Montgomery

PATIENT REGISTRATION FORM (PLEASE PRINT)
ALL FIELDS MUST BE COMPLETED

PATIENT'S LAST _____ FIRST _____ MIDDLE _____
DATE OF BIRTH ____/____/____ AGE: _____ SEX: M F SOCIAL SECURITY # _____
STREET ADDRESS _____ APT # _____
CITY _____ STATE _____ ZIP _____
HOME PHONE _____ CELL PHONE _____ EMAIL _____
EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP _____
PRIMARY PHYSICIAN _____ SPECIALTY _____
ADDRESS _____ PHONE _____
REFERRING PHYSICIAN _____ SPECIALTY _____
ADDRESS _____ PHONE _____
HOW DID YOU HEAR ABOUT US? _____
PHARMACY _____ ADDRESS _____ PHONE _____

COMPLETE THIS SECTION IF PATIENT IS A MINOR

NAME OF LEGAL GUARDIAN _____ RELATIONSHIP _____ SS# _____
HOME PHONE _____ CELL PHONE _____ EMAIL _____

GUARDIANSHIP FOR MINOR

I, the undersigned, on my behalf or that of a minor under my guardianship _____ (patient/minor name), hereby agree to be financially responsible for the cost of the services that the minor is about to receive. I also understand that of the service(s) are not paid in full at the time of service, I hereby authorize Eran Kessous, MD, PC or their agent to invoice me for any outstanding balances. Executed this ___ day of ___, 20___. Further, I understand that if the physician(s) do not participate with my insurance plan, I am legally and financially responsible for payment of services rendered.

Signature of Guardian _____ **Guardian Name** _____ **Date** _____

INSURANCE INFORMATION (PLEASE PRINT)

PRIMARY INSURANCE CO _____ GROUP # _____ ID # _____
INS CO ADDRESS _____ PHONE # _____
REALTIONSHIP TO INSURED: SELF / HUSBAND / WIFE / CHILD / OTHER: _____

SECONDARY INSURANCE CO _____ GROUP # _____ ID # _____
INS CO ADDRESS _____ PHONE # _____

POLICY HOLDER: ☐ PATIENT ☐ GUARDIAN

POLICY HOLDERS INFROMATION

POLICY HOLDER'S LAST _____ FIRST _____ MIDDLE _____
DATE OF BIRTH ____/____/____ SEX: M F SOCIAL SECURITY # _____
EMPLOYER _____ OCCUPATION _____ WORK PHONE # _____
HOME ADDRESS _____ PHONE _____

PLEASE CHECK IF OFFICE VISIT IS FOR THE FOLLOWING: ☐ MOTOR VEHICLE ACCIDENT ☐ WORKERS COMP ☐ NOT APPLICABLE
IF NOT APPLICABLE WAS SELECTED, PLEASE SIGN BELOW

SIGNATURE OF PATIENT OR PARENT/GUARDIAN : _____

By signing, you are confirming this appointment is unrelated to an injury sustained at your place of employment (which would deem it a Workers Comp Injury) or in a Motor Vehicle Accident. Failure to disclose this information would result in the patient ultimately being responsible for all medical visits and associated charges and by signing you are agreeing to this policy.

Montgomery

Appointment Cancellation Policy

Dear Patient,

In order to give you the best possible care, time has been specifically reserved for your physician appointment. In the event you are unable to keep your scheduled time, we ask that you give us a courtesy cancellation notice of 24 hours or more.

If you fail to show up for a scheduled appointment or do not notify the office of a cancellation at least 24 hours in advance, we reserve the right to charge your account the amount of $55.00.

Thank you for your understanding and cooperation.

_____

Print patient name

_____

Signature of patient or Guardian

11120 New Hampshire Ave., Suite 411◦ Silver Spring MD 20904
Office (301)754-0505 ◦ Fax (301)754-0509

Montgomery

PAYMENT RESPONSIBILITY (PLEASE READ CAREFULLY)

I understand that I have a personal and primary obligation to pay for all medical services when rendered and I agree to pay all bills promptly. I further understand that although Montgomery Sports Medicine Center may submit a bill to my insurance company for payments as a service to me, that service does not relieve me of my personal responsibility to ensure that the insurance company makes payment according to the terms of my policy. I am aware that insurance payment/reimbursement may not cover the total balance due for the medical services I received. I agree to pay any outstanding balance on my account, if such action is deemed necessary. In addition, I agree to pay interest **(at 1½ percent per month) on my outstanding account balance if this balance extends beyond thirty (30) days of receipt of my bill**. I agree to pay any additional fees and/or costs incurred in order to collect payments on account(s). I waive my rights under Maryland statute of limitation should reconciliation of my account extend beyond three (3) years from date of service.

Please be advised that some insurance carriers have limited or no benefits for durable medical equipment (slings, braces, prosthetics, etc.) Also custom-made braces are only partially covered by some insurance carriers. We will try our best to confirm your benefits at the time of service but be aware that you may have a co-insurance and or deductible that will remain your responsibility. Thank you for your cooperation.

_____**(Please initial)**

I request that direct payment of authorized medical benefits (including Medicare, Medigap, major medical benefits) be made to Eran Kessous, MD PC for any services furnished to me by these physicians. I authorize any holder of medical information about me to release this information to my insurance carrier (or intermediaries), to the Health Care Financing administration and its agents, to my attorney, or to another physician's office. Also, I permit a copy of this authorization to be used in place of the original copy. This assignment will remain in effect until I revoke, in writing, this authorization. I understand that because these services were performed for me or for my legal dependent, I am financially responsible for all charges whether or not paid by the insurance carrier.

Patient/Responsible Party Signature:_____**Date:** _____

11120 New Hampshire Ave., Suite 411 ● Silver Spring MD 20904
Office (301) 754-0505 ● Fax (301)754-0509

Montgomery SPORTS MEDICINE CENTER

PATIENT NAME:_____

ASSIGNMENT OF BENEFITS

I authorize payment directly to Montgomery Sports Medicine Center.

This is a direct assignment of my rights and benefits under the Payment Responsibility.

A photocopy of this assignment shall be considered as effective and valid as the original.

RELEASE OF INFORMATION

All information provided herein is true and correct.

I hereby consent to treatment.

I give permission for Montgomery Sports Medicine Center to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment.

I authorize Montgomery Sports Medicine Center to obtain medical records and/or professional information from my physician and other medical professionals as it relates to my treatment.

Information without patient identifiers may be used for quality assurance purposes.

NOTICE OF PRIVACY PRACTICES (HIPAA Acknowledgement / Consent)

I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations.

I have read the above and understand the information provided. I authorize treatment and the release of information as explained. I approve of the Assignment of Benefits, acknowledge I have received the HIPPA Notice of Privacy Practices and guarantee payment.

Patient or Guardian Signature: _____ **Date:**_____

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Office (301)754-0505 ◦ Fax (301)754-0509

Montgomery Sports Medicine Center

PERSONAL REPRESENTATIVE, FAMILY, FRIENDS OR OTHER ENTITIES AUTHORIZED PERMISSION TO PROTECTED HEALTH INFORMATION TO BE USED AND/OR DISCLOSED

Name of specific persons and/or entities that you are authorizing to use and disclose of your protected healthcare information pertaining to treatment payments, billing or other applications of healthcare.

Name of Authorized Person or Entity	Relationship	Phone Number
Name of Authorized Person or Entity	Relationship	Phone Number

Montgomery Sports Medicine Center physicians and staff often contact patients during normal business hours but are unable to reach them. Due to federally mandated HIPAA Privacy Rule, we must obtain your authorization in order to pursue this mode of communication. Protected Healthcare Information that may be possibly disclosed on your home, work or cell phone would include, but is not limited to: test/lab results, prescription/pharmacy information and appointment instructions.

____ (Initial) Yes, I agree to allow MSMC physicians and staff to leave messages that include Protected Healthcare information on the following communication devices:

home number_____ cell number_____ work number_____

____ (Initial) No, I DO NOT agree to allow MSMC physicians and staff to leave protected healthcare information on any communication devices.

_____

Patient's/Guardian's Signature **Date**

MSMC STAFF ONLY
UNABLE TO OBTAIN HIPPA POLICY ACKNOWLEDGEMENT

I attempted to obtain a signed Notice of Acknowledgement from the patient/guardian, but was unable for the following reason:

_____

_____

_____

MSMC Employee Signature **Date**