



Date \_\_\_\_\_

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell# \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Race: \_\_\_\_\_

Employed:  Full Time  Part Time  Retired Student:  Full Time  Part Time

Person to Notify in an Emergency \_\_\_\_\_

Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

**Insurance Information:**

**Primary Insurance** \_\_\_\_\_

Are you the policyholder?  Yes  No (\*this information is NOT on the card\*)  
If not, policyholder's name? \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Policyholder Date of Birth \_\_\_\_\_ Policyholder Employer \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_

Are you the policyholder?  Yes  No  
If not, policyholder's name? \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Policyholder Date of Birth \_\_\_\_\_ Policyholder Employer \_\_\_\_\_

**Insurance Authorization & Information Release**

I hereby authorize St. Agnes Healthcare to release information from my records to persons who have need for this information such as insurance companies, doctors, and other agencies or professionals involved in my care. St. Agnes Healthcare personnel are authorized to determine which persons or agencies are in need of such information. I hereby authorize Medicare, Medicaid and/or any insurance company(s) to pay St. Agnes Healthcare directly for services provided. I agree to accept financial responsibility for services provided at St. Agnes Healthcare for the patient.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Notice of Privacy Practices/Financial Policy Receipt: I hereby acknowledge that I have received a copy of the St. Agnes Healthcare Joint Notice of Privacy Practices & the Maryland Surgeons Financial Policy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please Turn Over



Date \_\_\_\_\_

### Acknowledgement and Consent

\_\_\_\_\_  
Patient Name – PLEASE PRINT

\_\_\_\_\_  
Date of Birth

By signing this form, I consent to MARYLAND SURGEONS/St. Agnes Healthcare use and disclosure of protected health information about me to the persons listed below. I understand that I have the right to revoke this consent in writing, except where MARYLAND SURGEONS/St. Agnes Healthcare has already made disclosures in trust on my prior consent.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please list family members or others with whom we may discuss your **medical information** or **account information**. Please designate by your **X** in the appropriate column, which information we may discuss with each party listed.

<i>Name</i>	<i>Relationship</i>	<i>Medical</i>	<i>Account</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

.....  
**Other Health Care Providers**

GYN Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Gastroenterologist \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Oncologist \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
.....

**So that we may better assist you in the future, please provide the following:**

Email address: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ City: \_\_\_\_\_

Pharmacy Phone #: \_\_\_\_\_

Please Turn Over



Date \_\_\_\_\_

Name: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

1. Reason for visit: \_\_\_\_\_ Work related? \_\_\_\_\_

2. Do you have allergies to medications?  No  Yes

List medication & reaction (i.e. rash, trouble breathing)

\_\_\_\_\_

3. Any allergy to:  latex;  tape;  betadine scrub;  contrast (IV dye)? (check item if allergic)

4. Current medications (include dosage):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Past or present medical problems: (check all that apply)

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> DVT                 | <input type="checkbox"/> High triglycerides       | <input type="checkbox"/> Phlebitis               |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Irregular heart beat     | <input type="checkbox"/> Pneumonia               |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Frequent UTI/       | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Pulmonary embolism      |
| <input type="checkbox"/> Chronic cough          | <input type="checkbox"/> Kidney Infection    | <input type="checkbox"/> Kidney disease/failure   | <input type="checkbox"/> Seizures                |
| <input type="checkbox"/> Chronic lung disease   | <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Multiple Sclerosis       | <input type="checkbox"/> Skin cancer             |
| <input type="checkbox"/> Cirrhosis of the Liver | <input type="checkbox"/> Heart murmur/       | <input type="checkbox"/> Ovarian cyst             | <input type="checkbox"/> Stomach/ duodenal ulcer |
| <input type="checkbox"/> Colon cancer           | <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Pancreatitis             | <input type="checkbox"/> Stroke or paralysis     |
| <input type="checkbox"/> Colon polyps           | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Parkinson's disease      | <input type="checkbox"/> Thyroid disease         |
| <input type="checkbox"/> Crohn's Disease        | <input type="checkbox"/> Hiatal hernia       | <input type="checkbox"/> High cholesterol         | <input type="checkbox"/> Transfusions            |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> High blood pressure |   | <input type="checkbox"/> Ulcerative colitis      |
| <input type="checkbox"/> Diverticulitis         |  |   |  |

6. Past surgeries:

NONE  Appendectomy  Gallbladder  Hernia Repair  Colon Resection  Other: \_\_\_\_\_

7. Have you or any family member ever had a problem with anesthesia?  No  Yes

8. Family history:

	Father	Mother	Brother	Sister
a) Heart Trouble:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Cancer:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Diabetes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Social history:

a) Tobacco use:  never smoked  smoker: how much \_\_\_\_\_  ex-smoker: quit when \_\_\_\_\_

b) Alcohol use:  none  rarely  often  daily

c) Occupation: \_\_\_\_\_

Please Turn Over

Patient Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

**REVIEW OF SYSTEMS**

Please circle any illness or problems that you are currently experiencing.

<b>GENERAL</b>	<input type="checkbox"/> NONE	Weight gain, Weight loss, other: _____
<b>EYES</b>	<input type="checkbox"/> NONE	Change in vision, poor vision, other: _____
<b>EAR/NOSE/THROAT</b>	<input type="checkbox"/> NONE	Sleep apnea, hearing loss, other: _____
<b>RESPIRATORY</b>	<input type="checkbox"/> NONE	Shortness of breath, wheezing, other: _____
<b>CARDIOVASCULAR</b>	<input type="checkbox"/> NONE	Chest pain with activity, pain in legs with walking, <b>Date of last</b> EKG _____, Stress Test _____, Echo _____, and/or Cardiac Cath: _____
<b>GASTROINTESTINAL</b>	<input type="checkbox"/> NONE	Blood in stool, yellow eyes/ skin, other: _____
<b>GENITOURINARY</b>	<input type="checkbox"/> NONE	Difficulty urinating, kidney stones, other: _____
<b>MUSCULOSKELETAL</b>	<input type="checkbox"/> NONE	Severe back pain, severe joint pain, other: _____
<b>SKIN</b>	<input type="checkbox"/> NONE	Rash, MRSA, other: _____
<b>NEUROLOGICAL</b>	<input type="checkbox"/> NONE	Severe headaches, pain/numbness in legs, other: _____
<b>PSYCHIATRIC</b>	<input type="checkbox"/> NONE	Depression, anxiety, other: _____
<b>HEMATOLOGIC</b>	<input type="checkbox"/> NONE	Blood clots, transfusions, other: _____
<b>ENDOCRINE</b>	<input type="checkbox"/> NONE	High blood sugar, excessive thirst, other: _____

Please Turn Over

**Baltimore Office on the St. Agnes Hospital Campus**

***Angelos Medical Pavilion  
3407 Wilkens Ave., Suite 410  
Baltimore, MD 21229  
Phone: 443.574.8500 // Fax: 410.719.0094***

From Baltimore Beltway 695 - Exit 12 Wilkens Avenue East. Travel approximately 2 miles east. Turn right at the traffic light into the Campus of St. Agnes Hospital. The Angelos Pavilion is the building immediately to your left as you enter the campus. Park in Lot F, in front of the building.

From Interstate 95 - Exit 50, north to Caton Ave. Travel north on Caton < 1 mile. Turn left at the light onto the Campus of St. Agnes Hospital. Wind through the Campus following signs for Angelos Medical Pavilion. The Angelos Medical Pavilion is the last building on the right before exiting hospital campus. Park in Lot F, in front of the building.

**Columbia Office between Howard County General Hospital and Howard Community College**

***Medical Pavilion at Howard County  
10710 Charter Drive, Suite 230  
Columbia, MD 21044  
Phone: 443.574.8500 // Fax: 443.708.9320***

**Local directions:**

From The Mall in Columbia drive westbound on Little Patuxent Parkway (Route 175). Continue past Howard County General Hospital and turn left onto Cedar Lane. Turn left onto Hickory Ridge Road. Turn left onto Charter Drive and continue to the MPHPC, which is the second building on the right.

**From Route 32:**

Exit onto Cedar Lane and continue to Hickory Ridge Road. Turn right onto Hickory Ridge Road. Turn left onto Charter Drive and continue to the MPHPC, which is the second building on the right.

**From all other points:**

Take Route 29 towards Columbia. Exit onto Broken Land Parkway toward Columbia Town Center/Merriweather Post Pavilion. Turn left onto Hickory Ridge Road. Turn right onto Charter Drive and continue to the MPHPC, which is the second building on the right.

## Financial Policy

### Maryland Surgeons

#### Patient Financial Policy

1. We have outlined our financial policy below. If you have any questions about the policy, please discuss them with our Patient Accounting Department. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.
2. Full payment of any amount that is your financial responsibility is due at time of service. For your convenience, we will accept VISA, Discover and MasterCard.
3. We have a participating agreement with many insurers and other health plans. We will bill those plans for whom we have an agreement and will require you to pay the designated co-payment at the time of service.
4. We will collect the co-payment when you arrive for your appointment. If your insurance plan requires you to have a written referral, we must have the referral before the service is rendered in order for the service to be covered. If the appropriate referral and/or co-payment are not present, the visit will be rescheduled, unless there is an immediate or urgent medical need for treatment.
5. As a courtesy, we will file your insurance claim for you with insurance companies with whom we do not have a participating contract. We will bill you directly for any patient liability; that is, applicable deductible, copays, coinsurance, etc. If your plan is not an HMO and your insurance company does not pay within six months from date of service, we will look to you for payment.
6. All health plans are not the same and do not cover the same services. In the event you do not have HMO coverage and your health plan determines a service to be "non-covered," you may be responsible for the complete charge. Payment is due upon receipt of a statement from our office. For services that are known to be non-covered by an HMO before they are rendered, you will be required to sign a financial responsibility form acknowledging your responsibility for payment.
7. If you wish to see our doctors for consultation and you are not covered by health insurance, all fees are to be paid at time of service. If you require surgery and you are not covered by health insurance, you must contact our Patient Accounting Department before the surgery will be scheduled to make payment arrangements. A deposit is required before the surgery.
8. Accounts not paid within our routine billing cycle of ninety-one days will be turned to collections. These accounts will be subject to additional fees – collection fees, legal fees and interest.
9. If at any time, during the course of treatment your healthcare coverage changes, please notify us immediately. Each insurance plan has different requirements for authorization and pre-certification of services. Some insurance plans require that certain procedures be performed by particular providers or in certain facilities with whom they have contracted in order to be covered. It is essential that we have correct insurance information when scheduling any procedure for you.
10. If at any time you are unable to make payment of the amounts you have been billed, call us as soon as possible to discuss the situation in order to avoid unnecessary collection and legal costs.
11. There is a \$35.00 fee for any returned checks.
12. There may be a \$100 fee for cancellation of surgery, for reasons other than medical.