be Prince George's County, Maryland, venue in any other jurisdiction being waived hereby.

I certify that the information I have reported with regard to my insurance coverage is correct, and I authorize the release of any information relating to my claim for benefits. Furthermore, 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.

\_\_\_\_\_  
 Signature (of patient or responsible party)

**Allergies to medications, X-Rays Dyes, insect stings or other substances?  No  Yes**

If yes, please list allergies and reaction below

(1) \_\_\_\_\_ (3) \_\_\_\_\_

(2) \_\_\_\_\_ (4) \_\_\_\_\_

**Your Medical History**

	N	Y		N	Y		N	Y		N	Y
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	If yes, type _____		Year diagnosed _____						
Other	_____										
Other	_____										

**Current Medications/ dosage and frequency**

(1) \_\_\_\_\_ (5) \_\_\_\_\_

(2) \_\_\_\_\_ (6) \_\_\_\_\_

(3) \_\_\_\_\_ (7) \_\_\_\_\_

(4) \_\_\_\_\_ (8) \_\_\_\_\_

**Surgical history**

Operation & Year

(1) \_\_\_\_\_ (3) \_\_\_\_\_

(2) \_\_\_\_\_ (4) \_\_\_\_\_

**Family history**

Which family members	Which family members
High blood pressure _____	Mental illness _____
Diabetes _____	Thyroid disease _____
Cancer _____	High cholesterol _____
Stroke _____	Other _____
Heart disease _____	Other _____

**Screenings/ Prevention**

When was your last:	N Y
Pap smear _____	Do you feel safe in your home? <input type="checkbox"/> <input type="checkbox"/>
Mammogram _____	Do you wear seatbelts? <input type="checkbox"/> <input type="checkbox"/>
Colonoscopy _____	Do you have a gun in your home? <input type="checkbox"/> <input type="checkbox"/>
For men: PSA _____	Do you have a "living will"? <input type="checkbox"/> <input type="checkbox"/>
Routine blood work _____	Do you have advanced directives? <input type="checkbox"/> <input type="checkbox"/>

**GYN history**

		N Y	
Last normal menstrual period _____	Last pap _____	History of HPV <input type="checkbox"/> <input type="checkbox"/>	Contraception method _____
Number of: Pregnancies _____	Live births _____	Miscarriages _____	Abortions _____ Ectopic _____

**Social history**

Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married (Spouse name _____) <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated
N Y
Are you a current smoker <input type="checkbox"/> <input type="checkbox"/> If yes, how many cigarettes a day _____ and for how many years _____
Are you a former smoker <input type="checkbox"/> <input type="checkbox"/> If yes, what age did you start _____ and what age/year did you quit smoking _____
Are you a coffee drinker <input type="checkbox"/> <input type="checkbox"/> If yes, how many 8 ounce cups of coffee do you consume in a day _____
Are you sexually active <input type="checkbox"/> <input type="checkbox"/> If yes, form of contraception _____
Do you drink alcohol <input type="checkbox"/> <input type="checkbox"/> If yes, how many drinks do you consume in 1 month _____
Do you use any drugs <input type="checkbox"/> <input type="checkbox"/> If yes, what _____
Do you exercise <input type="checkbox"/> <input type="checkbox"/> If yes, how often _____

**Immunizations**

When was your last:
Flu shot _____ Tdap (Tetanus) _____
Pneumonia vaccine _____ Shingles vaccine _____

**Any questions/ concerns for your first visit**

1. _____
2. _____
3. _____

**CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**Use and disclosure of your protected health information:** Your protected health information will be used by only Dr. Hardy or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day to day health care operations of the practice.

**Requesting a restriction on the use or disclosure of your information:** You may request a restriction on the use or disclosure of your protected health information. Dr. Hardy may or may not agree to restrict the use or disclosure of your protected health information. If Dr. Hardy agrees to your request, the restriction will be binding to the practice. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Revocation of consent:** You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

**Notice of privacy practices:** You have received the Notice of Privacy Practices with a complete description of how your protected health information may be used or disclosed.

**Reservation of right to change privacy practices:** Dr. Hardy reserves the right to modify the privacy practices outlined in the notice.

**I HAVE REVIEWED THIS CONSENT FORM AND GIVE MY PERMISSION TO DR. HARDY TO USE AND DISCLOSE MY HEALTH INFORMATION IN ACCORDANCE WITH IT.**

**Name of Patient (Please Print)** \_\_\_\_\_

**Signature of Patient (or legal guardian)** \_\_\_\_\_

**Date** \_\_\_\_\_

**OFFICE GUIDELINES**

- ◆ Our office hours are: Monday, Tuesday and Friday, 8:30a.m.-5:00p.m. (lunch 1-2), Wednesdays 8:30a.m.- 1:00p.m. and Thursday, 8:30a.m.-6:00p.m.(lunch 1-3)
- ◆ This practice employs a university trained, board certified Physician Assistant and she may be involved in the rendering of medical care along with an attending physician.
- ◆ General questions, appointments, prescription refills, lab slips, and referrals will be done during office hours only. There will be a \$3 charge for lost prescriptions and referrals.
- ◆ We **do not** Fax referrals
- ◆ If you need to cancel your appointment, it must be done 24 hours prior to your appointment time or you will be charged a **\$40** fee. Call the office to cancel. Please understand that Dr. Hardy and Mrs. Clark have reserved this time especially for you and another patient will not be able to be seen.
- ◆ Please remember that co-pays are due at the time of service or we will have to reschedule your appointment.
- ◆ Please note that if you have an outstanding balance on your account, 50% of that balance must be paid in order to be seen, unless it is determined that you have a medical emergency.
- ◆ As a service to you, we can fill out forms (disability documents, school forms, FMLA) for a fee of **\$30** due at the time forms are received. Please allow a minimum of 3 business days for completion of the forms.
- ◆ A copy of your medical records can be provided to another doctor at no charge. A copy of your medical records can be provided to you with a **minimum** fee of **\$30**, depending on the size of your chart.
- ◆ We accept personal checks and credit card payments. There is a **\$35** returned check fee.
- ◆ I give my permission for Dr. Hardy to be notified by any Maryland hospital of either my hospital admission/discharge or ER visits  Yes  No

***I have read and understand the policies of the practice and I agree to be bound by the terms. I also understand and agree that such terms may be amended from time to time by the practice.***

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**Signature of Patient (Parent) or  
Print name of Patient (Minor)**

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**Print name of Policy holder**

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**Date**