DATE OF APPT:_____________ TIME:__________ WITH:___________________________

NEW PATIENT INFORMATION LETTER

Dear Patients:

We are pleased to welcome you to University of Maryland Community Medical Group Spine and Neuroscience Center, office of Dr. Amiel Bethel, Dr. Larry Blum, Dr. Danny Liang, Dr. Clifford Solomon, Megan Bell, PA-C, Marla Mudon, PA-C, Brian Roeder,PA-C, Kelley Stefancik, CRNP

In order to facilitate the speed and comfort of your first visit to our practice, we are sending you in advance the forms which must be **completed before your appointment time.**

Please fill in all of the information and mail, fax or drop off to our office prior to your appointment so we can set up your chart. The address along with the fax number are on the last page with directions to our office. If you don't have access to a fax and are unable to mail or drop off the forms, please bring in your completed forms 20 minutes prior to your appointment time the day of your appointment.

It is essential you bring any and all medical reports as well as any imaging studies with you to your first office visit. **The most important thing to bring for your imaging studies are the actual DISCS so that they can be uploaded to our computer system before the visit.** Please make sure that you contact your referring provider and make arrangements to obtain these records so that you can bring them with you. If you **DO NOT** have these test results for your first visit, it will substantially delay our physician's ability to evaluate your situation thoroughly and **it may be required to re-schedule your initial visit if you arrive without the necessary records.**

***** Please note that there may be extended wait times due to emergencies that arise unexpectedly. We ask that you allow a 2 hour window for all appointments*****

Thank you for your cooperation, we look forward to seeing you in our office.

Sincerely,

Amiel W. Bethel, MD
Larry W. Blum, MD
Danny Liang, MD
Clifford T. Solomon, MD

Megan Bell, PA-C
Marla Mudon, PA-C
Brian Roeder, PA-C
Kelley Stefancik, CRNP

APPOINTMENT DAY CHECKLIST

__________ New Patient packet completely filled out

__________ Driver's license or Photo ID with current address

__________ Insurance Card

__________ Referral and Co-Pay if needed per your insurance company

__________ Authorization for your visit if you are a workman's comp patient (Dr. Banagan)

__________ All past and current MRI's, CT Scans and X-Rays on discs (cd's)

- If you are unable to bring any of the items listed above please call our office to reschedule your appointment.
- **It is patient's responsibility to make sure they bring a Referral and Co-Pay if required by the insurance company**. Failure to bring a Referral will result in rescheduling the appointment. As of Sept. 1, 2010 there will be a $25 service fee for all returned checks/credit cards.
- **Be sure to bring all MRI, CT and X-Rays on DISC and report the day of your appointment or before. Failure to do so will result in rescheduling the appointment.**
- We do not bill attorneys or third parties; you must provide a letter of exhaustion/PIP from your auto carrier if we are to bill your health insurance for an auto related injury.
- ***Effective Sept. 1, 2010, there is one week turn around for any and all forms and a charge of $25.***
- We require **48 hours' notice** for prescriptions. The physicians are in the operating room two days a week and need sufficient time for refills. Narcotics must be handwritten and picked up in the office.

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Name:______________________________SS#:__________________DOB:__________

Address:__________________________City:__________ State:________ Zip __________

Home Phone: ______________ Cell Phone: ______________Email:____________________

Sex (circle one): Male Female Marital Status (circle one): S M D W

DATE OF FIRST SYMPTOM/INJURY:____

Employer:__________________________ Work Phone: ______________Position:__________

Work Address: ______________________FT/ PT (circle one) If Disabled, since when?__________

Emergency Contact:

Name:______________________Phone:______________Relationship:________________

Who referred you to our Office? ____

Family Physician's Name: ____

Phone:______________ Fax: ________ Address:_______________________________

Date last seen by this physician: ____________________

HEALTH INSURANCE INFORMATION

PRIMARY HEALTH INSURANCE

Insurance Company:__________________________Phone#______________________________

Insurance ID:________________________Group#_____________________________________

Name of Policy Holder:__________________ DOB:___/___/___SS#:______________________

Relationship to Patient: Self Spouse Parent Other

Policy Holder's Employer: ______________________________

SECONDARY HEALTH INSURANCE

Insurance Company:__________________________Phone#______________________________

Insurance ID:________________________ Group#_____________________________________

Name of Policy Holder:__________________ DOB:___/___/___SS#:______________________

Relationship to Patient: Self Spouse Parent Other

Policy Holder's Employer: ______________________________

OTHER INSURANCE: Auto Accident________

Insurance Company____

Address: ______________________________________Phone: ______________________

Claims Adjuster Name/Phone:____

Fax:______________ Claim#______________ Date of Injury or Accident: ______________

Describe Problem, Injury or Reason for seeing the Doctor: ______________________________

If Minor Parents Name:______________________SS#: ______________DOB: __________

******Signature:** ________________________________ **Date:** ______________

REVISED 11/02/16

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Patient History & Data Base Form

Name: ________________________________ Age: ______ Date: ______________

Height__________ Weight: ________lbs. Marital Status: S M W D (Please circle one)

Occupation: ____

Referred by: ____

Description of job duties: ______________________________________

HISTORY OF PRESENT PROBLEM:

Symptoms/Presenting Problem: ______________________________________

Date of Injury: ______________ Problem first started about: ______________

This occurred at: Work ___ home ____ motor vehicle ____ other: ______________

Describe how you were injured: ______________________________________

P Location of your pain: ______________________________________

A Usual severity of pain: 1 2 3 4 5 6 7 8 9 10 (Please circle, worst pain = 10)

I Severity of pain today 1 2 3 4 5 6 7 8 9 10 (Please circle, worst pain = 10)

N Type/Quality of pain: dull ___ burning ____ aching _____ throbbing ____ sharp ____ radiating______

(indicate all appropriate)

Other type of pain describe: ______________________________________

Is WORSE by: Moving ____ lifting _____ twisting ____ walking _____ running _____

Other: ____

Get RELIEF by: ____

Is pain as bad at night? Y _____ N _______ Hours of sleep you now usually get: ______________

Is pain affecting your ability to sleep? Y ____ N _____ Sometimes _______

TREATMENT:

Treatment you have had: None ________ Medication(s) ______________________

Physical Therapy: ______ How long? When? ______________________________

Date stopped working _____________ I'm still working _________________

PAST HEALTH HISTORY:

Check if you have ever had:

__ Diabetes	__ Asthma	__ Kidney/bladder disease
__ High blood pressure	__ Chronic Cough	__ Blood clots in legs
__ Irregular heart beat	__ Ulcers	__ Bleeding disorder
__ Angina	__ Hiatal hernia	__ Infected/bleeding gums
__ Emphysema/lung disease	__ Jaundice/hepatitis	__ Stroke
__ Heart attack/disease	__ Depression	__ Thyroid Disease

__ Surgical Complications (please list) ____

__ Cancer of: ____

Other medical problems or details about past health history: ____

____

____

PLEASE LIST ANY SURGERIES YOU HAVE HAD, WITH APPROXIMATE DATES:

SPINAL SURGERY	PHYSICIAN	DATE

OTHER SURGERIES	PHYSICIAN	DATE

SOCIAL HABITS:

Smoking: ______ packs/day x _____ years. If quit, how long ago? ______ Never smoked _____

Drink: Number of: beers ____ glasses of wine _____ cocktails ____ per day/week

Exercise – Please indicate any of the following physical activities in which you regularly engage, and indicate frequency:

ACTIVITY/EXERCISE	# OF TIMES PER WEEK (FREQUENCY)	ACTIVITY/EXERCISE	# OF TIMES PER WEEK (FREQUENCY)
Walking		Running	
Golf		Tennis/Soccer/Football/Baseball	
Swimming		Aerobic Exercise	

CURRENT MEDICATIONS:

Please list any medications with dosage and frequency you currently take on a regular basis:

____

____

____

____

PHARMACY INFORMATION: (Please list name and number of current pharmacy)

NAME: ____________________ PHONE: ________________ FAX: ________________

ADDRESS: ____

ALLERGIES: Please list any **Allergies** to medicine and **type of reaction**:

____

____

____

FAMILY HISTORY: Please circle any positives

MOTHER: High Blood Pressure Heart Diabetes Stroke Cancer Thyroid Kidneys Lungs

FATHER: High Blood Pressure Heart Diabetes Stroke Cancer Thyroid Kidneys Lungs

SIBLINGS: High Blood Pressure Heart Diabetes Stroke Cancer Thyroid Kidneys Lungs

CHILDREN: High Blood Pressure Heart Diabetes Stroke Cancer Thyroid Kidneys Lungs

Grandparents: High Blood Pressure Heart Diabetes Stroke Cancer Thyroid Kidneys Lungs

REVIEW OF SYSTEMS: Please circle any positives

General: Unexplained Weight loss or gain weakness fever fatigue
Skin: Rashes lumps itching
HEENT: Headaches vision changes ringing in the ears frequent colds hoarse voice
Neck: swollen glands stiffness
Respiratory: Cough shortness of breath history of asthma bronchitis tuberculosis emphysema
Cardiovascular: high blood pressure chest pain palpitations
Gastrointestinal: constipation heartburn hepatitis irritable bowel disease incontinence
Peripheral vascular: varicose veins past clots in veins
Urinary: incontinence BPH (enlarged prostate) hesitancy frequency painful
Musculoskeletal: Muscle or joint pain stiffness arthritis gout
Psychiatric: Nervousness depression memory changes
Neurologic: Headaches dizziness fainting seizures weakness paralysis loss of sensation tingling or "pins and needles" tremors or other involuntary movements
Hematologic: anemia easy bruising or bleeding history of reaction from transfusion
Endocrine: thyroid trouble frequent urination recent weight gain or loss excessive thirst

________________________________ ____________

Signature of Patient (or parent if patient is under 18 years of age) Date

Follow-Up Patients Only:
No Changes: __________________________ ____________
Signature of Patient (or parent if patient is under 18 years of age) Date

<table>
<tr><td rowspan="2"></td><td>UNIVERSITY OF MARYLAND COMMUNITY MEDICAL GROUP

Subject: Prescribing of Medication Policy</td><td colspan="2">Policy Number:
[ ] New
[X] Revised May 2013
[X] Reviewed January 2013</td></tr>
<tr><td rowspan="1">Originator: Manager of Out Patient Surgical Practices</td><td>Effective Date
Next Review Date</td><td>May 2013
May 2016</td></tr>
<tr><td colspan="2">COO: ______________________________</td><td>Date:</td><td>Page 1
Supersedes</td></tr>
</table>

Purpose:

Establish a policy for prescribing of all medications in the office.

Responsibility:

It is the responsibility of all staff of the BW Spine and Neuroscience Center and BW Orthopedics Department at BWHS to adhere to this policy.

Procedure:

A. Surgical Patients at BWMC:

1. All medications will be prescribed by upon discharge from BWMC for the first **four weeks** following the patient's surgery.
2. After 4 weeks, all patients in need of additional medications will be asked to see a pain management specialist to help control the pain and prescribe any future medications.
3. Please schedule an appointment with your pain management provider as soon as you have your surgery date for 4 weeks from the date of surgery.

B. Pre-Operative Prescription Management:

1. All patients scheduled to have surgery within 14 days of their appointment with the physician and/or nurse practitioner may receive medications for that 14 days prior to surgery. (If surgery is rescheduled by the patient for any reason that patient will be asked to go to their PCP or Pain management physician for any further prescriptions).
2. All patients scheduled to have surgery after 14 days of their appointment with the physician and/or nurse practitioner will be referred back to their PCP or Pain Management Specialist for any medications. (We will provide a prescription for pain medications for these patients for up to two weeks pending their appointments with the PCP or pain management physician)

All patients who are seeing multiple physicians will be asked to honor the office policy of full disclosure of any medications currently being prescribed by any other physicians prior to receiving any additional medications from our office. Any patients who choose not to abide by this policy and are found to be receiving multiples of the same types of medications from different physicians will be terminated from the practice immediately. Exceptions to this policy will be made on a case to case basis by the Physician and/or Nurse Practitioner only.

____

Signature **Date**

____

Printed Name

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COMMUNITY MEDICAL GROUP

Authorization to Disclose Health Information

I, __________________________, grant permission for the following person(s) to obtain information regarding medical care, speak with the provider, and/or staff and pick up any information regarding the patient listed above.

Name	**Relationship**

______________________________ ____________________
Patient or Responsible Party Signature **Date**

______________________________ ____________________
Patient or Responsible Party Name **Relationship to Patient**

Consent Form

FINANCIAL AGREEMENT: I understand that I am responsible for deductibles, co-pays, non-covered services, coinsurance, and items considered "not medically necessary" by my insurance company. I agree to pay co-payments and coinsurances as services are rendered. I understand my insurance is a contract between myself and my insurance company and the University of Maryland Community Medical Group Inc. (herein UMCMG Inc.) will bill my insurance as a courtesy to me. The remaining balance will be taken care of within 30 days of notice from the insurance company. Although my insurance company may estimate what they may pay, it is the insurance company that makes the final determination. I agree to pay any portion of the charges not covered by insurance. If a referral and/or preauthorization is required by my insurance company, I will assist UMCMG Inc. in obtaining the referral and/or preauthorization. If payment can not be made at each visit I will notify the front-desk staff to make other arrangements. I understand that I am ultimately responsible for any balance on my account. I certify that the information provided to UMCMG Inc. is accurate and up-to-date. Current insurance information must be on file at each visit for claims to be submitted appropriately. If new insurance information is provided after services are rendered I may be responsible for the account balance. If all attempts to collect reasonable amounts due fail and this account has been referred to a collection agency for action, I agree to pay all costs associated with the process allowed by law.
ASSIGNMENT OF BENEFITS: I hereby assign UMCMG Inc. such benefits to which are entitled under my insurance plan(s).
RELEASE OF INFORMATION: I hereby allow UMCMG Inc. to furnish any information pertaining to my medical treatment to my insurance carrier, worker's compensation representative, attorney, or other providers of service as necessary to obtain payment for services and provide additional care.
CONSENT FOR TREATMENT: I hereby allow UMCMG Inc. to examine, treat, and perform diagnostic tests and office procedures that the physician deems necessary.
PRIVACY PRACTICES: UMCMG Inc. is required by law to maintain the privacy of a patient's protected health information. In addition, we are required by law to provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. You must notify us in writing of any restrictions on the release of your protected health information. I have read and agree to the above. My signature below indicates that I have also received a copy of the UMCMG Inc. Notice of Privacy Practices and I have indicated any restrictions of my protected health information. Scanned signatures suffice as originals.
APPOINTMENT REMINDERS: If any telephone contact information I have provided is a mobile phone number, I hereby expressly consent to the placing of auto-dialed or prerecorded health care related calls to such number(s).
The undersigned certifies that he/she has read the foregoing and is the patient or the parent or guardian of the patient or is duly authorized as patient's agent to execute the above and accept its terms. By signing below, I represent that the information given by me to UMCMG Inc. is accurate to the best of my knowledge.

______________________________	____________________
Patient or Responsible Party Signature	**Date**
Patient / Responsible Party Name	**Relationship to Patient**
Witness Signature	**Witness Name**

REVISED 11/02/16

UNIVERSITY *of* MARYLAND COMMUNITY MEDICAL GROUP

301 Hospital Drive, Suite 803
Glen Burnie, MD 21061
Phone 410-553-8160 Fax 410-553-8159

DIRECTIONS

PARKING:
Free parking is available at the visitors garage. There is also free valet parking at the main entrance of the Hospital.

From Baltimore:
Take 95 South to Baltimore Beltway 695 to exit 4-Route 97 South to Route 100 East toward Gibson Island. Take Exit 15 (Oakwood Road), take Right off exit and immediate right onto Hospital Drive. The Hospital is on the left.

From Washington D.C.
Take 95 North to exit 43, Route 100 East, Take exit 15 (Oakwood Road). At bottom of exit, turn right and a quick right on to Hospital Drive. The Hospital is on the left.

From Columbia
Take 95 North, 295 North or 29 North to Route 100 east to Exit 15 (Oakwood Road) quick right at bottom of exit and quick right onto Hospital Drive. The Hospital is on the left.

From BWI Airport:
Leaving the airport, via Elm Street turn right at the light onto Aviation Blvd. Take to Dorsey Rd. Turn left at the traffic light for entrance ramp onto 97 South right lane and follow signs to Route 100 East. Take Route 100 East to Exit 15 (Oakwood Road), right onto Oakwood and immediate right onto Hospital Drive. The Hospital is on the left.

From Annapolis/Eastern Shore
Take Route 50 West until Route 97 North to Baltimore. Follow Route 97 to the New Cut Road Exit (Exit 12). At the traffic light turn right onto Crain Highway and continue until Hospital Drive. Make a Right onto Hospital Drive. The Hospital is on the right.

From Points North:
Take 95 South to 895 South toward Annapolis. Keep right to take I-895 Spur South Via exit 6 toward 97 South Annapolis/Bay Bridge. Take the MD-2 South Exit toward Glen Burnie. Merge onto I-97 South. Take Route 100 East via Exit 14A on the Left toward Gibson Island. Take Exit 15 (Oakwood Road) Right onto Oakwood and an immediate right onto Hospital Drive. The Hospital is on the left.