M.S. SHARIFF M.D. P.A.

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YOUR HEALTH, OUR PRIORITY

PATIENT REGISTRATION FORM

Today's Date:					
PATIENT INFORMATION					
Patients First Name: Last:		Middle:	Marital status: Circle one Single / Mar / Div / Sep / Wid		
Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ◯ M ◯ F
Address:	City:	State:	Zip code:		
Social Security no.:	Home phone no.:	Cell phone no.:			
Occupation:	Employer:	Employer phone no.:			
Email address:					
I was referred by (please check one box):	❑ physician	❑ Hospital	❑ Insurance Plan	❑ Insurance co	
❑ Family	❑ Friend	❑ Close to home/work	❑ Other		

MEDICAL INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:		
Is this person a patient here?	◯ Yes ◯ No	Is this patient covered by insurance?	◯ Yes ◯ No		
Occupation:	Employer:	Employer address:	Employer phone no.:		
Please indicate primary insurance:		| Other:			
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
Patient's relationship to subscriber:		| Other:			
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:

Past Medical History: (Please circle all that apply)

ADHD
Alcoholism
Allergies (Seasonal)
Anemia
Anxiety
Arrhythmia (Irregular heart beat)
Arthritis
Asthma
Bladder Problems / Incontinence
Bleeding Problems
Cancer / Type :_____
COPD/Emphysema
Crohn's Disease
Dementia
Depression
Diabetes: 1 or 2
Diverticulitis
DVT (Blood Clot)
GERD (Acid Reflux)
Glaucoma
Headaches
Heart Attack (MI)
Heart Disease
Hepatitis
Hernia / Type: _____
High Blood Pressure
High Cholesterol
HIV
Irritable Bowel Syndrome
Kidney Disease
Kidney Stones
Liver Disease
Lupus
Macular Degeneration
Mental Illness
Neuropathy
Osteopenia/Osteoporosis
Parkinson's Disease
Peripheral Vascular Disease
Psoriasis
Pulmonary Embolism (PE)
Rheumatoid Arthritis
Seizure Disorder
Sleep Apnea
Stroke (CVA)
Thyroid Disorder
Ulcerative Colitis

Any other medical problems not listed above:_____
_____.

Surgical History: Please list any surgeries and approximate date preformed

_____ _____
_____ _____
_____ _____

Family History:

Mother: Living / Deceased

Anemia
Arthritis
Cancer / Type:_____
COPD/Emphysema
Dementia
Depression
Heart Disease
High Blood Pressure
High Cholesterol
Kidney Disease
Mental Illness
Osteoporosis
Stroke (CVA)
Thyroid Disease

Father: Living / Deceased

Anemia
Arthritis
Cancer / Type:_____
COPD/Emphysema
Dementia
Depression
Heart Disease
High Blood Pressure
High Cholesterol
Kidney Disease
Mental Illness
Osteoporosis
Stroke (CVA)
Thyroid Disease

Social History:

Smoking / Tobacco Use: (Circle One) Current Past Never
Alcohol Use: (Circle One) Current Past Never
Recreational Drug Use: (Circle One) Current Past Never Type: _____
Marital Status: (Circle One) Single Married Divorced Separated Widowed

Please list any other medical providers you see on a regular basis: (i.e. Cardiologist, Mental Health, Kidney Doctor, GYN, etc.)

_____
_____

Please list all medication allergies / reaction: _____
_____
_____

Please list all medications you are currently taking: (Include dose and how often you take)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Menstrual Period Y / N	Date:	Normal / Abnormal
Colonoscopy Y / N	Date:	Normal / Abnormal
Mammogram Y / N	Date:	Normal / Abnormal
Dexa (Bone Density) Y / N	Date:	Normal / Abnormal
Pap Smear Y / N	Date:	Normal / Abnormal

Any other information you would like to provide: _____
_____
_____

Patient Signature: _____ Date: _____

Insurance Assignment Policy Statement

M.S.Shariff, M.D., P.A. the corporation, will submit your commercial insurance claims as a courtesy. Your claim for services rendered will be submitted as insurance assignment, which indicated that you are authorizing your insurance company to make payment directly to our office. Please read, understand and agree to the following:

1. You are considered a self-pay patient until you provide this office with your correct insurance information and a copy of your current insurance care.
2. You are ultimately responsible for full payment for any and all changes for services rendered, regardless of the insurance payment; you must pay all deductibles, co-insurance and non-covered services.
3. If your insurance carrier has not paid your claim within 45 days of submission, you are responsible to take an active part in the recover of you claim. If payment has not been received after 60 days you will be responsible for payment in full of any outstanding balance. If is also understood that any determined overpayment will be refunded to the patient if applicable.
4. By affixing your signature below, you are authorizing the insurance company to pay M.S. Shariff, M.D., P.A. directly for any services rendered.
5. I authorize the release of any necessary information, including medical information for the purpose of treatment, payment and health care operations.
6. I permit a copy of this authorization to be used in place for the original.

This insurance assignment must be followed and we ask that you sign this form as acknowledgement that you understand our policy, accept full financial responsibility, and any question regarding this policy have been clearly answered.

_____ Date_____

Patient/guardian signature

Medicare Patient authorization Form

Many of our established patients have yearly preventive service examinations which include: a comprehensive history, identification of risk factors, ordering of appropriate labs and /or diagnostic procedures, as well as counseling on lifestyle and prevention of disease. Medicare does not generally cover preventative medicine services. (Preventive service exam: including breast exam, pelvic and /or pap $175.00) We fell that preventive service exams are of great value for our patients, however the practitioners in this practice cannot perform routine physical exams without a clear understanding by the patient that this may not be covered service and that the patient maybe responsible for payment of all fees associated with these services.

I understand that medical services/supplies recognized, as non-covered services are the responsibility of the patient and assume financial responsibility for these charge if Medicare and or my insurance carrier denies payment.

Signature_____ Date:_____

M. S. SHARIFF, M.D., P. A.
Cambridge, MD 21613

POLICIES

Payment Policy

Co-payments and any previous balances are due at the time of the visit. We accept Visa, Master Card, Discover, American Express, Cash and Check. Returned checks are subject to a fee of $35.00 and legal collection action. Unpaid accounts are subject to assessment of collection fees and legal collection action.

Collection Policy & Agreement

When payment is not made as agreed, account balances, inclusive of all charge and reasonable collections costs agreed to herein including but limited to reasonable attorneys fees, may be sent to outside collection firms for legal collection action. The patient and/or guarantor/ responsible party shall be responsible for and agree to pay all reasonable collections costs including but not limited to, reasonable collection agency fees, attorney's fees and court costs. Such fees represent administrative, accounting, bookkeeping, account maintenance, legal and management fees associated with delinquent accounts. In consideration of the acceptance of the patient named on this form by Provider and for services rendered or to be rendered to such patient, the undersigned promises to pay for and guarantees payment of all amounts due and any and all charges including collection costs described herein. If payments due hereunder is not made as agreed, Provider may without notice or demand, declare the entire unpaid balance of the account including collection costs agreed to herein to be immediately due and payable. If court action is necessary to enforce payment hereunder the venue for any such court action shall be Dorchester County, Maryland unless Provider elects otherwise. The undersigned waives any object in to venue or jurisdiction. A copy of this Agreement shall be as valid as the original.

I have read the above and agree to the stated terms and to pay, guarantee and otherwise accept financial responsibility for all amounts due arising from the services provided by this office to the patient named below as provided herein and foregoing on all policies listed above.

Patient Printed Name:_____ Date:_____

Signature of Patient:_____

Printed Name of Legal Guardian/Guarantor:_____

Signature of Legal Guardian/Guarantor:_____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 *weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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HIPPA
PATIENT CONSENT FORM

There is a copy of the complete policy available in the waiting room or by asking the office manager to supply a copy.

I (Patient Name):_____ Date of Birth_____
grant permission for the following person(s) to obtain information regarding my medical care, and speak with the provider and/or staff regarding my care.

Name:	Relationship:
_____	_____
_____	_____
_____	_____

The patient understands that:
Protected health information may be disclosed or used for treatment, payment, or health care operation.
This practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
This practice reserves the right to change the Notice of Privacy Practices.
The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.
The patient may revoke this consent in writing at any time and all future disclosures will then cease.
The practice may condition receipt of treatment upon the execution of this consent.

We have chosen to participate in the Chesapeake Regional Information Systems for our patients (CRISP) , a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an opt-out form to CRISP by mail, fax, or through their website.

Patient or responsible party signature:_____
Date:_____