Michael A. Randolph, M.D., P.C.

200 33rd Street, Suite 136
Baltimore, Maryland 21218
Telephone: (410)554-6489
Fax: (410)554-4498
www.michaelrandolphmd.com

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

_____

Name of Patient (please print)

I understand that as part of my healthcare, Michael A. Randolph, M.D. P.C. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information *(optional)*:

_____

"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 at www.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."

My health information may be shared with the following family members, guardians, or friends *(this includes information regarding appointments, prescriptions, referrals, billing and other health related information)* Patient Health Information will ONLY BE SHARED WITH THE PATIENT OR INDIVIDUALS LISTED ON THIS FORM providing patient consent :

Name: _____ Relationship: _____ Phone #:_____

Name: _____ Relationship: _____ Phone #:_____

_____ _____

Signature (patient, parent, guardian or legal representative) Date

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Patient Practice Policies

Michael A. Randolph, MD PC is committed to providing quality healthcare service to our patients. However, we have found it necessary to implement the following policies to offset the continued rising cost of medical supplies, equipment and services.

Initial:

_____1. ****A return check fee of forty-five dollars ($45) will be charged for any checks not honored by the bank. Future payments will then be payable by cash or credit card ONLY.**

_____2. ****A minimum of twenty four hours notification prior to appointment time is required to cancel appointments. A fee of thirty-five dollars ($35) per incident will be charged to patients for all "non-cancelled" or "no show appointments. After three (3) "no-shows", during one year's time, the patient may be notified of their discharge from the practice.**

_____3. **All patient balances are due and must be paid in full within 30 days of receiving the billing from our office.**

_____4. ****All co-pays, coinsurance, self-pay fees and past due patient balances are due at time of service. Patients with unmet deductibles associated with their coverage are expected to pay towards the allotted payment amount determined by the insurance carrier. Any additional balance incurred will be due upon receipt of your statement from our office. Accounts past 60 days will be transferred to a Collection Agency and charged a fee of $9.75, in addition to any attorney fees for collection services. The patient may also be notified of their discharge from the practice due to an account being sent to Collections.**

_____5. **Charge to patients (or the patient's "personal representative") for copying of Medical Records**
A preparation fee of $22.88 plus .75 cents for each page copied will be applied to the patient's account. When your written request for the copy of your medical record is received in the office, you will be sent a bill for this service. Upon receipt of your payment a copy of the medical record will be available for pick up from our office. For patients requesting records for outside entities such as other physicians or legal purposes, it is recommended that patients instruct the appropriate entities to send a 'Medical Records Release Request' to the office via mail or fax.

_____6. **Proof of insurance and identification are required at the time of service.**

_____7. **If you are more than fifteen minutes late for an appointment, you may be asked to reschedule your appointment to a later date. Patients who are late for appointments may be worked same day at times appropriate for the practice and provider's schedule capacity.**

_____8. **Prescription refills will be authorized within three (3) business days of the day of request. Please plan accordingly. Patients are encouraged to contact the practice and refill request line in advance instead of contacting their respective pharmacy in respect to prescription refill needs.**

_____9. **Patients should allow 5-7 business days for receipt of referrals from our office prior to the scheduled visit to the specialist. Backdated referrals WILL NOT be issued. Patients requesting expedited referrals are advised that these requests will be processed at the convenience of the providers' schedule.**

_____10. **Completion of ALL forms (FMLA, MTA, Short Term Disability, etc.) MUST be accompanied with an in-office appointment. Form completion for non-patients in reference to a current patient (ex. FMLA) may require an administrative charge at the discretion of the practice.**

If you have any questions regarding the above-mentioned policies, procedures or billing questions, please contact the office at 410-554-6489. (** revised policy August 1, 2017)By signing below, the patient acknowledges receipt and understands the above-mentioned policies.

_____ _____

Patient/ Guardian's Signature Date

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Office Policies

Office Hours

Office hours are Monday-Friday 8:30 a.m. – 4:30 p.m. except Wednesday hours are 8:30 a.m. – 12 Noon

Appointments & Cancellations

Appointments for a Complete Physical may be scheduled up to 6 months in advance. Sick visits or acute visits may be scheduled the same day or within 48 hours depending on availability. Call the office at 410-554-6489 and **press 4** for the front desk to schedule an appointment. A 24 hour notice for cancellation of appointments is required.
Please Note: ***If a staff member is not available to take your call and you are forwarded to voice mail, please leave a message that details your cancellation including your name, phone number and the scheduled appointment date and time that you are canceling.***

Missed appointments:

****A missed appointment fee of $35 will be applied to your account for an appointment not canceled 24 hours prior to your appointment. Patients will be required to pay missed appointment fees in full before the next appointment.**

Please bring your insurance card and personal identification to every appointment.

Co-Pays , Coinsurance, Deductibles and Statements

Payments may be made by cash, check, Visa or MasterCard. (No postdated checks.) **A $45 fee will be assessed for returned checks and no checks will be accepted from that patient for payments thereafter.

- **All co-pays are due at the time of your appointment. (This is not only our policy but meets the agreement you have with your insurance company.)**
- **Patients unable to provide a co-pay may reschedule their appointment for a later date.**
- **Patients with yearly deductibles will be required to pay for services rendered at the time of services.**
- **Patients without insurance will be required to pay for their visit in full at the time of service.**
- **Patient balances are due and must be paid in full within 30 days of receiving the statement from our office. If you receive a statement in the mail, please mail in your payment promptly and do not wait for your next office visit.**
- **Accounts not paid in full within 60 days may be transferred to a Collection Agency and charged a fee of $9.75 plus attorney fees for collection services. Patients may also be notified of discharge from the practice due to having an account that has gone into**

Referrals

It is the member's responsibility to be familiar with the referral process and know their insurance guidelines including participating radiology center, laboratory and physician specialist, should these services be needed. **Please allow 5-7 business days** prior to your specialist visit. **NO backdated referrals will be issued.**
Call the referral line at 410-554-6489, **press 3** and leave the name of the specialist, address, phone number, fax number, reason for referral and date of the appointment. The office will fax the referral to the specialist's office prior to your appointment.

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Please NOTE: ***It is the member's responsibility to make sure the referral has been received by the specialist office at the time of or prior to their visit.***

Prescriptions

To request **routine refills** on prescriptions, patients may call the Prescription Refill line at 410.554.6489 and **press 2**. State your name, date of birth, pharmacy name, phone number ant the prescription needed.

Prescriptions refills will be filled within 3 business days. Please plan accordingly and don't wait until the entire prescription has been used before requesting a refill.

Forms

**Completion of all forms must be accompanied with an office visit. Form completion for non-patients in reference to a current patient (ex. FMLA) may require an administrative charge at the discretion of the practice.

Transfer of Medical Records

The fee for copying is $22.88 preparation fee plus .75 cents for each page of the medical records, plus the actual cost of postage. Please send a written request for a copy of your medical record to our office. We will in turn send a bill for the preparation and copying to you. Upon receipt of your payment a copy of the medical record will be available for pick up from our office or mailed per your request.

+Please NOTE: ***All patient balances must be paid in full before transfer of medical records. Patients may provide a fax number for a new provider and the office will send chart notes at no charge to the new primary care provider provided.***

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Identifying Your Wellness Care Plan

Name:_____ Date:_____ Age:_____
Address:_____ City:_____ State:_____ Zip:_____
Email Address:_____ Phone:_____ Date of Birth: ___/___/___

Diet	Strongly Disagree	Disagree	Moderately Disagree	Neutral	Moderately Agree	Agree	Strongly Agree
I eat fruit daily	☐	☐	☐	☐	☐	☐	☐
I eat vegetables daily	☐	☐	☐	☐	☐	☐	☐
I eat protein daily	☐	☐	☐	☐	☐	☐	☐
I eat bread/crackers/pasta daily	☐	☐	☐	☐	☐	☐	☐
I eat home cooked meals daily	☐	☐	☐	☐	☐	☐	☐
I eat until I am full, and no more	☐	☐	☐	☐	☐	☐	☐
I eat even when I do not feel hungry	☐	☐	☐	☐	☐	☐	☐
I drink multiple glasses of water everyday	☐	☐	☐	☐	☐	☐	☐
I prefer sugary beverages to water	☐	☐	☐	☐	☐	☐	☐
I consume dietary supplements regularly	☐	☐	☐	☐	☐	☐	☐
I consume fast food regularly	☐	☐	☐	☐	☐	☐	☐

What beverage do you consume the most?_____

How often do you consume alcoholic beverages? (beer, wine, etc.) _____

How many cigarettes do you smoke per week? ☐ 1-10☐11-20☐20+ ☐Non-smoker

Do you live with anyone that smokes? _____

Do you have any chronic illnesses? (Asthma, diabetes, hypertension, etc.) _____

Do you use any substances? _____

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Physical Activity	Strongly Disagree	Disagree	Moderately Disagree	Neutral	Moderately Agree	Agree	Strongly Agree
I exercise multiple times per week	☐	☐	☐	☐	☐	☐	☐
I engage in physical activity multiple times per week	☐	☐	☐	☐	☐	☐	☐
I walk rather than drive when possible	☐	☐	☐	☐	☐	☐	☐
I tend to take the stairs instead of an elevator	☐	☐	☐	☐	☐	☐	☐
I perform strength training exercises with weights or my body weight regularly and often	☐	☐	☐	☐	☐	☐	☐
Lifestyle Habits							
During the past month, I have often been bothered by feeling down, depressed, or hopeless	☐	☐	☐	☐	☐	☐	☐
During the past month, I have often been bothered by little interest or pleasure in doing things	☐	☐	☐	☐	☐	☐	☐
I feel refreshed and energetic in the morning after waking up	☐	☐	☐	☐	☐	☐	☐
I feel that the quality and quantity of sleep that I get is satisfactory	☐	☐	☐	☐	☐	☐	☐
I have an effective method to manage stress	☐	☐	☐	☐	☐	☐	☐

Where do you fall on the Wellness Scale? Please see below for the scale. _____
Where would you like to be on the Wellness Scale? _____

Wellness Scale

-5	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	**5**
I have serious concerns about my overall health	**I feel worried about my health**	**I have constant concerns that affect my health**	**I have health challenges that affect me on a daily basis**	**I have some minor complaints about my health**	**I feel okay about my health with no complaints**	**I feel good on most days**	**I feel well on a daily basis**	**I feel energetic and healthy**	**I feel active, energetic, and fit**	**I feel great and am proactive about my health**