925 Bishop Walsh Rd., Ste 10
Cumberland, MD 21502
Phone: 240-362-7025
Fax: 240-362-7064

Welcome to Proactive Primary Care!

We want to make sure we are the right provider for you and that we are participate with your insurance company. Please complete the following information.

Date: _____

Patient Name: _____ DOB: _____

Patient Address:

_____

_____ Phone:_____

Previous Primary Care Provider:

._____

Other Specialists:

_____

Please be aware that we do not prescribe controlled substances. If you are expecting us to prescribe narcotic pain medicines or chronic use of benzodiazepines (Ativan, Klonopin, Valium, Xanax), we may not be the right practice for you.

Information included in this packet:

- Cancellation and Missed Appointment Policy
- Demographic and Billing Information
- HIPAA release form
- New Patient history and physical
- Release of information forms to obtain records from your other provider(s)

We look forward to caring for you!

Proactive Primary Care Medical History

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Place of Birth: _____

Please list any hospitalizations, surgeries, major events, ie. Accidents, injuries, childbirth

Illness	Date	Hospital (If hospitalized)

Please list any allergies and what your allergy symptoms are: _____

_____

Please list any ongoing medical problems such as diabetes, high blood pressure, asthma, etc.

Medical Problem	Date of Onset

Please tell us about your family's medical history.

	Alive Y/N	Age	Health Issues	Cause of Death
Mother				
Father				
Brother(s)				
Sister(s)				
Children				
M. Grandmother				
M. Grandfather				
P. Grandmother				
P. Grandfather				

Preventative Health Care:

When was your last:

Pap Smear: _____ Mammogram: _____ PSA: _____ Colonoscopy: _____

Tetanus _____ Influenza _____ Meningitis _____ Hepatitis A _____

Hepatitis B _____ Pneumovax _____ Varicella _____

Personal History:

Occupation _____ Previous occupations _____

Marital status _____ History of domestic violence _____

Who lives in your household? _____

Alcohol use _____ Tobacco use _____ Caffeine use _____

Recreational drug use _____ Have you ever been treated for a STD? _____

Do you follow any special diet? _____ What is the highest grade or degree that you obtained?_____

Current Pharmacy: _____

Please list your current medications. Include herbal and nonprescription medications.

Name of Medications	Dosage	Frequency

Is there any additional information that you think we should know about you?

_____

_____

_____

_____

_____

_____ _____

Signature Date

Name: _____ Date of Birth: _____ / _____ / _____

Authorization to Bill/Pay Insurance Benefits

I heareby authorize Proactive Primary Care to bill my medical insurance, not to exceed the balance due of the provider's charge for services rendered by the provider. I also authorized insurance benefit payment to be assigned/payable to Proactive Primary Care. I understand that I am financially responsible for any balance not paid by my insurance company.

Missed appointment, cancellation fee

I understand that I must give Proactive Primary Care a 24 hour notice upon having to cancel or reschedule any appointment. I also understand that I may be billed and responsible to pay any fees that apply to a missed appointment, no show or cancelled same day appointment.

Authorization to Release Information

I hereby authorize Proactive Primary Care to release information about me which may be necessary to process claims that are payable, under medical insurance plans to which I am potentially entitled.

Acknowledgement

I have read, understand and agree with the above policy procedures. I understand this authorization will be in effect for **12 months** from the date of signature unless cancelled by me or legal representative in writing.

PATIENT SIGNATURE* _____ **DATE:** _____

*Patients 18 years of age and older must sign for themselves

If other than patient, please state relationship: _____

Proactive Primary Care Staff: _____ **Date:** _____

PPC Medical Information Release Form & HIPAA Release Form

Name: _____ Date of birth: ___/___/___

Release of Medical Information

I authorized the release of medical information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

( ) Spouse _____

Name Phone Number

( ) Child(ren) _____

Name Phone Number

( ) Other _____

Name Phone Number

( ) INFORMATION IS NOT TO BE RELEASED TO ANYONE.

This Release of Information will remain in effect until terminated by me in writing

Messages

Please call ( ) my home phone ( ) my work phone ( ) my cell phone _____

If unable to reach me: ( ) you may leave a detailed message on my phone/cell phone

( ) please leave a message requesting me to return your call

( ) _____

(Specific instructions for phone calls)

Patients 18 years and younger

( ) I give permission for my child to be seen without a parent present.

( ) I **DO NOT** give permission for my child to be seen without a parent present.

_____ Date: ____/____/____

(Signature of Patient/parent/legal guardian)

Proactive Primary Care

The Office of Greta Cain, CRNP

925 Bishop Walsh Dr.

Cumberland, MD 21502

Demographic and Billing Information

Name: LAST _____ FIRST _____ MI _____

ADDRESS: _____ DOB: _____ / _____ / _____

CITY: _____ STATE _____ ZIP _____

CELL # _____ HOME # _____ M _____ F _____

RACE _____ ETHNICITY _____ LANGUAGE _____ MARITAL STATUS _____

SSN# _____ - _____ - _____ EMAIL _____

Employer: _____ Phone # _____

Preferred Pharmacy: _____ City: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone # _____

Primary Insurance: _____ Policy # _____

Policy Holder (If different from SELF) _____

Policy Holder's DOB: _____ / _____ / _____ Relationship to Patient _____

Secondary Insurance: _____ Policy # _____

Policy Holder (If different from SELF) _____

Policy Holder's DOB: _____ / _____ / _____ Relationship to Patient _____

PPC Cancellation, Missed Appointment, and Financial Policy

If you need to cancel your appointment:

Please call the office to cancel your appointment at 240-362-7025 at any time. If you call during nonbusiness hours or we are not able to answer the phone, please leave this information on our voicemail. Please leave your name, date of birth and phone number and we will return your call to reschedule your appointment. Your appointment is time set aside to specifically address your personal healthcare needs. Please notify us as soon as possible if your need to cancel or reschedule your appointment.

Missed appointment or No-shows:

Any appointment that is missed or is cancelled with less than a 24 hour notice is considered a missed appointment. *If you do not keep an appointment or give less than a 24 hour notice, you may be charged a missed appointment fee.*

Late for an appointment:

Since your appointment time is set aside to specifically address your personal healthcare needs and we strive to stay on time, if you arrive late for your appointment, you may be asked to reschedule your appointment. Patients that arrive late for their scheduled appointments cause a disruption in the schedule and cause our providers to get behind. Please consider traffic, weather conditions, road construction, EMT or bus schedules, taxi and other factors when determining the amount of time it takes to travel to your appointment.

Please note that any repeated missed appointments and late arrivals may result in your dismissal from the practice.

Account balance:

Some insurances policies have copays, coinsurances and/or deductibles that must be met before your office visit will be paid or processed. These payments are due before you are seen by a provider. Patient balances must be paid within 30 days of receipt of statements.

Non-Sufficient Funds and Returned Check Fees:

There will be a $35.00 fee for any checks that are returned. This must be paid in full within 48 hours and prior to scheduling another appointment or medication requests.

Proactive Primary Care

MEDICAL RECORDS RELEASE FORM

Patient's Name: _____

Address: _____

_____

Date of birth: _____

I hereby authorize _____
(Provider's Name)

_____
(Provider's Address)

_____

_____

_____
(Provider's Telephone & Fax # if known)

to release my medical records via fax/mail to:

Proactive Primary Care (office of Greta J Cain, CRNP)
925 Bishop Walsh Road, Suite #10
Cumberland, MD 21502
240-362-7025 (T)
240-362-7064 (F)

Please send:
□ All records (Notes, Labs, Reports, CD)
or
□ Specific Item Only (please list): _____

_____
(Signature of Patient/Guardian/Power of Attorney) (Date)

Relationship:_____