Westview Primary Care
5100 Buckeystown Pike Suite 186
Frederick, MD 21704
Ph: 301-682-8888 Fx: 301-682-3515

Dear Patient,

We are happy to welcome you to our medical practice and want you to know that we appreciate the opportunity to take care of you and your family. Our office is focused on delivering world class patient care.

Enclosed, you will find new patient registration forms as well as new patient medical history forms. Please complete the forms and return them to the office at your first appointment.

Please arrive 20 minutes prior to your appointment and bring the following items with you:

- Your insurance card(s).
- Driver's license or other picture ID.
- Completed forms (attached).
- Medical records from previous or current medical providers and/or specialists. Medical records must be received in our clinic within 2 months of initial intake visit.
- Your medicines in original pill bottles.

***********HELPFUL TIPS FROM OUR OFFICE***********

RUNNING LATE? We understand that circumstances can sometimes prevent you from arriving on time. If this happens, we will try our very best to accommodate you within the schedule. If we are unable to see you or you cannot wait, we will be happy to reschedule your appointment.

CANCELLATION. If you need to cancel or reschedule an appointment, please call our office at least 24 hours before your appointment. Missed appointments represent a cost to us, and to other patients who could have been seen in the time set aside for you. We reserve the right to charge for missed or late-canceled appointments. Excessive missed scheduled appointments may result in discharge from the practice.

PAYMENT. If you have any questions about your insurance, or about payment of your deductible or copay please call our office. Benefits will be checked at each office visit.

PERSCRIPTION REFILLS. If you need to refill your medication that we have prescribed, call your pharmacy. They will contact us for you to obtain the refill authorization. Please allow us 72 hours to respond to your refill request, therefore please do not wait until you are out of your medication to request the refill. Based on your medical condition, your medical provider may request to see you in the office calling in your refill.

If you have any questions prior to your appointment, please call our office at 301-682-8888 between 8am and 9pm Monday-Friday, and weekends 9am-6pm.

Thank you for choosing our office. We are looking forward to meeting you.

Sincerely,

Westview Primary Care

5100 Buckeystown Pike, #186
Frederick, MD 21704
Phone: (301) 682-8888
Fax: (301) 682-3515

Westview Primary Care is excited to announce the arrival of their new patient portal.

What does that mean?

Test results available in real time (Lab results will no longer be routinely mailed)	**It's there to assist you in managing your care**
Quicker communication with your primary care provider by sending and receiving messages in a secure environment	**Ability to view parts of your medical chart in a secure environment**
Request Appointments	**Check your appointment dates and times**
Please report any discrepancies in your medical history, medication list, and allergies	

Our medical providers would like all patients to have this capability. All communications are encrypted and HIPAA compliant.
Your User Name: First letter of your first name and your entire last name. The first two are caps. (ie. JDoe)
We used *Password! and last 4 digits of your Social Security number* as your first password. This meets the criteria for a password, but you can't use it. You must come up with something new, and will be prompted to do so.
You will be prompted to change your password on your first entrance into the website. You will receive information on how to do this once your account is set up.

Visit our web page at https://webview.mckesson.com/wucp/

What we need from you:

Question you will need to answer:

Print Your Name: ____

Your Email address: ______________________________________

Security Question: ____________________________________

Security Answer: ____

Last four of your Social Security Number: ___________________

I do not have a computer or email ☐ **Please check if applies**

Please wait 24 hours for the staff to set this up for you. Thank you.

Important Notice to Patients Regarding Annual Physicals

The physicians at Westview Primary Care are committed to helping you stay healthy. Please review the following information on preventative health services, such as physicals, and well-visits and acknowledge that you have read and understand this policy.

If you have a complex medical history, your primary care provider may need to schedule another visit to address those issues. Management of complex medical problems beyond the scope of the Annual Wellness Visit may cause your insurance company to charge you, the patient, a copay/co-insurance/deductible for that service depending on your benefits. Patients with Maryland Medical Assistance will not be charged an additional amount.

What is the purpose of a routine preventative exam?

The purpose of a routine preventative exam is to identify potential health concerns in their earliest stages when they may be less costly and difficult to treat.

What is the definition of a routine preventative exam?

A routine preventive exam is technically defined as a periodic comprehensive preventative medicine evaluation and management, and includes the following:

• Past medical, social, and family history	• Immunization (flu, pneumonia vaccine)
• Complete physical exam and review of body systems	• Counseling/anticipatory guidance/risk reduction
• Review of medications	• Review of age/gender appropriate screening tests

How does this affect my visit and bill?

This exam is prevention focused, not problem focused. Please note that an Annual Physical and/or Wellness Visit should be scheduled separately from other visits that are intended to discuss treatment of acute problems, management of chronic conditions, or to request prescription refills. If you have scheduled a routine preventative exam but your provider believes that the majority of the time was spent with medical concerns, the provider may bill your insurance an additional charge for the treatment of your current and/or existing problems in addition to the preventative exam. It's important to note that your healthcare provider has the right to code and bill based on the services of your visit.

Will my provider address only what my health plan covers for a routine preventative exam?

Your provider does not know your health benefits and sees many patients with various insurance plans throughout the day. You are responsible for knowing what services are covered under your health plan. Review your summary of benefits or call customer service prior to your preventative exam.

*****PATIENT ACKNOWLEDGEMENT*****

I have read and understand Westview Primary Care's policy on routine preventative exams. I understand that a preventative exam is not intended to discuss acute problems, chronic conditions, or to request medication refills. I understand that if I must address non-preventative medical problems with my physician, I will be billed for the services rendered.

Patient Signature:	**Date:**

Financial Policy

We hope to make your visits in our office as thorough and pleasant as possible. We also want you to have a full understanding of our financial policies and expectations for payment for services. Please carefully review and sign our financial policy, and let us know of any questions you may have.

The primary and final relationship is between the provider(s) at Westview Primary Care and you (the patient) and our contract is with you. We will not compromise your medical care to satisfy ANY insurance company. Bear in mind, insurance is meant to help defray the cost of medical care and is NOT intended to dictate your treatment.

Payment is due and expected in full at the time services are rendered. This includes deductibles, co-payments, co-insurances and non-covered services.

As a courtesy we are happy to assist you in the filing of your insurance claims, completing insurance forms, and insurance pre-certification. You will be responsible for any and all balances not covered by your insurance. As the insured client, you are in the best position to follow up and exert pressure on your insurance carrier to ensure payment is being processed.

You will receive a monthly statement requesting payment of any unpaid balance. If your account becomes past due, please contact our office to discuss payment arrangements and avoid further collection efforts. We are committed to being sensitive to patient financial difficulties, but we are unable to assist if you do not contact us to discuss your account.

Any balance that is over 90 days old will be subject to be sent to Valley Credit Services for collections.

There is a fee (currently $35) for any checks returned by the bank. Appointments not cancelled with 24 hour notice may result in charges for time reserved.

There is a fee of $25 for any missed appointments or appointments not canceled within 24 hours of the appointment date. This fee is not billed to the insurance and is the responsibility of the patient at their next visit.

We are here to serve your health needs and will work hard on your behalf, to contain fees and other charges while providing you with quality health care.

I have read and understand the above policies. I understand that I may receive a copy of this form upon request.

Patient Signature:	**Date:**

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights coming to your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 05/26/2015, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and discuss your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or payment for you healthcare, but only if you agree that we may do so.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS
Access: You may have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.75 for each page, $35 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of the Notice for a full explanation of our fee structure.)

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location by your request.

Electronic Request: If you receive this notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Patient Signature:	**Date:**

PNJ Primary Care
New Patient Contract

Please Print Clearly **Today's Date: _____________**

Please initial on the lines provided then sign at the bottom of the page.

	Arrive at least 10 minutes before your appointment time to fill out paperwork. If you are at least 15 minutes late for your appointment, it will be rescheduled to a later date.
	If you need to cancel or reschedule your appointment, please give us 24 hours notice. There will be a $25 fee for every missed appointment that was not rescheduled within this time frame. The fee will be collected at the time of your next visit and will not be billed to your insurance.
	If you miss 4 scheduled appointments within a 6 month period, this may be grounds for dismissal from the practice.
	Please be aware the provider will not be able to manage chronic pain or psychiatric illness. A referral to a psychiatrist or pain specialist will be provided. You must keep the appointment with the specialist/psychiatrist. If referred to an outside doctor/practice, you must keep the initial appointment. If follow-up treatment is also discussed, you must continue to see the outside practice until your primary care provider notifies you otherwise.
	We are committed to providing you and our other patients with the best care possible want to give everyone the attention they deserve; therefore if you have more complex health issues that need to be addressed, the provider may ask you to schedule a follow-up appointment to address additional issues. Please be aware that we are also an Urgent Care facility and while we do try to honor your appointment time, patients with urgent medical needs may be seen first.
	You are responsible for providing Westview Primary Care with your outside medical records. If we do not get medical records within 60 days of your initial visit, we may ask you to establish primary care with another office.
	We reserve the right to perform random toxicology screen

The following may be grounds for dismissal from the practice:

	Disrespectful and the use of abusive language towards our providers and staff.
	Any dishonesty with your medical history or treatment plans from other medical providers.
	Non-adherance with the treatment plan provided by your medical provider.
	Failure on the random toxicology screen.

By signing this you are agreeing to the above terms as part of your primary care contract with Westview Primary Care. If you break the above contract, you understand that your case will be reviewed for further action, which may include dismissal from our practice.

Patient Signature:	**Date:**

Patient Authorization for Verbal Release of Information

Patient Name:

Last Name:	**First Name:**

It is the office policy of Westview Primary Care to not leave information concerning a patient's care on an answering machine, voice mail, with an unauthorized person, or send an appointment reminder via text or e-mail unless directed to do so by the patient.

I authorize Westview Primary Care to leave medical information concerning my health by the following methods:

Home Answering Machine	________ YES	________ NO	Phone:
Work Voice Mail	________ YES	________ NO	Phone:
Cell Phone Voice Mail	________ YES	________ NO	Phone:

I also authorize Westview Primary Care to verbally release information pertaining to my care and treatment to the following individuals:

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

I understand that Westview Primary Care has the right to deny verbal release of information based on professional judgment. Westview primary care also reserves the right to limit information disclosed to the minimum necessary in order to comply with HIPAA Federal Privacy Regulations.

I understand that I have the right to revoke or amend this release at any time. Unless revoked, this authorization is good for **1 year** from date signed and renews yearly unless revoked by me.

Patient Signature:	**Date:**

Patient Registration Form, Page 1

Please Print Clearly **Today's Date** ____________

Patient Information

Name: (Last)_________________________________ (First)_______________________________(MI)______

Street Address: ____ Apt# ___________

City:____ State:_________ Zip:________

Mailing Address (If different): ____Apt#______

City: ____ State: ________ Zip:_________

Home Phone:_____________________ Work:___________________Ext:_____ Cell:______________________

SS#:_________________ Sex: ___ M___ F Marital Status:______________ Date of Birth:___/____/_____

Email Address: _______________________________ How you like to be contacted: _________________

Family Doctor: _______________________________ phone#______________________

Emergency Contact*-please list an alternative contact if we are unable to contact you*

Name:_______________________________ Phone ______________________ Relationship:______________

Demographic Information

Ethnicity

__ Hispanic or Latino
__ Not Hispanic or Latino
__ Decline

Race

__ American Indian
__ African American
__ Hispanic or Latino
__ Caucasian
__ Asian
__ Decline

Preferred Language:

____

Parent or Legal Guardian (for patients under 18)

Name (Last):________________________________ (First):____________________________ (MI): ______________

Date of Birth:____/_____/_____ Relationship to Patient: _____________________

Address (if different from patient) Street:____ Apt:________

City:_______________________________ State:_________ Zip:________ Phone: _____________________

Patient Registration Form, Page 2

Primary Insurance Information

Insurance Company Name:____

Member #: ___________________________________ Group: _______________________________________

If policy holder is different than patient:

Policy Holder Name (Last):______________________________(First): ___________________________________

Address *(if different from patient)*: ____Apt:___________

City: ___________________________ State: _____ Zip:____________

Phone#: ___________________________________ SS#: ___________________

Date of Birth: ____/____/_____ *(Required)*

Sex: ___M___F

Relationship to patient: ______________________

Secondary Insurance Information

Insurance Company Name:____

Member #: ___________________________________ Group: _______________________________________

If policy holder is different than patient:

Policy Holder Name (Last):______________________________(First): ___________________________________

Address *(if different from patient)*: ____Apt:___________

City: ___________________________ State: _____ Zip:____________

Phone#: ___________________________________ SS#: ___________________

Date of Birth: ____/____/_____ *(Required)*

Sex: ___M___F

Relationship to patient: ______________________

Please inform us if you have a third insurance

New Patient Health History, Page 1

Last Name:	**First Name:**

Please check any significant medical history for yourself or family member and include the year deceased, if applicable.

Condition	Self	Father	Mother	Sibling	Mother's Parent(s)	Father's Parent(s)	Details
Alcoholism							
Anemia							
Anxiety							
Arthritis							
Asthma							
Birth Defects							
Blood Clots							
Bowel Problems							
Cancer –Type:							
COPD							
Depression							
Diabetes							
Eczema							
Eye Disease							
Epilepsy/Seizures							
Fibromyalgia							
Fracture							
Heart Attack							
Heart Disease							
Heart Murmur							
Heartburn/Reflux							
Hepatitis							
HIV/AIDS							
High Blood Pressure							
High Cholesterol							
Kidney Disease							
Liver Disease							
Lung Disease							
Mental Illness – Type:							
Migraines							
Stomach Ulcer							
Stroke							
Suicide/Suicide Attempt							
Thyroid Disease							
Tuberculosis							

New Patient Health History, Page 2

Last Name:	**First Name:**

Past Surgical History:

Surgery	Reason	Year	Hospital

Allergies: List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

Allergy	Reaction

Medications: List all of the medications you are taking, including over-the-counter and vitamins.

Medication	Strength	Frequency Taken

Health Maintenance: Please put the date of last procedure or N/A if it doesn't apply

Test	Date	Result (Please Circle)
Complete Physical		Normal Abnormal
Colonoscopy		Normal Abnormal
Lipid (Cholesterol)		Normal Abnormal
Eye Exam		Normal Abnormal
Bone Density		Normal Abnormal
PSA (Men 50-70 y.o.)		Normal Abnormal
PAP Smear (Women)		Normal Abnormal
Mammogram (Women)		Normal Abnormal

Immunization	Date	Immunization	Date
Pneumonia Shot		Flu Shot	
Tetanus		Zostavax (Shingles)	

New Patient Health History, Page 3

Last Name:	First Name:

Social History:

Occupation		Employer
Birth location		Who lives at home with you?
Do you have children?	How Many?	Ages

Alcohol Use	Exercise History
○ N/A ○ Daily: #____/day ○ Weekly: #____/week ○ Less ○ Former: Year quit: ________	○ Moderate ○ Vigorous ○ Sedentary How often do you exercise? _________________ What kind of exercise? _____________________
Tobacco Use	**Sexual History**
○ N/A ○ Daily: #____/day ○ Weekly: #____/week ○ Less ○ Former: Year quit: ________	Are you sexually active? ___No ___Yes Current sex partner(s) is/are: ___Male ___Female ___Both Have you ever had any sexually transmitted diseases? (STD's) ___No ___Yes, _____________________ Are you interested in being screened for STD's? ___No ___Yes
Illicit Drug Use	**Birth Control**
○ N/A ○ Daily: #____/day ○ Weekly: #____/week ○ Less ○ Former: Year quit: ________	○ None needed ○ Condom ○ IUD ○ OCP ○ Tubal ligation ○ Hysterectomy ○ Vasectomy ○ Other: ___________________
Caffeine Use	**Women Only**
○ N/A ○ Daily: #____/day ○ Weekly: #____/week ○ Less ○ Former: Year quit: ________	Age of first period: __________________ Age of menopause: __________________ Total # of pregnancies: ________________ Total # of abortions: __________________ Total # of miscarriages: ________________

Preferred Pharmacy Information:

Name	Location	Telephone Number	Fax Number

New Patient Health History Sheet

Last Name:	First Name:
Date of Birth:	**Gender:** _____ Male _____ Female

Please mark any symptoms you are experiencing that are related to your wellness visit today:

Allergic/Immunologic		**Ear/Nose/Mouth/ Throat**		**Genitourinary**		**Men Only**	
Frequent Sneezing		Bleeding Gums		Pain with Urinating		Pain/Lump in Testicle	
Hives		Difficulty Hearing		Blood in Urine		Penile Itching, Burning, Discharge or Odor	
Itching		Dizziness		Difficulty Urinating		Problems Stopping or Starting Urine Stream	
Runny Nose		Dry Mouth		Incomplete Emptying		Waking to Urinate at Night	
Sinus Pressure		Ear Pain		Urinary Frequency		Sexual Problems/Concerns	
Cardiovascular		Frequent Infections		Loss of Urinary Control		Sexually Transmitted Disease	
Chest Pressure/Pain		Frequent Nosebleeds		**Musculoskeletal**		**Women Only**	
Irregular Heart Beats		Hoarseness		Back Pain		Bleeding Between Periods	
Lightheaded		Mouth Breathing		Joint Pain		Heavy Periods	
Swelling (Edema)		Mouth Ulcers		Muscle Aches		Extreme Menstrual Pain	
Shortness of Breath When Lying Down		Nose/Sinus Problems		Muscle Weakness		Vaginal Itching, Burning, Discharge or Odor	
Shortness of Breath When Walking		Ringing in Ears		**Integumentary (Skin)**		Waking to Urinate at Night	
Constitutional		**Endocrine**		Changes in Moles		Hot Flashes	
Exercise Intolerance		Increased Thirst/Urination		Dry Skin		Breast Lump	
Fatigue		Heat/Cold Intolerance		Eczema		Breast Pain	
Weight Gain (___lbs)		**Gastrointestinal**		Growth/Lesions		Nipple Discharge	
Weight Loss (___lbs)		Abdominal Pain		Itching		No Periods	
Travel Within 10 Days Where:		Black/Tarry Stool		Jaundice (Yellow Skin or Eyes)		Painful Intercourse	
Eyes		Change in Appetite		Rash		Sexually Transmitted Disease	
Dry Eyes		Frequent Indigestion		**Respiratory**		**Neurological**	
Eye Irritation		Hemorrhoids		Cough		Dizziness	
Vision Changes		Trouble Swallowing		Coughing Up Blood		Fainting	
Psychiatric		Vomiting		Shortness of Breath		Headache/Migraines	
Anxiety/Stress		Constipation		Sleep Apnea		Memory Loss	
Depression		Diarrhea		Snoring		Numbness	
Do Not Feel Safe in Relationship		Nausea		Wheezing		Restless Legs	
Mania		**Hematologic/Lymphatic**		Difficulty Breathing		Seizures	
Sleep Problems		Easy Brusing/Bleeding				Weakness	
		Swollen Glands					

OFFICE USE ONLY

Chart #	Room #

BP: _____/_____	HT:
PULSE:	WT:
TEMP.:	LMP:
RR:	LAST PAP:
SPO2:	LAST MAMMO:

REFERRALS NEEDED