6305 IVY LANE, SUITE 260. GREENBELT, MD 20770
P: 301-552-3500 F: 866-207-0983

PATIENT INFORMATION							
Last Name:		First Name:			MI:	Preferred Name:	
Date of Birth:	Age:	**Birth Sex:**	M ☐	F ☐	Unk. ☐	SSN:	
Address:		City:			State:	Zip Code:	
Home Number:		Cell Number:				**Preferred Number:** **Cell** ☐ **Home** ☐	
Marital Status:	Single ☐	Married ☐	Divorced ☐	Widowed ☐	Widowed ☐	Life Partner ☐	Legally Separated ☐	Other:
Race:		Ethnicity:				Preferred Language:	
Email:		Employer:				Occupation:	

S.O./G.I.

Sexual Orientation:	Lesbian or Gay ☐	Straight or Heterosexual ☐	Bisexual ☐	Queer, Pansexual, and/or questioning ☐	Something else ☐	Don't know ☐	Decline to answer ☐
Gender Identity:	M ☐	F ☐	Transgender man/trans man ☐	Transgender woman/trans woman ☐	Genderqueer/gender nonconforming neither exclusively male nor female ☐	Additional gender category (or other) ☐	Decline to answer ☐
Pronouns:	He/him	She/her	They/them	Other			

Primary Insurance Information

Insurance Name:	Policy #:	Group #:
Name of Policy Holder:	DOB:	Relationship to patient:

Secondary Insurance Information **(Only if Applicable)**

Insurance Name:	Policy #:	Group #:
Name of Policy Holder:	DOB:	Relationship to patient:

The information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize DAJA HEALTH, LLC or insurance company to release any information required to process my claim.

Patient's Signature: ______________________________________ Today's Date: _________________________

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IN CASE OF EMERGENCY	
Name of friend or relative:	
Relationship to patient:	
Home Number:	Cell Number:

I, ___________________________________ authorize the release of my private health information to
Patient's Name

____ ____
Authorized Person's Name Relationship to the patient

I understand this information may include test results, referral information, scheduling, cancelation or confirming appointments, as well as any other medical information pertinent to my care.

I acknowledge that this authorization is valid throughout my relationship with DAJA HEALTH, LLC. I understand that I may revoke this agreement at any time by submitting a request in writing.

OR

I, _____________________________________ do not want my private health information released to
Patient's Name
anyone currently. Should I choose to designate someone later, I will submit a new request in writing.

SIGN BELOW

Patient's Signature: __________________________________ Today's Date: _____________________________

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OFFICE POLICIES

BILLING

Patients must pay co-pay before each visit. Any returned checks will be subject to a $65.00 charge. After three bills, the account will go to collections. We are happy to make payment arrangements with you.

Our goal is to provide you with the best medical care possible. Annual physical exams give us a chance to address your overall physical and emotional health. The **preventative** care we provide during a physical also includes *an assessment of dietary and exercise habits, review of vaccinations, discussion of screening tests, lifestyle behaviors, etc.* We often look in on chronic stable problems such as high blood pressure, arthritis, and/or other ongoing controlled medical conditions.

Regular office visits differ from the **preventative** and wellness care provided at a physical because they focus on *other new ongoing or poorly controlled medical concerns.* These types of problems need to be addressed in an appointment separate from a **preventative** or physical exam. If, however, we adequately cover required preventative and wellness care during the physical, sometimes we will have time to discuss new problems identified by you or the provider.

We would like to correct a misperception that is occurring regarding "double charges". Please note that the insurance companies do allow providers to address additional complaints beyond a physical examination. If new problems are found or poorly controlled problems are addressed, an additional office evaluation code will be generated *in addition* to a preventative physical examination code. Essentially, part of the visit is preventative, but part of the visit is not part of a wellness exam.

Therefore, this generates another charge to the insurance company which in turn may require you to pay your copayment, coinsurance or deductible charge.

Refund Policy:
It is the policy of DAJA HEALTH, LLC that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their copay, deductible and or coinsurance payment at the beginning of each visit. At the conclusion of your visit, you may be billed for any outstanding balance. If there is a valid credit applied to your account and your account has been reviewed and approved a refund will be provided by mail in the form of a check.

If you have any further questions regarding your payments/refund for any date of service, please contact the billing department.

Initials _____

APPOINTMENTS

Once an appointment has been made, please respect the time that has been reserved in our office schedule for you. **There will be a $50.00 charge for missed appointments and appointments not cancelled within 24 hours.** We make every attempt to give our patient a courtesy call reminding you of your appointment time, but it is your responsibility to make sure you have this information, so you do not miss your appointment. Just as a friendly reminder, if you are running late to your appointment, we do allow for a 15-minute grace period.

Initials_____

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REFERRALS

Your insurance company, not this office, establishes referral policies. **Please note that referrals require up to 72 hours to process.** When requesting a referral, please include your name, date of birth, insurance company name, insurance ID number, specialist name, specialty, and reason for visit. We will notify you when your referral is ready for pick up or we can send it to you via USPS Mail. We will automatically send it via facsimile or electronically to your specialist. Same day referrals are limited to medical emergencies. **WE DO NOT BACK DATE REFERRALS**, per your insurance and our office policies. If you are unsure whether your insurance plan requires referrals, please ask the front desk or you may call your insurance company.

Initials _____

LAB SERVICES

Our preferred laboratory is **LabCorp.** We are able to draw and collect specimens for all insurance plans, which you may be subject to a copayment and or a deductible if you use our preferred laboratory. Please be aware that you are fully responsible for any and all charges associated with our lab services.

Initials _____

PRESCRIPTION REFILLS

Please be aware that it is your responsibility to have an adequate supply of your routinely prescribed medication on hand to last you until your next office visit. For example, blood pressure, cholesterol and diabetes medication. You will be instructed as to when you are required to schedule your next follow-up appointment. If you are running out of medication, please inform our office within an adequate amount of time. We will not prescribe pain medication or antibiotics without having an appointment with one of our providers. You are required to have a follow up appointment every 3 months for refills on your controlled substance medications. Some examples would be medication for anxiety, sleep aid, ADHD or depression.

Initials _____

LAB RESULTS

We do not mail results of any kind. We have a patient portal through our website for patients to review their lab results. This will allow patients to access a portion of their medical record securely online. For abnormal results, we will make every effort to promptly contact you. Please be sure the office has your correct telephone number.

If you are contacted due to an abnormal result, you may be asked to schedule a follow up appointment with your provider. We understand that some patients may not have access to the web or may still want an actual copy of their results. In those instances, be sure to notify the office so we can leave a copy of your results at the front desk for pick up.

If you do not hear from us within 15 business days after completing the test, be sure to contact the office to obtain the results.

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PRIOR AUTHORIZATION

Your insurance company, not this office, sets medication formularies. We make every effort to adhere to these formularies, which frequently change. If the medication prescribed is not covered by your insurance, our preference is to change to an alternative medication on your formulary-preferred list. As a second option, we will work on completing a prior authorization on your behalf. Please be aware that this process may take 3 to 5 business days to complete. This may vary based upon your insurance plan and or the medication prescribed.

Initials _____

PATIENT FORMS

There will be a $35.00 fee for all forms that are dropped off during unscheduled appointments. In order to be exempt from this charge you will need to schedule an appointment with a provider. If your forms are not available at the time of service, you have 7 days to drop them off to avoid the fee. After 7 days the $35.00 form fee will apply.

Initials _____

MEDICAL RECORDS

To obtain medical records from our office, please send a signed HIPAA compliant medical record release form. Please be sure to complete the form in its entirety. A fee may apply to this request. Payment is required prior to releasing the medical records. If you have any additional questions, please contact the medical record department.

Initials _____

ADVANCED MEDICAL DIRECTIVES

Advanced Medical Directives are available in the office, please ask a staff member or your provider if you would like to obtain one. Once completed, please provide us with a copy so we can incorporate it into your medical record.

Initials _____

By signing below, I certify that I have read and completely understand the office policies of DAJA HEALTH, LLC

Patient Signature ____________________________ Today's Date ______________________

Print Name _________________________________

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Consent to Obtain External Prescription History Medical Records through Health Information Exchange

I, ____, whose signature appears below, authorize DAJA HEALTH, LLC and its providers to view my external prescription history via OPTIMANTRA EHR system. I understand that this includes but is not limited to prescription history from other unaffiliated medical providers, insurance companies, and or pharmacy benefit managers may be viewable by provider and staff at DAJA HEALTH, LLC. This also may include prescriptions dating back several years.

In addition, I authorize DAJA HEALTH, LLC and its providers to securely access my medical records electronically through the Health Information Exchange (HIE). This includes but is not limited to lab and procedure results, current medications, allergies and immunizations.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTOOD THE CONSENT TO OBTAIN EXTERNAL PRESCIPRTION HISTORY AND MEDICAL RECORDS THROUGH HIE

Patient's Signature ____________________________ Today's Date ________________________

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Health

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

DAJA HEALTH, LLC. is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our organization and outlines your rights regarding your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of DAJA HEALTH, LLC.

Today's Date: ____________________

Print Name: ____

Patient's Signature: ____

Name of Personal Representative (if appropriate): ____

Signature of Personal Representative (if appropriate): _______________________________________