ADVANCED NEIGHBORHOOD PEDIATRICS, LLC.
12239 Cypress Spring Rd, Clarksburg, MD 20871
1111 Spring Street, Ste 220, Silver Spring, MD 20910
Consent for Services

Patient Name_____ **Date of Birth**_____

AUTHORIZATION FOR TREATMENT:
I authorize Advanced Neighborhood Pediatrics, LLC. to provide treatment to myself or the above named patient.

NOTICE OF PRIVACY PRACTICES:
I have been given a copy of Advanced Neighborhood Pediatrics, LLC.. Privacy Practices in compliance with HIPAA legislation.

ASSIGNMENT OF BENEFITS:
I authorize my insurance company to pay and hereby assign directly to Advanced Neighborhood Pediatrics all benefits, if any, otherwise payable to me for services. This authorization may be revoked by either me or my insurance company at any time in writing.

REFERENCE LABORATORY SERVICES:
I understand that Advanced Neighborhood Pediatrics, LLC.. utilizes the services of an outside lab to perform some of the lab tests requested by its physicians. I further understand that the Reference Laboratory will bill separately for its services. I consent to Advanced Neighborhood Pediatrics providing demographic information as necessary for billing purposes.

CANCELLATION OF APPOINTMENTS
I understand that I must give a 24 hour notice to cancel my appointment. I further understand that future services may be denied if I fail to keep my scheduled appointments and may be charged for not canceling or showing up for my appointment.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:
I authorize release of copies of pertinent medical records to providers outside of Advanced Neighborhood Pediatrics, LLC. who are being consulted with and/or I am being referred to in connection with my current treatment, to insurance companies for the purpose of determining benefits for services provided, and to reference laboratories for billing purposes.

AUTHORIZATION FOR RELEASE FOR RESEARCH OR QUALITY IMPROVEMENT:
Maryland Law requires us to inform you that a copy of your medical record, no matter when created, may be released to outside groups for medical research or quality improvement purposes unless you object. Researchers cannot use patient names or identifying characteristics when reporting any results of their research. We evaluate these requests to ensure that the release of patient records is necessary to accomplish the research purpose.

PAYMENT AGREEMENT/COLLECTION POLICY:
I, the undersigned, do hereby expressly guarantee payment of all charges for medical services rendered, or to be rendered by Advanced Neighborhood Pediatrics, LLC. I understand that it is my responsibility to provide Advanced Neighborhood Pediatrics with current insurance information. I understand that a finance charge of 8 % per annum is charged to any balance 60 days or older on my account. I will be responsible for the balance due, plus any costs that are incurred by S Advanced Neighborhood Pediatrics, LLC. in collecting my account.

NON VIOLENCE POLICY
I understand that Advanced Neighborhood Pediatrics, .is committed to providing its employees with a safe, nonviolent workplace and reserve the right to determine whether particular conduct violates this policy or is otherwise inappropriate.

USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION
•My insurer may share my past, current and future health and account records with Advanced Neighborhood Pediatrics, LLC.. about services I've received from Advanced Neighborhood Pediatrics, LLC. and other care providers unrelated to Advanced Neighborhood Pediatrics, LLC. These records may be used by Advanced Neighborhood Pediatrics, LLC. as needed to manage or coordinate my care and to improve the quality of that care. If I do not agree to this, I will initial below.

•_____My insurer **MAY NOT RELEASE** any of my identifiable health records from providers unrelated to Advanced Neighborhood Pediatrics, LLC. for the purposes described above.

By signing this form, I am consenting to treatment and agreeing to these policies. I understand this authorization will remain in effect until I revoke it in writing.

_____ _____ _____
Date *Signature Patient (if 18 yr.) / Parent / Legal Guardian* *Relationship to Patient*

Advanced Neighborhood Pediatrics, LLC.

Patient Registration

(PLEASE PRINT CLEARLY)

Patient's Legal Name: _____ (Last) _____ (First) _____ (Middle)

Address: _____ (Street) _____ (Apt#)

_____ (City) _____ (State) _____ (Zip)

Date of Birth (Mo/Day/Year): _____ Sex (circle): M F

Home#: (___)_____ Cell#: (___) _____ Other#: (___) _____

Referred by: _____ Previous Clinic: _____

Pharmacy: (Circle One): CVS, Wal-Mart, Safeway, Harris Teeter, Shoppers, Walgreens, Other:_____
Address:_____ Phone:_____

COMPLETE IF PATIENT IS 0 -17 YEARS OF AGE:

Parent/Legal Guardian:_____ Parent/Legal Guardian:_____

Birthdate: _____ Birthdate: _____

Address (if different): _____ Address (if different): _____

_____ _____

Hm Phone: (_____)_____ Hm Phone: (_____)_____

Work Phone:(__)_____ Cell Phone: (___)_____ Work Phone:(___)_____ Cell Phone: (___)_____

Parent's Marital Status (circle): Married Widowed Divorced Single Legally Separated Other
Siblings & Birthdates: _____ _____ _____

_____ _____ _____ _____

INSURANCE INFORMATION:

PRIMARY INS. NAME: _____ **SECONDARY INS. NAME:** _____

Policy Holder: _____DOB:_____ Policy Holder: _____DOB:_____

Sex (circle): M F Sex (circle): M F

Patient's Relationship to Insured: _____ Patient's Relationship to Insured: _____

Policy ID#: _____ Group#: _____ Policy ID#: _____ Group#:_____

Date Coverage Effective: _____ Date Coverage Effective: _____

Copay Y N Amt:_____ CoPay Y N Amt:_____

I agree that the above information is true and correct to the best of my knowledge.

_____ _____ _____

Print Name (Patient or Parent if minor) ***Signature (Patient or Parent if minor)*** ***Date***

_____

Relationship to Above Patient

Advanced Neighborhood Pediatrics & LASER SKIN SERVICES FOR ALL AGES

12239 Cypress Spring Rd
Clarksburg, MD 20871
Ph: 240-374-8616
Fax: 240-780-7159

1111 Spring Street, Ste 220
Silver Spring, MD 20910
Ph: 240-641-8160
Fax: 240-641-8166

Dear Patient/ Parent,

Thank you for choosing Advanced Neighborhood Pediatrics as your health care provider. You are scheduled for a "Preventive Health Assessment" today. Please take a few minutes to review this letter and let us know if you have any questions or need to be because of health problems today.

"Preventive Health Assessment" (also called a "PHYSICAL EXAM ")

For these visits, the goal is to do an age appropriate history and physical examination, review general health goals and habits, and order age appropriate health screening tests.

These cannot include reviews of new or chronic health problems such as asthma, behavioral problems, and injuries.

If you or your child have any acute or chronic health problems that need to be addressed by the doctor during today's visit, please be advised that your insurer's payment policy may require you to be responsible for additional costs (such as an additional copay) associated with the visit.

If you prefer, the clinician address you or your child's physical exam (preventive health assessment).

We realize the inconvenience this may cause, and regret that your insurance's payment policies restrict our clinicians from combing these visits without a possible additional cost to you.

Thank you.

Sign and Date: _____

Advanced Neighborhood Pediatrics

12239 Cypress Spring Road
Clarksburg, MD 20871
Ph: (240) 374-8616 & fax: (240) 780-7159

Thank you for choosing our office. In order to serve you properly, we need the following information.
Please Print. All Information will be confidential.

Responsible Party Information

The following is for: □the person responsible for payment
Name:_____ □ Male □ Female □ Married □ Single □ Child □ Other:_____
Social Security#:_____ Birth Date:_____
Phone (Home):_____ (Work):_____ Ext:_____ Best time to call:_____
Address:_____
City:_____ State:_____ Zip Code:_____

Employment Information

The following is for: □the person responsible for payment
Employer Name:_____ Occupation:_____
Address:_____
City:_____ State:_____ Zip Code:_____

Insurance Information

Primary

Name of insured:_____ Is insured a patient? □Yes □No
Last First MI
Insured's Birth Date:_____ ID#:_____ Group #:_____
Insured's Address:_____
Street City State Zip Code
Insured's Employer Name:_____
Address:_____
Street City State Zip Code
Patient's relationship to insured: □ Self □ Spouse □ Child □ Other_____
Insurance Plan Name and Address:_____

Secondary

Name of insured:_____ Is insured a patient? □Yes □No
Last First MI
Insured's Birth Date:_____ ID#:_____ Group #:_____
Insured's Address:_____
Street City State Zip Code
Insured's Employer Name:_____
Address:_____
Street City State Zip Code
Patient's relationship to insured: □ Self □ Spouse □ Child □ Other_____
Insurance Plan Name and Address:_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency services, or any clinical services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry health insurance with co-pay understand that all services furnished are charged directly to their health insurance except for their co-pays.. I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form. I understand and agree that as a courtesy to the doctor, staff, and other patients, 24 hour prior notice must be given in the event of canceling, and or rescheduling an appointment I further understand that if I fail to give proper notice a broken appointment charge will incur, to which I am responsible. I have read the above conditions of treatment and payment and agree to their content.

_____ Date:_____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date:_____ Relationship to Patient: _____ *Signature of guarantor of payment/responsible party*

Please take the completed form to the front desk with your current insurance cards. Thank you for choosing ANP.

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HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

Other concerns: _____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	**REACTION**
1._____	_____
2._____	_____
3._____	_____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____
7._____	_____	_____
8._____	_____	_____

IMMUNIZATION HISTORY

Immunizations and most recent date:

Chickenpox	Date:_____	Meningococcus	Date:_____
Flu Shot	Date:_____	MMR *(Measles, Mumps, Rubella)*	Date:_____
Gardasil/HPV	Date:_____	Pneumonia	Date:_____
Hepatitis A	Date:_____	Tdap *(Tetanus and pertussis)*	Date:_____
Hepatitis B	Date:_____	Tetanus	Date:_____
		Zostavax *(Shingles)*	Date:_____

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ Abnormal

Last Mammogram Date _____ Abnormal

Age of first menstrual period: _____

Bleeding between periods

Heavy periods

Extreme menstrual pain

Date of last menstrual period or age of menopause:
_____

Number of pregnancies: _____ births: _____
miscarriages: _____ abortions: _____
Cesarean sections If yes, then number: _____

Vaginal itching, burning, or discharge
Wake in the night to go to the bathroom
Hot flashes
Breast lump or nipple discharge
Painful intercourse
Sexually active
Current sexual partner is Female Male
Do you use condoms Yes No
Other Birth control method used:_____
Interested in being screened for STDï¿½s

PAST MEDICAL HISTORY

Please check all that apply:

- o Anxiety Disorder
- o Arthritis
- o Asthma
- o Bleeding Disorder
- o Blood Clots (or DVT)
- o Cancer
- o Coronary Artery Disease
- o Claustrophobic
- o Diabetes - Insulin
- o Diabetes - Non-Insulin
- o Dialysis
- o Diverticulitis
- o Fibromyalgia
- o Gout
- o Has Pacemaker
- o Heart Attack
- o Heart Murmur
- o Hiatal Hernia or Reflux Disease
- o HIV or AIDS
- o High Cholesterol
- o High Blood Pressure
- o Overactive Thyroid
- o Kidney Disease
- o Kidney Stones
- o Leg/Foot Ulcers
- o Liver Disease
- o Osteoporosis
- o Polio
- o Pulmonary Embolism
- o Reflux or Ulcers
- o Stroke
- o Tuberculosis
- o Other

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1. _____	_____	_____	_____
1. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Grandfather (maternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Grandmother (paternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Grandfather (paternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Father	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Mother	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Brother/Sister	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Brother/Sister	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Other:_____	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke

SOCIAL HISTORY

Education Less than 8th grade **Caffeine** None If not currently, did you ever use

High school
2 year college 4 year college
Post graduate

Marital Status Married Single
Divorced Separated Widowed
Domestic partner

Exercise Level
None (No exercise)
Occasional exercise
Moderate exercise
High level exercise

Occasional Moderate Heavy
# of cups/cans per day? ____

Alcohol Do you drink alcohol?
Yes No
If so, how often?
Occasionally < 3 times a week
> 3 times a week
How many drinks per week?
—

Tobacco Do you use tobacco?
Yes No

tobacco? Yes No
Cigarettes -____pks./day
Chew - ____/day
Cigars - _____/day
# of years____
Or year quit _____

Drugs Do you currently use recreational or street drugs? Yes No
If yes, list:
_____
_____

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic
- Frequent Sneezing
- Hives
- Itching
- Runny Nose
- Sinus Pressure

Cardiovascular
- Arm Pain on Exertion
- Chest Pain on Exertion
- Chest Heaviness/Pressure on Exertion
- Irregular Heart Beats (Palpitations)
- Known Heart Murmur
- Light-headed on Standing
- Shortness of Breath When Lying Down
- Shortness of Breath When Walking
- Swelling (edema)

Constitutional
- Exercise Intolerance
- Fatigue
- Fever
- Weight Gain (____lbs)
- Weight Loss (____lbs)

Eyes
- Dry Eyes
- Irritation
- Vision Change

Date of Last Exam:_____

Ears/Nose/Mouth/Throat
- Bleeding Gums
- Difficulty Hearing
- Dizziness
- Dry Mouth
- Ear Pain
- Frequent Infections
- Frequent Nosebleeds
- Hoarseness
- Mouth Breathing
- Mouth Ulcers
- Nose/Sinus Problems
- Ringing in Ears

Endocrine
- Fatigue
- Increased
- Thirst/Hunger/Urination

Gastrointestinal
- Abdominal Pain
- Black or Tarry Stool
- Blood in Stool
- Change in Appetite
- Frequent Indigestion
- Hemorrhoids
- Trouble Swallowing
- Vomiting
- Vomiting Blood

Genitourinary
- Blood in Urine
- Difficulty Urinating
- Incomplete Emptying
- Increased Urinary Frequency
- Urinary Loss of Control

Hematologic/Lymphatic
- Easy Bruising/Bleeding
- Swollen Glands

Integumentary (Skin)
- Changes in Moles
- Dry Skin
- Eczema
- Growth/Lesions
- Itching
- Jaundice (Yellow Skin/Eyes)
- Rash

Musculoskeletal
- Back Pain
- Joint Pain
- Muscle Aches
- Muscle Weakness

Neurological
- Dizziness
- Fainting
- Headaches
- Memory Loss
- Migraines
- Numbness
- Restless Legs
- Seizures
- Weakness

Psychiatric
- Alcohol Overuse
- Anxiety/Stress
- Depression
- Do Not Feel Safe in Relationship
- Mania
- Sleep Problems

Respiratory
- Cough
- Coughing Up Blood
- Shortness of Breath
- Sleep Apnea
- Snoring
- Wheezing

Please add any other information about your health that you would like your provider to know here:

_____

_____ _____

Parent, Guardian, or Caregiver Signature Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Medical Record No._____

Relationship to Patient: _____

I have been given a copy of Advanced Neighborhood Pediatrics' *Notice of Privacy Practices ("Notice")*, which describes how my health information is used and shared. I understand that Advanced Neighborhood Pediatrics has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Facility Privacy Official, or by visiting the Advanced Neighborhood Pediatrics web site at www.anpediatrics.com.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Office Use Only: Complete this section if you are unable to obtain a signature.

1. If the resident or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

_____

2. Describe the steps taken to obtain the resident's (or personal representative's) signature on the *Acknowledgement:*

_____

Completed by:

_____ _____
Signature of Office Representative Date

_____
Print Name

File original in patient's Medical Record.

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Health Insurance Portability & Accountability Act

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you or your child significant new rights to understand and control how you or your child's health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.
As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your or your child's health information and how we may use and disclose your health information.

We may use and disclose you or your child's medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim for you or your child's visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.
We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

We have chosen to participate in the Chesapeake Regional Information System 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 atwww.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

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Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.
You have the following rights with respect to you or your child's protected health information, which you can exercise by presenting a written request to the Privacy Officer in my practice.

- The right to request restrictions on certain uses and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy you or your child's protected health information.
- The right to amend you or your child's protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your or your child's protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of January 1, 2007 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that you or your child's privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, about violations of the provisions of this notice. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue, S.W
Washington, D.C.
20201(202) 619-0257
Toll Free: 1-877-696-6775