4111 Lower Beckleysville Road
Hampstead, MD 21074
Phone: 410-374-0808 Fax: 410-374-0045
office@hampsteadPCP.com

New Patient Information Packet

Please read this first, and keep this first sheet for your reference in the future

Thank you for choosing Hampstead Primary Care to support your health and wellness. We are honored to be part of your healthcare journey and look forward to partnering with you to help you become the healthiest version of yourself.

Please complete the forms attached and return them to our office. You may return them by dropping them off during office hours, faxing them to our office at 410-374-0045, or emailing them to office@hampsteadpcp.com. Please note that our email is not encrypted. While it is generally safe to send forms this way, we cannot guarantee 100% security.

About Our Practice

Hampstead Primary Care is a small, independently owned, provider-led practice. We are not affiliated with any hospital systems, allowing us to spend more time with our patients and offer truly personalized care tailored to your needs.

We emphasize preventive care and require all patients to come in at least once a year for an annual wellness visit. These visits are essential to recommend age-appropriate screening tests such as colonoscopies and mammograms, offer vaccines based on CDC guidelines, and discuss your health concerns in depth and collaboratively set goals. While all medical decisions are yours to make, we ask that you attend your annual wellness visit so we can fully explore all aspects of your health and offer comprehensive care. Most insurance companies not only pay for this annual wellness visit, but also mandate that we perform this on you once per year. In addition to routine care, we offer same-day sick visits, telehealth appointments for certain conditions, extended office hours on Tuesdays and Thursdays, and medical aesthetic services

We participate in an accountable care organization called Aledade, which is a network of clinicians committed to improving patient care through shared resources and coordinated efforts. As part of this, you may be invited to participate in care management programs that support areas like medication management, hypertension and kidney health, and advanced care planning. These programs are designed to help you meet your health goals with extra support between visits.

Next Steps
Once you return the completed forms, your information will be reviewed by one of our providers to ensure that we are the right fit for your care needs. In rare cases, if we feel that a larger practice may better serve you, we will let you know.

Typically, we schedule new patients within two months, though during busy times it may take up to four months. Please note that we do not schedule new patients during the months of November or December. We will schedule you with the provider of your choice within our group. We encourage you to continue seeing this provider for all your chronic medical needs. However, for sick visits, you may occasionally be seen by another provider based on availability. Rest assured, our team practices in a similar manner, and your primary provider will always be kept informed of any changes to your health.

Please complete the attached Medical Record Release form, but do not send it to your previous provider. Because new patient appointments are scheduled several months out, sending the release too early could cause issues with obtaining medication refills from your current provider. Our office will submit the completed release to your prior provider as your appointment date approaches.

Once your first appointment is scheduled, you'll be able to set up your Athena Patient Portal. As part of this process, you'll be asked to complete a self check-in before your visit. This check-in allows us to collect important health information and ensures all required forms are completed for billing purposes. It also gives you the opportunity to take an active role in your care. Please review all documents carefully to avoid any surprises regarding billing. Through the portal, you can update your medical information at any time and message our office with any health concerns. Please note that the self check-in must be completed prior to your appointment to avoid rescheduling and a potential $65 late cancellation fee. If you have any trouble accessing the portal, feel free to call us at 410-374-0808 for assistance or alternative options.

Thank you again for trusting Hampstead Primary Care. We're excited to support you in reaching your health goals and are grateful for the opportunity to care for you.

---

athenahealth

Getting Started with Your Patient Portal

1. Once your first appointment is scheduled, visit our website at www.hampsteadpcp.com. Click the "Access Patient Portal Here" link on the homepage, or simply use the link provided in the email from our staff.
2. Select "Create an Account" to begin the setup process.
3. Enter the requested information to complete your registration and gain access to your secure patient portal.
4. For added convenience, you can also download the athenaPatient app from the Apple App Store or Google Play Store to access all your information right from your smartphone.

If you run into any trouble while setting up your account, don't hesitate to contact our office — we're happy to help!

New Patient Information Form

Legal First Name: _____ Legal Last Name: _____Preferred Name: _____

Date of Birth: _____ Sex Assigned at Birth: ð Male ð Female

Street Address: _____

City: _____ State: _____ Zip: _____

E-mail Address ***(mandatory)***: _____

Mobile Phone: _____ Home Phone (if different): _____

ð I consent to text messages from the office. ð I consent to phone calls from the office.
ð I consent to emails from the office.

Contacts

Emergency Contact: _____Phone: _____Relationship: _____

HIPAA Consent. Whom may we discuss your medical care/ billing with:

Name: _____Phone: _____Relationship: _____

Insurance Information

Please note that we must verify that your insurance is active prior to your first appointment. To avoid delays, please send a copy of both sides of your insurance card with this form.

Primary Insurance Company: _____ID _____

Insurance Phone Number (usually on back of card): _____

Guarantor (if different from patient): _____

Guarantor Date of Birth: _____ Guarantor Phone Number: _____

Patient's Relationship to Guarantor: ð Self ð Spouse ð Child (Mother) ð Child (Father) ð Other_____

Guarantor Street Address (if different from patients): _____

City: _____ State: _____ Zip: _____

For office use only:

Date Submitted	Provider Reviewed	Insurance Verified	1st Appointment

Patient's Name: _____ Patient's Date of Birth: _____

Secondary Insurance Company: _____ID _____

Insurance Phone Number (usually on back of card): _____

Guarantor (if different from patient): _____

Guarantor Date of Birth: _____ Guarantor Phone Number: _____

Patient's Relationship to Guarantor: ð Self ð Spouse ð Child (Mother) ð Child (Father) ð Other_____

Guarantor Street Address (if different from patients): _____

City: _____ State: _____ Zip: _____

Preferred Provider

Susan Harris, CRNP is not accepting new patients currently.

ð Jason Day, CRNP ð Amy Yankolonis, CRNP ð Amber Johnson, CRNP ð No Preference

HAMPSTEAD PRIMARY CARE

Feel free to add additional pertinent medical information here.

Patient's Name: _____ Patient's Date of Birth: _____

Last Primary Care Provider: _____ Office Phone: _____

Date of last annual wellness physical (if known): _____ ð Over a year

Please list any health concerns you currently have and would like to be sure to discuss at your first visit?

Female Patients
GYN Name: _____Last Pap Smear: _____Last Mammogram: _____

What medical conditions have you been diagnosed with and are currently seeing a medical provider for, taking medication for, and/or monitoring with testing?

Please list any specialists you have seen in the last 2 years as well as their phone numbers.
Attach additional sheets of paper if necessary.

Provider's Name	Specialty	Phone Number

Patient's Name: _____ Patient's Date of Birth: _____

Please list any past surgeries.

Social History

Are you ð Married ð Single ð Divorced ð Widowed

Do you have children? ð Yes ð No

What is your occupation? _____

Are you currently in school? ð Yes ð No

Do you wear a seat belt? ð Yes ð No

Are there smoke/carbon monoxide detectors in the home? ð Yes ð No

Are you a ð current or ð past smoker?

Does anyone smoke in the home? ð Yes ð No

What is your level of alcohol consumption? ð None ð Occasional ð Moderate ð Heavy

Do you have an Advanced Directive? ð Yes ð No Do you have a current MOLST? ð Yes ð No

Are you on a special diet? ð Yes ð No If so, then what type of diet? _____

What is your level of caffeine consumption? ð None ð Occasional ð Moderate ð Heavy

Family History

Do any of your immediate family members (parents, siblings, children) have a history of significant medical conditions? ☐ Yes ☐ No ☐ Not sure
If yes, please specify:

Patient's Name: _____ Patient's Date of Birth: _____

Allergies: _____

Pharmacy: _____Pharmacy Phone: _____

Medication List

Include any prescriptions, supplements (including brand names), or over the counter medications you take on a regular basis. Attach additional sheets of paper if necessary.

Drug/Supplement Name	Dosage	How often do you take the medication?	What do you take the medication for?

Do you use Medical Marijuana? ð No ð Yes, Indication: _____

Do you use any recreational drugs? ð No ð Yes, List all: _____

Please note that it is the policy of Hampstead Primary Care that we do not prescribe long-term opioid medications or benzodiazepines. We will ask you to see a pain management specialist and/or a psychiatrist if you require these medications.

By signing this form, you acknowledge and agree to the following:

- All the information provided above is accurate and complete to the best of your knowledge.
- Hampstead Primary Care (HPC) staff are required to verify your insurance prior to your first appointment. If we are unable to verify your insurance coverage, your appointment may be rescheduled, or you may choose to pay the self-pay rate of $200 prior to being seen.
- You authorize HPC staff to obtain prior medical records, including labs, imaging, and other medical tests, from your previous primary care provider (if listed) and any specialists you have seen or are currently seeing (if listed).
- You authorize HPC staff to access your health information through CRISP, a regional health information exchange, and any other medical system portals, for the purpose of reviewing relevant medical history prior to your visit.
- You agree to complete the self-check-in process via our medical records portal before your first appointment. Failure to do so may result in your appointment being rescheduled, and a missed appointment fee of $65 may be charged.
- If you miss your first appointment without providing at least 24 hours' notice, you may be subject to a late $65 fee.

Patient's Signature: _____ Date: _____

Patient's Name: _____ Patient's Date of Birth: _____

Page intentionally left blank. Feel free to add additional pertinent medical information here.

Patient's Name: _____ Patient's Date of Birth: _____

4111 Lower Beckleysville Rd, Ste C
Hampstead, MD 21074
410-374-0808 410-374-0045 fax

Authorization to Disclose Protected Health Information

I authorize: _____

where am I requesting medical records from

Office Phone: _____Fax: _____

To disclose the following information from the health record of:

Patient Name: _____ Date of Birth: _____

Address:_____ Phone #: _____

City: _____State: _____Zip code:_____

Covering the period(s) of healthcare:

From (date) _____ To (date) _____

Information to be disclosed:

ð Last history and physical
ð Last 3 laboratory tests
ð Discharge summary
ð Last 3 progress notes
ð Immunization List
ð Imaging (e.g. x-ray, CT, US, MRI)
ð Other (Please specify) _____

I understand that this will include information relating to (check if applicable):

ð Infectious disease
ð Psychiatric care
ð Treatment for alcohol and/or drug use

The information is to be disclosed to **Hampstead Primary Care** for treatment and evaluation.
I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition. The office, its employees, and providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

If I have questions or change my mind, I know I can call.

Patient Signature: _____ Date: _____