THOMAS B. DAY, M.D., P.A.

7001 JOHNNYCAKE ROAD, SUITE 104
WINDSOR MILL, MD 21244
(410)747-4711 **FAX** (410)747-4766

PLEASE FILL OUT FORMS AND BRING TO YOUR APPOINTMENT
FIRST VISIT NO CHECKS

FINANCIAL POLICY

Thank you for choosing me as your healthcare provider. I am committed to providing you with the best quality medical care possible and the best service possible. The following is a statement of my Financial Policy which I ask that you read and sign prior to any treatment.

- **CO-PAYMENTS AND BALANCES ARE DUE AT THE TIME OF SERVICE, IN FULL.**
- **ONLY CASH, CREDIT CARDS, AND BANK/DEBIT CARDS ARE ACCEPTED ON THE FIRST VISIT**
- **PERSONAL CHECKS ARE ACCEPTED ON FOLLOW-UP APPOINTMENTS ONLY.**
- **ALL HMO PATIENTS MUST HAVE A REFERRAL PRIOR TO TREATMENT, OR YOU WILL BE RESPONSIBLE FOR THAT VISIT.**
- **BRING YOUR PICTURE I.D., INSURANCE CARDS AND REFERRALS IF NECESSARY, TO EACH VISIT. IF YOU'RE NOT SURE A REFERRAL IS NEEDED, YOU NEED TO CONTACT YOUR INSURANCE COMPANY.**

Regarding Insurance

Your insurance policy is a contract between **you and your insurance** company. It is the responsibility of the patient to provide accurate insurance and personal information. Please be aware that some and perhaps all services provided may be non-covered services (or considered not medically necessary under the Medicare Program) and therefore, your responsibility. **NOTE:** If your insurance is not paid within 45 days, the balance will automatically be billed to you.

Self-Pay/CASH Patient

Payment is expected in full at the time of service.

Missed Appointments

You are responsible for your appointment date. It is the responsibility of the patient to give at least a **24-hour notice** to the office if cancelling an in office or Tele-Med (video or audio) appointment. If not, there will be a **$35.00** charge that must be paid before any future appointments can be made. This charge is not something that can be covered by your insurance. Also, it is your responsibility to reschedule your appointment. **NOTE:** There is/are no guarantees you will get another appointment right away. We strongly recommend keeping your scheduled date.

Past Due Accounts

Accounts are considered past due after 30 days. A service charge of $35.00 will be added to your account if the check is returned from the bank for any reason. Accounts turned over to our attorney for collection will be subject to interest charges at a rate of 1-1/2% per month plus 30% attorney's fee. Checks will not be accepted during the months of November, December, and January from any patient.

Overpayments

All overpayments are credited to your account. After an overpayment has been applied, anything more than $20.00 will automatically be refunded to you in the same form that you made the payment.

Return Policy

Products can be returned up to thirty **(30) days** from purchase date.

I have read, understand, and agree to this Financial Policy, and take full legal and financial responsibility for all services rendered.

Patient (Parent or Guardian if the patient is a minor) Date

EFFECTIVE DATE: 06/19/2020

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FIRST VISIT
NO CHECKS

REGISTRATION FORM
(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status:

Home phone no.: Pref ❑	Cell phone no.: Pref ❑	Social Security no.:	Birth date: / /	Age:	Sex: F M O

Street address (NO P.O. BOX):

Apt/Unit:	City:	State:	ZIP Code:

E-mail:	Employer:	Employer phone no.: ( )

Referred by (please check one box):

❑ Family ❑ Friend ❑ Doctor ❑ Internet ❑ Other

Other family members seen here:

Problem or symptom(s) for which you are being referred:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /		Address (if different):	Home phone no.:
Is this person a patient here?	❑ Yes	❑ No		Cell phone no:

Insurance company name:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician I authorize. I also authorize your practice or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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MEDICATION RECORD

PLEASE LIST ALL FORMS **(PILLS, CREAMS)** OF MEDICATIONS THAT YOU ARE USING AT THE PRESENT TIME

NOTE: THIS INCLUDES BIRTH CONTROL PILLS. IF NONE PUT **N/A**

1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

REFERRED BY: _____
(EXAMPLE: FRIEND, RELATIVE, OR PATIENT)

IF YOU HAVE ANY ALLERGIES TO ANY MEDICATION(S), PLEASE LIST THEM BELOW:

NOTE: IF NONE PUT **N/A**

1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

PATIENT/GUARDIAN **DATE**

PATIENT QUESTIONNAIRE

Patient's Name _____ Birth Date _____ Sex _____ S. M. LTP. W. D.

Address _____ Tel. No. _____

Cell Phone _____ Email Address _____

Insurance Co. _____ ☐HMO Copay $ _____ ☐PPO Copay $ _____ Referred By _____ Occupation _____

Mail Claim To _____ Policy No. _____

Instructions: Put ☑ In Those Boxes Applicable To You And In The "Yes" Or "No" Space. If Lines Are Provided Write In Your Answer.

Family History

	Father	Mother	Brother 1	Brother 2	Brother 3	Brother 4	Sister 1	Sister 2	Sister 3	Sister 4	Spouse/ Partner	Children 1	Children 2	Children 3	Children 4	Children 5	Children 6
Age (if Living)																	
Health (G) Good (B) Bad																	
Cancer																	
Tuberculosis																	
Diabetes																	
Heart Trouble																	
High Blood Pressure																	
Stroke																	
Epilepsy																	
Nervous Breakdown																	
Asthma, Hives, Hay Fever																	
Blood Disease																	
Age (At Death)																	
Cause Of Death																	

Personal History

Have You Ever Had . . .	No	Yes	Have You Ever Had . . .	No	Yes	Have You Ever Had . . .	No	Yes
Scarlet Fever			Jaundice			☐Broken Bones ☐Cracked Bones		
Diphtheria			Epilepsy			Recurrent Dislocations		
Smallpox			Migraine Headaches			☐Concussion ☐Head Injury		
Pneumonia			Tuberculosis			Ever Been Knocked Unconscious		
Pleurisy			Diabetes			☐Food ☐Chemical ☐Drug Poisoning		
☐Rheumatic Fever ☐Heart Disease			Cancer			Explain		
☐Arthritis ☐Rheumatism			Colonoscopy / Sigmoidoscopy			Latex Sensitivity		
☐Bone Disease ☐Joint Disease			☐High ☐Low Blood Pressure			Chronic Fatigue Syndrome		
☐Neuritis ☐Neuralgia			Nervous Breakdown			Any Other Disease		
☐Bursitis ☐Sciatica ☐Lumbago			☐Hay Fever ☐Asthma			Explain		
☐Polio ☐Meningitis			☐Hives ☐Eczema					
☐Gonorrhea ☐Syphilis ☐HIV			Frequent ☐Colds ☐Sore Throat			Weight: Now One Yr. Ago		
Anemia			Frequent ☐Infections ☐Boils			Maximum When		

Allergies

Are You Allergic To . . .	No	Yes	Are You Allergic To . . .	No	Yes	Are You Allergic To . . .	No	Yes
☐Penicillin ☐Sulfa Drugs			Any Other Drugs			Any Foods		
☐Aspirin ☐Codeine ☐Morphine			Explain			Explain		
☐Mycins ☐Other Antibiotics			Iodine Or Radiologic Dye					
☐Tetanus ☐Antitoxin ☐Serums			Adhesive Tape			☐Nail Polish ☐Other Cosmetics		

Surgery

Have You Had Removed . . .	No	Yes	Have You Had Removed . . .	No	Yes	Have You . . .	No	Yes
Tonsils			☐Ovary ☐Ovaries			Had Hernia Repaired		
Appendix			Hemorrhoids			Had Any Other Operations		
Gall Bladder			Ever Have A Transfusion			Been Hospitalized For Any Illness		
Uterus			☐Blood ☐Plasma			Explain		

X-Rays

Ever Have X-rays Of . . .	No	Yes	Date	Disease Present
Chest				
☐Stomach ☐Colon				
Gall Bladder				
Extremities				
Back				
Mammogram				
Sigmoidoscopy / Barium Enema				
Other				

Form #21100

Review Of Systems

Do You Now Have Or Have You Ever Had . . .	No	Yes	Do You Now Have Or Have You Ever Had . . .	No	Yes
☐ Eye Disease ☐ Eye Injury ☐ Impaired Sight			Kidney ☐ Disease ☐ Stones		
☐ Ear Disease ☐ Ear Injury ☐ Impaired Hearing			Bladder Disease		
Any Trouble With ☐ Nose ☐ Sinuses ☐ Mouth ☐ Throat			Blood In Urine		
Fainting Spells			☐ Protein ☐ Sugar ☐ Pus ☐ Other In Urine		
Convulsions			Difficulty In Urination		
Paralysis			Narrowed Urinary Stream		
Dizziness			Abnormal Thirst		
Headaches: ☐ Frequent ☐ Severe			Prostate Trouble		
Enlarged Glands			☐ Stomach Trouble ☐ Ulcer		
Thyroid: ☐ Overactive ☐ Underactive ☐ Enlarged			Indigestion		
Enlarged Goiter			☐ Gas ☐ Belching		
Skin Disease			Appendicitis		
Cough: ☐ Frequent ☐ Chronic			☐ Liver Disease ☐ Gall Bladder Disease		
☐ Chest Pain ☐ Angina Pectoris			☐ Colitis ☐ Other Bowel Disease		
Spitting Up Blood			☐ Hemorrhoids ☐ Rectal Bleeding		
Night Sweats			Black Tarry Stools		
Shortness Of Breath ☐ Exertion ☐ At Night			☐ Constipation ☐ Diarrhea		
☐ Palpitation ☐ Fluttering Heart			☐ Parasites ☐ Worms		
Swelling Of ☐ Hands ☐ Feet ☐ Ankles			☐ Any Change In Appetite ☐ Eating Habits		
Varicose Veins			☐ Any Change In Bowel Action ☐ Stools		
Extreme ☐ Tiredness ☐ Weakness			Explain		

Immunization - EKG

Have You Had . . .	No	Yes	Have You Had . . .	No	Yes
Smallpox Vaccination (Within Last 7 Years)			Polio Shots (Within Last 2 Years)		
Tetanus Shot (Not Antitoxin)			An Electrocardiogram When		
Hepatitis Vaccination					

Social History

Do You . . .	No	Yes	Do You Use . . .	Never	Occ.	Freq.	Daily
Exercise Adequately			Laxatives				
How?			Vitamins				
Awaken Rested			Sedatives				
Sleep Well			Tranquilizers				
Average 8 Hours Sleep (Per Night)			Sleeping Pills				
Have Regular Bowel Movements			Aspirins				
Sex - Entirely Satisfactory			Cortisone				
Like Your Work (Hours Per Day) ☐ Indoors ☐ Outdoors			Alcoholic Beverages				
Watch Television (Hours Per Day)			Tobacco: Cigarettes (Pks Per Day)				
Read (Hours Per Day)			☐ Cigars ☐ Pipe ☐ Chewing Tobacco				
Have A Vacation (Weeks Per Year)			☐ Snuff				
Have You Ever Been Treated For Alcoholism			☐ Other Drugs				
Have You Ever Been Treated For Drug Abuse			Appetite Depressants				
Recreation: Do You Participate In Sports Or Have Hobbies Which Give You Relaxation At Least 3 Hours A Week?			Thyroid Medication: ☐ No ☐ Yes, In Past ☐ None Now Now On Gr. Daily Have You Ever Taken: ☐ Insulin ☐ Tablets For Diabetes ☐ Hormone Shots ☐ Tablets ☐ No				

Women Only

Menstrual History . . .	No	Yes		No	Yes
Age At Onset			Are You Regular: ☐ Heavy ☐ Medium ☐ Light		
Usual Duration Of Period Days			Do You Have ☐ Tension ☐ Depression Before Period		
Cycle (Start To Start) Days			Do You Have ☐ Cramps ☐ Pain With Period		
Date Of Last Period			Do You Have Hot Flashes		
Pregnancies . . .	**No**	**Yes**		**No**	**Yes**
Children Born Alive (How Many)			Still Born (How Many)		
Cesarean Sections (How Many)			Miscarriages (How Many)		
Prematures (How Many)			Any Complications		

Emotions

Are You Often . . .	No	Yes	Are You Often . . .	No	Yes
Depressed			Jumpy		
Anxious			Jittery		
Irritable			Is Concentration Difficult?		

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NOTICE OF PRIVACY PRACTICES

Federal and State laws require us to maintain the privacy of your health information. This practice has implemented the following policies and procedures to ensure the confidentiality of your personal and/of medical information.

Your physician and all other employees working in the practice will keep any information related to you (medical and /or non-medical) in a confidential manner. However, so that we may provide you with appropriate care, for general practice operations and/or for the purposes of obtaining payments, we will, at our discretion provide information pertaining to the treatment you receive in this practice, the charges for this treatment, and related information regarding the treatment and charges to other health care related entities. This information will be submitted through the following mechanisms; US Postal Service, fax submissions, Internet submission, voice mail, and/or personal communications. The following is a list of the most common types of entities that we most typically would provide personal health related information. This list is not an all-inclusive list. Other entities may be added to this list.

I. Physicians and non-physician providers (i.e. physician therapist, nutritional counselors) who work outside of this practice.
II. Medical facilities (i.e. hospitals, outpatient centers).
III. Laboratories for the purpose of running medical tests.
IV. Other health care providers, such as pharmacies, durable medical equipment suppliers, ambulance service.
V. School health departments.
VI. Insurance companies (for third party administration) for the purpose of obtaining payments, reviewing medical necessity and or general case management.
VII. State or Federal agencies that require the submission of specific health related information.
VIII. Billing services
IX. Finance companies
X. Attorneys

We may need to contact you, by phone, to discuss your appointments, test results, treatments, referrals, account balance and/or return your phone call. We will first attempt to contact you at home; however, if you are not available and you provide us with a work number, we will attempt to contact you at work. If you are not available, we may leave a message for you or we will remind you of your appointment time.

In the event you do not pay all of your charges in full at the time of visit, we will mail a statement to your home. Also, depending upon your situation, we may mail recall cards to your home noting that you need to get in contact with the office to schedule an appointment. We will use the home address you provided (NO P.O. BOXES) us with at the time you registered with the practice.

We may contact your insurance company to determine your coverage, eligibility, unmet deductable and /or your co-insurance and co-pay requirements. If necessary for obtaining payment, we will provide credit bureaus and/or collection agencies with your account information.

When you arrive at our practice for your appointment, we will ask you to sign in and note your arrival time. We do our best to see you promptly. However, there may be times when your provider is running behind schedule and you will need to wait in the waiting room and NOT disturb the front desk.

If you would like information sent to another physician of medical facility, you must authorize the release of this information in writing (we will provide you with the necessary form to complete). Also, you must provide written authorization for the release of the information to your life or disability insurer.

You may review and/or obtain a copy of your medical record. You may request, in writing, changes be made to your medical record. We will review your reason(s) for such a request and if we agree, will make the changes(s). If we do not agree with your request, you are entitled to have your statement added to the record. Also, you may request information regarding who we have disclosed your medical information to for purpose other than treatment, payment and health care operation.

Please provide us with current information regarding your phone numbers (work and home) and home billing address. This will allow us to make the correct contact when trying to reach you.

When necessary, these policies will be modified to ensure compliance with practice operations and with State and Federal privacy regulations.

If you have any questions or concerns with the policies and/or procedures noted above, please contact our HIPPA office at the above address and phone numbers to report any and all concerns. We trust that you are comfortable with our sincere efforts to maintain the confidentiality of the information related to your medical care. You may revoke any aspects of this consent at any time by giving written notice. Finally, if you believe we have not maintained the privacy of your records, you may file a complaint with the Secretary of the US Dept. of Health & Human Service. There will be no retaliation for filing a complaint.

I, _____ **(PRINT),** acknowledge the receipt of these policies and consent to their use relevant the the information in my medical records.

Signature _____

Date _____ Witness _____

Effective Date: 01/01/2010