UNIVERSITY of MARYLAND
COMMUNITY MEDICAL GROUP

301 Hospital Drive, Suite 801
Glen Bunie, MD 21061
Phone: 410-553-8170 Fax: 410-553-8171

NEW PATIENT INFORMATION LETTER

Dear Patients:

We are pleased to welcome you to University Of Maryland Community Medical Group Orthopaedics, office of Dr. John Barry, Dr. Leo Courtney, Dr. Hal Crane, Jenna Berninger, PA-C, and Amanda Dombrowski, PA-C.

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 is 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 30 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,

Dr. John Barry
Dr. Leo Courtney
Dr. Hal Crane
Jenna Berninger, PA-C
Amanda Dombrowski, PA-C

REVISED 5/3/2016

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

_____ 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.
- The following applies to Workman's Compensation patients ONLY. You are responsible for obtaining any authorizations for your initial appointment (**Dr. Barry**)
- **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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Patient Billing and Demographic Sheet

Name: _____ SS#: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip _____

Home Phone: _____ Alternate Phone (Cell) _____ Email: _____

Sex: M/F 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 _____

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

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: _____ Claim# _____

Date of Injury or Accident: _____

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

If Minor Parents Name: _____ SS: _____ DOB _____

*****Signature:** _____ **Date:** _____

REVISED 5/3/2016

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Patient History & Data Base Form

Name: _____ Age: _____ Date: _____

Height_____ Weight: _____lbs.

Occupation: _____ Referred by: _____

Description of job duties: _____

Exercise you participate in regularly: _____

HISTORY OF PRESENT PROBLEM

Symptoms/Presenting Problem: _____

Date of Injury: _____ Problem first started about: _____

This occurred at: work ___ home ____ motor vehicle accident____ 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 ____ numbness____ tingling_____

Other type of pain describe: _____

Is WORSE by: moving ____ lifting _____ twisting ____ walking _____ running _____ when resting _____

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

Treatments you have had:

_____ None____

Date stopped working _____ I'm still working ___

PAST HEALTH HISTORY

Check all that apply:

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

___ Diabetes: If yes, What is your most recent Hba1c? _____ Do you check your BG daily? ____ What is your usual reading? ____

Do you have numbness/tingling in your toes? ____ Other diabetic issues? _____

___ Cancer of: _____

Please continue to next page

Other Medical Problems or details about past health history: _____

_____

_____

Please list any surgeries you have had, with approximate dates:

Surgery	Date	Surgery	Date

Have you ever had a surgical complication? If yes, please explain: _____

HABITS

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

Alcohol use: No ___ Yes ___ Number of drinks/week: _____ Quit _____

Substance abuse: No ___ Yes ___ Elaborate: _____ Quit _____

Exercise – Please list any forms of exercise, in which you regularly engage, and indicate frequency: _____

_____

CURRENT MEDICATION

Please list any medication you currently take on a regular basis: _____

_____

_____

_____

_____

_____

_____

_____

Any allergies to any medications:

No _____ Yes (list med and reactions)

_____

PHARMACY:

NAME: _____ PHONE: _____ FAX: _____

ADDRESS: _____

_____ _____

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

REVISED 5/3/2016

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 ☑ any positives

General: ___Recent Weight Loss/ Gain ___Weakness ___ Fever ___Fatigue ___Fever, chills or night sweats

Skin: ___Rashes __Lumps ___Itching

HEENT: ___Headaches ___Vision Changes ___Difficulty hearing ___Frequent Colds

Neck: ___Swollen Glands ___Stiffness

Respiratory: ___Cough ___Shortness of Breath ___History of Asthma ___Bronchitis
___Tuberculosis ___Emphysema

Cardio: ___High Blood Pressure ___Chest Pain ___Palpitations

GI: ___Constipation ___Heartburn ___Hepatitis ___Irritable Bowel Disease ___Incontinence

Vascular: ___Varicose Veins ___History of leg clots/vacuities ____Cramping in legs at night or while walking

Urinary: ___Incontinence ___BPH (enlarged prostate) ___Hesitancy ___Frequency ___Painful

Musculoskeletal: ___Muscle pain ___ Joint pain ___Stiffness ___Difficulty walking

Psychiatric: ___Nervousness ___Depression ___Memory Changes

Hematologic: ___Anemia ___Easy Bruising or Bleeding ___History of a reaction from transfusion

Endocrine: ___Thyroid trouble ___Frequent Urination ___Excessive Thirst

Neurologic: ___Headaches ___Dizziness ___Fainting ___Seizures ___Weakness ___Paralysis
___Loss of Sensation ___Tingling or "pins and needles" ___Tremors or other involuntary movements

_____ _____

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

REVISED 5/3/2016

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Consent Administrative UMCMG

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**

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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 / Responsible Party Name Relationship to Patient

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DIRECTIONS

Parking: Parking is available on the side of the Hospital in the parking garage (behind the Tate Center) that is attached to the building (free parking). There is also free valet parking at the main entrance.

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 righ 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 Johns Hopkins

Out of the Johns Hopkins Outpatient garage make a left on to North Caroline Street. Make a right onto Orleans Street. Orleans Street turns into Franklin Street @ St. Paul. Stay straight to Green Street and make a left turn. This turns into 295-S. Take exit for Route 100 east towards Glen Burnie. Follow Route 100 to Exit 15 (Oakwood Road). Make a right onto Oakwood and an immediate right onto Hospital Drive. The Hospital is on the left.

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.

OFFICE USE ONLY	BALTIMORE WASHINGTON HEALTH SERVICES Subject: Prescribing of Medication Policy - Dr. Hal Crane	Policy Number: [X] New October 5,2015 [ ] Revised [ ] Reviewed	
	Originator: Manager of Out Patient Surgical Practices	Effective Date	October 2015
		Next Review Date	October 2016
COO: _____	Date:	Page	1
		Supersedes	

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 **14 days** following the patient's surgery.
2. At your first Post-Operative appointment additional medications will be provided as needed. We will provide these medications for up to 90 day from the date of your surgery. If additional medication is needed after the 90 period is up, you will be asked to obtain them from another provider such as Pain Management or your PCP.
3. Please allow 48 hours for all medication refills. **PLEASE DO NOT WAIT UNTIL FRIDAY TO CONTACT US FOR MEDICATION REFILLS AS MOST CANNOT BE CALLED INTO YOUR PHARMACY .**

B. Pre-Operative Prescription Management:

1. All patients scheduled to have surgery within 14 days of their appointment with the physician 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 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 only.

_____

Signature Date

_____

Printed Name

	BALTIMORE WASHINGTON HEALTH SERVICES Subject: Prescribing of Medication Policy	Policy Number: [ ] New [X] Revised May 2013 [X] Reviewed January 2013	
	Originator: Manager of Out Patient Surgical Practices	Effective Date	May 2013
		Next Review Date	May 2014
COO: _____	Date:	Page	1
		Supersedes	

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.
4. Please allow 48 hours for all medication refills. Medications will not be filled after 4:30pm Monday-Friday or on Saturdays or Sundays. **PLEASE DO NOT WAIT UNTIL FRIDAY TO CONTACT US FOR MEDICATION REFILLS .**

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