Thank you for choosing CareFirst 360. Attached is the new patient paperwork that needs to be completed prior to your appointment.

Please bring the following with you on your appointment:

- Ø **New Patient Paperwork**
- Ø **Picture ID**
- Ø **Insurance Card(s)**
- Ø All **Medications, including any over the counter medications**

If you were unable to complete the paperwork packet, please arrive at least 15 minutes prior to appointment time, so that this can be completed.

Thank you in advance!

CareFirst 360

Phone: 682-400-8639
Fax: 682-400-8719
Email: carefirst360@gmail.com

PATIENT REGISTRATION

Patient Information: (*Please use legal* name*, no nickname)*

Last Name: ____________________First Name: __________________ Middle Initial: ____

Address: ____

City: __________________________________ State: __________ Zip Code: ___________

Cell Phone: ______________Home Phone: _______________Work Phone: _____________

Social Security Number: _____________________Drivers Lisc: _______________________

Date of Birth: _______________Age: _____Sex:__________Marital Status: ____________

Employer Name & Address: ____

____

Emergency Contact Name: ____________________Phone number: ____________________

Primary Care Physician: ______________________ Phone number: ____________________

Pharmacy: ________________________________ Phone Number: ____________________

GUARANTOR INFORMATION: *(If different from patient)*

Last Name: _____________________First Name: ________________Middle Initial: ________

Date of Birth: ___________Social Security #: _________________Relationship: ___________

Employer Name: ______________________________________Phone #: _________________

INSURANCE INFORMATION: *(OR COPY OF INSURANCE CARD(S))*

Primary: ___________________________________Address: ____________________________

Phone #: ________________________ID#: ______________________Group #_____________

Subscriber: ____________________________Relationship: _____________________________

***NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES** *(on website for review*

Patient Name____ **DOB:**________________

Allergies to medications, foods, x-ray dye:

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

Pharmacy: ____ **Phone#:**____________________________

MEDICATIONS/OVER THE COUNTER MEDICATIONS/SUPPLEMENTS/HERBS*: (Bring all to your appointment)*

Medication	Dosage	Frequency

Patient Name:____ DOB: _______________

PAST MEDICAL HISTORY

Please check if you have a personal history of any of the following:

Kidney Disease	____Chronic Kidney Disease (CKD) Stage: 1 2 3 4 5 ____Transplant ____Cadaveric ____Living Related ____Living-Unrelated	____Dialysis ____Hemodialysis ____Peritoneal Dialysis ____Polycystic Kidney Disease ____Acute Kidney Disease ____Glomerulonephritis
Diabetes	____Type 1 Type 2______	____Type Unknown
Hypertension (High Blood Pressure)	____Essential	____Other
Cancer	____Kidney ____Bladder ____Breast ____Prostate	____Colon ____Leukemia ____Pancreatic ____Other
Cardiac	____Atrial Fib ____Pacemaker	____CHF (Congestive Heart Failure)
Respiratory	____COPD ____Asthma	____Pneumonia ____Tuberculosis
Ears, Nose, Throat Gastrointestinal	____Emphysema ____Bronchitis ____Blindness ____Cataracts ____Gastric Reflux (GERD)	____Sleep Apnea ____Hearing problems ____Irritable Bowel Syndrome
Neurological	____Gallbladder disease ____Blood in stools ____Multiple Sclerosis ____Seizures ____Numbness ____Weakness	____Gluten Intolerance ____Lactose intolerance ____Parkinson's ____Dementia ____Alzheimer's ____Fainting
Genitourinary	____Frequent urinary tract infections	____Enlarged Prostate
Musculoskeletal	____Blood in urine ____Kidney Stones ____Joint pain ____Back problems	____Incontinence ____Painful urination ____Arthritis ____Osteoporosis
Other Conditions		

Patient Name: ____ **DOB:**____________________

PAST MEDICAL SURGICAL HISTORY

Please check if you have had any of the following surgeries:

____Appendectomy	____Carotid surgery	____Hip replacement --____Right ____Left		
____CABG	____Gastric Bypass	____Knee replacement-____Right ____Left		
____Hysterectomy	____Bariatric procedure	____Kidney Transplant		
____Prostatectomy	____Hernia repair	____Thyroidectomy	____AV Fistula	____PD catheter
____Nephrectomy	____Hemorrhoidectomy	____Tonsillectomy	____AV Graft	

List any other surgeries or any other health problems not listed above:

RELEASE OF MEDICAL RECORDS

Patient name ________________________________ DOB ________________________
I Request and Authorize ________________________ to release the medical records of above-named patient to

Name of recipient:____
Address: ____
City and State: _______________________________________ Zip Code:_________________
Telephone number: __________________ Fax number: _________________________________

Reason for Release: ____

This request and authorization apply to: (check appropriate line)

_____Healthcare information relating to the following treatment, condition, or dates of treatment:
- Please send Face sheet, H&P, Consultation notes, Discharge Summary, Laboratory results, and Radiology reports.

_____All healthcare information including information relating to HIV/AIDS testing, sexually transmitted disease, psychiatric disorders/mental health, or drug and/or alcohol use.

_____ All healthcare information excluding information relating to HIV/AIDS testing, sexually transmitted disease, psychiatric disorders/mental health, or drug and/or alcohol use.

____
Signature of patient or authorized representative Date
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative)

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, CareFirst 360 originates records and maintains health information about me describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this health information may be used or disclosed by CAREFIRST 360 for treatment, payment, and health care operations. For example, my health information serves as:

- A basis for planning my care and treatment;
- A means of communication among other health professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payor can verify that services billed were actually provided;

I acknowledge that I have been provided with CAREFIRST 360 Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that CAREFIRST 360 reserves the right to change its Notice of Privacy Practices at any time and that I will be provided a copy of the revised Notice of Privacy Practices.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations, and that CAREFIRST 360 is not required to agree to the restrictions requested but if it does, it is bound by such restrictions.

I understand that I may revoke this consent in writing, except to the extent that CAREFIRST 360 has already taken action in reliance thereon.

By signing this form, I consent to CAREFIRST 360 use and disclosure of my health information for treatment, payment, and health care operations.

☐ I request the following restrictions to the use or disclosure of my health information:

____

____

____

☐ Restrictions Accepted ☐ Restrictions Denied

Print Patient Name ____

Signature of Patient/Patient Representative ________________________________Date _____________

CONSENT FOR MEDICAL CARE AND TREATMENT

CONSENT FOR ALTERNATE COMMUNICATION

I understand that I may have a medical condition that could require examination, diagnosis and treatment and other medical services which may include x-rays, laboratory procedures, tests and medications. I do hereby voluntarily consent to such examination, diagnosis, treatment, and other medical services, and procedures that may be recommended under the general and specific instructions of the physicians of CareFirst 360 (CAREFIRST 360), their assistants, nurses, or designees. I acknowledge that the practice of medicine is not an exact science and that the physicians of CAREFIRST 360 have made no guarantees to me as to the result of examination, diagnosis, treatment, or other medical services.

CAREFIRST 360 recognizes the importance and significance of maintaining confidentiality of information regarding a patient's medical condition. We also want to provide our patients timely communication as to laboratory/diagnostic test results from either CAREFIRST 360 in house laboratory or any other laboratory and other patient medical information. We understand that because of the patient's schedules and our office schedules, personal communication may sometimes be difficult. CAREFIRST 360 policy is not to leave messages regarding sensitive medical information with unauthorized third parties. However, acknowledging that it may be difficult for the physician/physician's staff to personally communicate with the patient regarding laboratory/diagnostic test results, or patient medical information, it is the policy of CAREFIRST 360 to leave such information on the patient's telephone answering machine unless you indicate that you do not consent to leaving such messages on your answering machine.

○ I consent ○ I do not consent

If the physician/physician's staff cannot reach the patient at the home, cell, or business telephone, it is the policy of CAREFIRST 360 that a message will be left with the person that answers the telephone to advise the patient to return the phone call unless you indicate you do not consent.

○ I consent ○ I do not consent

It is the policy of CAREFIRST 360 not to release confidential medical information to patient's family members unless the patient consents to the release. We will not discuss your medical condition, or release diagnostic test results to anyone without your consent. Information regarding my medical condition, including laboratory and diagnostic test results, can be given to the following designated persons

____. (Names of Designated Person)

○ I consent ○ I do not consent

It is the policy of CAREFIRST 360 to participate in or support clinical research designed to use patient data to improve diagnosis and treatment of medical illnesses and to identify potential study subjects for clinical research; such research support may include the review or disclosure of a patient's medical records to research staff unless you indicate you do not consent.

○ I consent ○ I do not consent

It is the policy of CAREFIRST 360 to send appointment reminders to our patients, either by telephone, e-mail, or reminder cards unless you indicate you do not consent.

○ I consent ○ I do not consent

Page 2: Consent for Medical Care and Treatment

At some of its medical offices, CAREFIRST 360 collaborates with nursing and medical school teaching programs enabling students as well as physicians in residency and fellowship programs to observe patient care, and if permitted by a physician based upon their level of training and experience to assist the office medical personnel in the delivery of medical services under the supervision and direction of a CAREFIRST 360 physician unless you indicate you do not consent.

○ I consent ○ I do not consent

CAREFIRST 360 physicians allow future students and those involved in current teaching programs to accompany them at some of its medical offices and on hospital and dialysis rounding with patient consent and appropriate permission from those facilities.

○ I consent ○ I do not consent

All of the foregoing consents are continuing in nature during the entire course of my care unless specifically revoked by me.

Print Name of Patient________________________________ Date__________________________

Signature of Patient __________________________________ Date _________________________

If you have a Personal Representative /Guardian who has been given authority to act on your behalf, please provide us with that name and contact information.

_____________________________ ________________

Personal Representative/Guardian Telephone Number

_____________________________ ________________

Witness Date

(Any individual consent or this entire consent can be revoked at any time upon receipt of your written request.)

CAREFIRST 360

PATIENT INFORMED CONSENT FOR TELEMEDICINE SERVICES

CareFirst 360 has implemented an electronic health record (EHR) in part to meet the U.S. Department Health and Human Services initiative to improve health information technology, toward the goal of improving quality of health care. Our EHR integrates your clinical record with appointments, registration, and billing and makes this information available to the clinicians who are involved in your health care.

In connection with its electronic communication systems, CAREFIRST 360 has also implemented and has in place privacy and security policies and procedures to minimize risk of inadvertent or unauthorized disclosure, corruption and/or loss or distortion of data, but as with all record keeping systems, whether paper or digital, some risks remain of loss, inadvertent disclosure, or errors in the recorded data.

I have read and understand the information provided regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine including electronic transfer of medical data to other medical practitioners participating in my medical care.

I hereby authorize CAREFIRST 360 to use telemedicine in the course of my diagnosis and treatment and consent to the electronic communication of my personal health care information to other entities for treatment, payment or health care operations.

INFORMED CONSENT FOR PRESCRIPTIONS

CAREFIRST 360 continues its position as the network exchange for the flow of vital patient information to physicians and other health care providers. It is essential to improve patient safety and the continuity of care with electronic connectivity between payers, physicians and pharmacists. CAREFIRST 360 electronic health record (EHR) provides secure access for patients with prescription coverage in the United States.

Prescription eligibility, benefit, formulary and medication history information is provided for consenting patients to authorized physicians at the point of care. Electronic prescriptions are delivered in real-time to pharmacists in the retail and mail order settings.

I consent to electronic prescriptions and acknowledge that CAREFIRST 360 will use electronic connectivity between payers, physicians, and pharmacists.

PATIENT PORTAL CONSENT

CAREFIRST 360 is offering the patient portal as a convenience to you. The patient portal is a secure web portal that allows you, as a patient, to view your medical chart and to access our online bill pay via the internet. It also allows you to communicate with our office via secure messaging. You may request appointments, schedule changes, and medication refills (not including controlled substances).

CAREFIRST 360 reserves the right to suspend or terminate the patient portal at any time and for any reason.
I understand that the patient portal will be offered at no charge and acknowledge that communications over the internet using the portal is secure. I
also, agree to the policy defined herein for suspension or termination of portal access.

Signature of Patient/Legal Representative____Date_____________

Witness ____Date_____________