**Foster Medical Care, LLC. 501 N. Frederick Avenue,**

**Suite 304**

**Kamala A. Foster, MD Gaithersburg, MD 20877**

*Reason for Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Local Pharmacy Name/ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*(Last) (First) (MI)*

*Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M or F Age: \_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_*

*Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*(Street Address) (City/Town) (State) (Zip)*

*Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Primary Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergies to Any Medication? Y or N: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Person to Contact in Case of Emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Primary Insurance Billing Information Secondary Insurance Billing Information***

|  |  |
| --- | --- |
| *Ins. Co. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *City, State & Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Group Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_* | *Ins. Co. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *City, State & Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Group Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_* |

*Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_*

*Payment Policy*

*All professional services are rendered to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office. In the event to an attorney/ Agency for collections, I will pay any fees/costs incurred during the collection process.*

*Insurance Authorization and Assignment*

*I hereby authorize Foster Medical Care, LLC to furnish information to insurance carriers (including Medicare/Medicaid) concerning my illness and treatments for any amount not covered by insurances.*

***I understand that I will be responsible for a charge of $25.00 for missed appointments without at least 24-hour prior cancellation notice. I certify that the above information I provided is correct. I acknowledge that I have been offered a copy of the privacy notice of Foster Medical Care, LLC.***

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*(Date) (Signature of Patient)*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*(Date) (Signature of Subscriber/Beneficiary)*

***Rev 4/23/18***

***Notice of Privacy Practice***

*Protecting the confidentiality of the information you and your healthcare providers share with us is important to Foster Medical Care, LLC. This notice describes how medical information about you may and disclosed and how you can get access to this information. Please review if carefully.*

***Uses and Disclosure of Health Information***

*We use health information about you for treatment, payment and administrative purposes. We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to several requirements, we may give out health information for public health purposes, for auditing purposes and for emergencies. We provide information when required by law, such as for law enforcement in specific circumstances.*

*In any and all other circumstances, we will ask for your written authorization to stop any further uses of disclosure.*

*We may change our policies at any time. Before we make significant changes, however, we will post a notice of change in writing in the waiting area of our clinic. You can also request a copy of our policy at any time. For more information about our privacy practices, please do not hesitate to ask.*

***Individual Rights***

*You have certain rights under Federal Privacy Standards which are:*

* *The right to receive confidential communications concerning your medical conditions and treatment.*
* *The right to inspect and copy your protected health information.*
* *The right to amend of submit corrections to your protected health information.*
* *The right to receive an accounting of how and to when your protected health information has been disclosed.*
* *The right to receive a printed copy of this notice.*

***Complaints***

*If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, please inform the front desk.*

***Our Legal Duty***

*We are required by law to protect the privacy of your information provide this notice about our information practices and follow the information practices that are described in this notice. The name and address of the persons you can contact for further information concerning out privacy practices is:*

*Kamala A. Foster, MD*

*501 N. Frederick Avenue*

*Suite 304*

*Gaithersburg, MD 20877*

***Acknowledgment Statement:***

***I have received/ read a copy of Foster Medical Care, LLC Notice of Privacy Practices.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Date) (Printed Name) (Signature)*

*If patient is under 18 years old:*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*(Printed Name) (Relationship to Patient) (Signature)*

Rev 4/23/18

Foster Medical Care, LLC

Permission to Share **Limited** Health Information with Family/Friends

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Patient’s Name) (DOB) (Medical Record #)*

*By signing this paper below, I give permission to the person(s) listed below to receive limited information about my care. I understand my healthcare provider will use their professional judgement to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information that does not pertain to assisting with my health care and any copies of medical records will require a signed HIPAA compliance authorization. This permission will be considered ongoing until I state in writing otherwise.*

|  |  |  |  |
| --- | --- | --- | --- |
| *Date of Permission:* | *Name of Individual & Relationship to Patient:* | *Comments/ Instructions:*  *(i.e., may pick up meds, may disclose test results, etc.)* | *Patient/ Guardian Initials:* |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

*The Physician/ Staff has my permission to: (Please check all boxed that apply)*

* *Leave message at home with my spouse or : Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

* *Leave a message on my cell phone: Cell Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*
* *Leave a message on my work phone: Work Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*
* *Leave a message on voicemail*
* *Leave a detailed message on answering machine*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*(Signature of Patient or Legal Guardian) (Date)*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*(Printed Name of Patient or Legal Guardian) (Relationship; If Not Self)*

*Rev 4/23/18*