

6334 Cedar Lane

Suite 103

Columbia, MD 21044

Phone (410)531-2355 Fax (410)531-7041

[office@ppcmd.com](mailto:office@ppcmd.com)

We would like to welcome you as a new patient to PPC. Please take the time to fill out our health intake form. The confidentiality of your information is protected in accordance with the federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPPA). Please read our enclosed privacy policy. We can only start your medical services after you have signed the CCM, HIPAA, and billing forms, and after we have verified your insurance.

**Office Hours:** Our office is open Monday through Thursday 7am-3pm, and 7am-1pm on Friday. Please try to handle all issues during our office hours. You can contact the office by email at office@ppcmd.com or by phone at 410-531-2355. If the front staff is busy when you call, feel free to leave a message. If you have any billing concerns, please contact our billing manager at 443-717-4203 or billing@ppcmd.com

**Insurance:** It is very important that we have the correct and most up to date insurance information. If you change insurance, either primary or secondary, please notify us immediately.

**Medications, Forms, and Appointments:** Please call or email the office for all refill requests and appointments. Do no contact the providers directly for those matters. Prescriptions will be handled within that business day. Routine half-hour appointments should be made at least a few weeks in advance. Same day acute slots are 15 minutes and are designed to address a single problem. We do have acute slots available every day, but please call early. Our late policy is that if you are late your appointment will be shortened by the amount if time you are late. If you are more than a few minutes late it is probably best to call in and reschedule. Generally we try to run on time. Please always call if you cannot make an appointment.

**Chronic Care Management:** All Medicare patients will be required to fill out a CCM form. CCM is a Medicare program that allows us to bill for services outside the scope of an office visit. Those patients who choose not to agree to CCM visits may be subject to fees for certain services.

Please be aware that all forms and letters can take up to two weeks to complete. If you need forms filled out, please leave them with the front desk. The more information you can provide, the quicker we can complete the forms.

**Doctor and NP Contact:**

 Dr. Lazris: alazris@ppcmd.com

 Allison Carew acarew@ppcmd.com

 Kathy Jantac: kjantac@ppcmd.com

 Michelle Klima: mklima@ppcmd.com

 Elizabeth Shadis: [eshadis@ppcmd.com](mailto:eshadis@ppcmd.com)

 Pamela Zisselman: [pzisselman@ppcmd.com](mailto:pzisselman@ppcmd.com)

**Patient Portal:** PPC now has a patient portal, where you can sign in to view your profile, labs, x-rays, medications, etc. Please ask the front desk for information about our portal. The web address is [www.ppcmd.com](http://www.ppcmd.com)

**Lab Draws:** We have someone to draw labs, give shots, and do pre-op testing 5 days a week during office hours. Please call ahead of time to assure someone will be in the office when you plan to come.

**PPC PRIVACY POLICY**

We are required by law to maintain the privacy of your protected health information (PHI). We will only disclose pertinent PHI for essential clinical purposes such as discussions with specialist doctors or hospitals, to convey information to you or your POA, for insurance purposes to obtain payment, or to federal or state agencies when mandated by law. We will use names and other limited identifying information in the office when we call patients or speak to them about certain items, and we will always assure that such information is kept as limited and confidential as is possible. Any other disclosure of PHI will be done only with your consent. Under all circumstances we will only disclose the minimal amount of PHI that is necessary for the particular purpose for which it is used. We will use every precaution to assure that your PHI is always protected. If we do determine that your PHI has been breached or exposed, we will report that to you immediately.

We typically communicate with patients, doctors, and nurses by email, fax, or phone. We will not include any identifying information in our correspondence other than a patient’s name. Our email is hosted locally and is secure; we utilize every precaution to assure that no one will be able to access our correspondence other than those to who it is directed. If a patient prefers that the practice not convey PHI through a specific means, such as email, such a request can be made to the practice in writing, and other accommodations can be made for communication.

At times we may be asked by family members, physicians, or even friends to disclose medical information about you. We will only send such information if the person requesting such information is a POA, a person you designate as being able to access information, or a physician who you are currently seeing. We will always provide PHI to a hospital or health center if they require that information for clinical purposes. We will also provide information for public health purposes if requested. There are also extenuating circumstances such as subpoenas, law enforcement demands, or even mandates by federal health agencies when we will be asked to provide limited PHI, and in those circumstances we will comply.

All PPC patients have a right to look at or get copies of their PHI upon request. We will always make PHI available through our patient portal, which our patients can voluntarily access at any time, and which is safe and protected. Our patients also have a right to receive a list of any instances when we have disclosed some of your PHI.

If you seek more information about our privacy practices or you have any questions or concerns, you have the right to contact us at any time. If you believe that we have violated your privacy rights or you disagree with a decision we made about disseminating your PHI, you can complain to us or submit a written complaint to the US Department of Health and Human Services.

**We ask that all of our patients sign a form to assure that they understand and accept our privacy policy. Such a form is available on our website and can be provided by our front staff.**

HIPPA requires that patient information be kept confidential. Email and phone messages are our primary means of communication and are safe and secure. Please be sure to read our office privacy policy and ask us any questions.

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Signature Date

**MEDICAL FORM:**

**General History:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Occupation (past or present)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Power of Attorney for Heatlh:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have an Advanced Directive? [ ]Yes [ ] No

Did you sign a DNR form? [ ] Yes [ ] No

If you answered yes to the above questions, please bring appropriate forms to your first appointment. Please include any general wishes you would like to share about your advances directives:

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Prior Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you asked for your medical records to be released to us? [ ]Yes [ ] No

Specialist you see:

Name Specialty Phone /Fax

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Pharmacy Information:

Pharmacy Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Insurance Information:**

Primary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Member Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\*Copays are due at the time of visit. We do not accept credit cards. Only cash, checks, or money order\*

Secondary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Group:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Recent Tests and Screening:

Test Date

Colonoscopy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mammogram:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bone Density:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pap Smear:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PSA:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EKG:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stress Test:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cholesterol Lab:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Lab Tests:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Recent Immunization:**

Immunization Date

Flu Shot:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pneumovax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shingles:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tetanus:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Others:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Health Habits:**

Have you, or do you, smoke? [ ]Yes [ ]No When did you quit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? [ ]Yes [ ]No How much do you drink daily?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies:

Drug Reaction

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Surgeries:

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2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications: (please include strength and dose)

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_9.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Current Medical Problems:

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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9.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PPC BILLNG AGREEMENT**

At PPC, we do not use an outside billing agency and thus we cannot offer all of the services available with large billing companies such as credit card payment processing. However what we can provide that a large billing agency cannot is personal service and the ability to work with patients and families to resolve billing issues. Below are the patient billing and payment responsibilities that we are asking that you, as the patient or an individual authorized to act on behalf of the patient; read, acknowledge and agree to as follows:

 That you shall provide accurate insurance information before the first visit and with any subsequent change in your insurance coverage including obtaining pre-authorizations and referrals. If we receive inaccurate insurance information we will be unable to bill correctly and we will have to bill you directly.

 If you are of Medicare age and have primary insurance other than Medicare, we will need to verify your insurance to be sure that we can accept it. Please do not give us your Medicare card if you are not part of Medicare B. If we are not given the correct insurance card and the charges are rejected, you agree you are responsible to pay the charges for all services rendered.

 You agree you are responsible for all deductibles, co-pays, and other charges for all services rendered and not paid for by insurance. **Please note that the Medicare deductible is required to be paid at the start of every year before Medicare begins paying for services.**

 As a courtesy to you, our patient, we will submit a claim for payment to your insurance company; however, if several attempts we are unable to recoup insurance payment from either a primary or secondary insurance, please understand that you agree to guarantee and accept all financial responsibility to pay PPC for the billed services and to rectify your insurance reimbursement issue.

 **If you fail to show up for your scheduled appointment without first notifying us of the need to cancel or re-schedule that appointment within 24 (twenty-four) hours advanced notice, you acknowledge and agree to pay a missed appointment charge of $50.00.**

 All patients are welcome to discuss billing issues with our Office Manager, Pat Cernik. She can be reached via e-mail at [billing@ppcmd.com](mailto:billing@ppcmd.com) or by phone at 443-717-4203.

I have read and understand this Billing Agreement and by signing below agree to the billing and payment responsibilities as a patient, guardian or authorized acting Power of Attorney for a patient of PPC as described herein.

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

Patient/Guardian/Power of Attorney (Please circle one)

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Dear Personal Physician Care Patient,

We are writing to you about a new program that we are being asked to institute by Medicare and which directly impacts you. As part of the Affordable Care Act, Medicare will be changing physician payment over the next few years, having more of a focus on management of chronic medical conditions and less of actual patient visits. As a participating Medicare practice, we will now be allowed to charge patients for services that were previously non-reimbursed, including communication with patients/families/nurses, filling out certain forms, changing medicines, treating illness outside of the scope of a visit, coordinating care, reviewing labs, ect. Medicare will pay us up to $45 per month for such services; the program is called Chronic Care Management (CCM). At the same time, starting in 2016, Medicare will be cutting our payment for office visits by 10%, a very large cut for a small practice like ours, and one that Medicare expects us to make up by collecting CCM revenue. Therefore, we are compelled to shift some of our efforts to the collection of CCM revenue for services that we previously have done without charge.

If during a given month we perform any services eligible for CCM reimbursement, we will be billing Medicare for that service. We can only bill for this once a month, and will only bill if we perform a covered service for that month. Patients have two options. They can sign a permission slip enabling us to bill Medicare for CCM services; the slip is available on our website, and will be attached to this letter. Or they can sign the permission slip stating that they do not want to participate in the CCM program, in which case we will be unable to perform some of the services listed above unless the patient is seen for a visit by one of our providers, including communication about anything other than simple or urgent issues with either our staff or providers, filling out any forms, and communication with pharmacies and other agencies about the patient.

These changes in Medicare are not of our making, but they have such enormous impact on our practice and our ability to continue delivering care to our patients, that we are compelled to participate in them. Without CCM visits, the 10% cut will be enough to compromise our ability to continue caring for our patients, answering emails, filling out forms, and doing the hours of work that are not directly related to patient visits. Therefore, we implore you to fill out the form as soon as possible, in which case it will be put in your chart and make you a participant in the CCM program. Any Medicare patient who has not filled out the form will be assumed to not be part of the program, and can expect to have some curtailment of services that are not deemed to be medical emergencies.

Thank you for your cooperation and your understanding. As more Medicare and Affordable Care Act changes hit us over the next few years, we will try to make their institution as easy as possible. Please feel free to contact the office for any questions at [office@ppcmd.com](mailto:office@ppcmd.com), or you can go to the CMS website to find out more about CCM and other programs that will be coming soon.

Sincerely,

Andy Lazris, MD Michelle Klima, CRNP

Allison Carew, CRNP Libby Shadis, CRNP

Kathy Jantac, CRNP Pamela Zisselman, CRNP

**PPC CHRONIC CARE MANAGEMENT CONSENT FORM**

As a patient with two or more chronic conditions, you may benefit from a new program that Personal Physician Care is now offering all Medicare patients. Our goal is to make sure you get the best care possible from everyone that is involved with your care. Medicare will allow us to bill for services such as; care coordination, correspondence with patients and family, discussion with nurses or specialists, and medication management during any month that we have provided at least 20 minutes of non-face-to-face care of you and your conditions. However, you must provide your consent to participate in this program. The assigned practitioner in charge of your care will be a licensed care team member from Personal Physician Care. Failure to consent to CCM may mean that certain services done outside the scope of an office visit may no longer be able to be performed unless they are deemed to be medical emergencies.

You agree and consent to the following:

* As needed, we will share your health information electronically with others involved in your care. Please rest assured that we continue to comply with all laws related to the privacy and security of your health information.
* We will bill Medicare for this chronic care management for you if and when the services are provided. Our office will have a record of our time spent managing your care if you ever have a question about what we did each month.
* Only one practitioner can bill for this service for you. Therefore, if another one of your practitioners has offered to provide you with this service, you will have to choose which practitioner is best able to treat you and all of your conditions. Please let our staff know if you have entered into a similar agreement with another practitioner/practice.

You have the right to:

* A comprehensive care plan from our practice to help you understand how to care for your conditions so that you can be as healthy as possible. This will be provided to you upon request.
* Discontinue this service at any time for any reason. Because your signature is required to end your chronic care management services, please ask any of our staff members for the Chronic Care Management termination form.

Our goal is to provide you with the best care possible, to keep you out of the hospital, and to minimize costs and inconvenience to you due to unnecessary visits to doctors, emergency rooms, labs, or hospitals. We know your time and your health is valuable and we hope that you will consider participation in the program with our practice.

I agree to participate in the Chronic Care Management program. Yes\_\_\_ No\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or POA Signature Date

(Please circle Patient or POA)

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Print Patient Name POA Email Address