ACCESS carroll
INTEGRATED HEALTH CARE

Access Carroll, Inc
10 Distillery Drive, Suite 200
Westminster, MD 21157
410-871-1478
Fax 410-871-3219

OFFICE USE ONLY
Today's Date:

Keyed By:

Access Carroll, Inc. Patient Data Sheet, Part I

Name: Last : First: MI:		**Date of Initial Visit:**	
Address: Apt#:	**City:**	**Zip Code:**	
Home Phone: ( )	**Date of Birth:**	**Age:**	**Sex:** M F
Social Security #:	**Marital Status (circle):** Single Married Divorced Separated Widowed		
Income Source (circle all that apply): Soc Sec Disability SSI VA Benefits ADC Unemployment Employment Other:	**Student Status:** Full time Student Part time Student Non Student	**Are you Hispanic/Latino?** Y N **Race** (select all that apply, one or more if multiracial) 1. American Indian or Alaska Native 2. Asian 3. Black or African American 4. Native Hawaiian/Pacific Islander 5. White	

Employment Status (circle): Full time Part time Seasonal Temp Agency Retired None

If Employed, Employer Name:	**Supervisor:**
Employment Address:	
Work Phone:	**Hourly Wage:**

Insurance (circle Y,N,P on each line: Y = Yes, N = No, P = Pending, clarify for each)

Commercial	Y	N	P
Medicare	Y	N	P
Medicaid	Y	N	P
Veterans	Y	N	P

If Medicaid spend down, how much?

Please indicate Yes or No for the Following:

Yes	No		Yes	No	
		I am over 65 years of age			I am under 19 years of age
		I am blind			I have children under 21 yr residing with me
		I am disabled			I potentially have 12 months of disability
		I have an injury caused by my employment			I am applying for Disability
		I am applying for Workers Compensation			I am pregnant, if Yes, Due Date:
		I am a US Military Veteran			I am homeless

Transportation Problem Frequency (circle): Always Frequently Sometimes Rarely Never

Primary Language (circle): English Spanish Other If Other please specify:

Emergency Contact Person:	**Phone:**	**Relationship:**

How did you hear about Access Carroll, Inc?

Patient or Guardian Signature: _____ **Date:**_____

Screener Signature: _____ **Date:**_____

Consent for Services

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10 Distillery Drive • Suite 200 • Westminster, MD 21157

Consent for Integrated Services:
I consent to receiving integrated health care services from Access Carroll, Inc. I understand integrated health services may include medical, dental, behavioral health and substance abuse recovery care within a network of service providers. I understand professional health care students may participate in my care.

I understand Access Carroll, Inc. is open for scheduled appointments Monday through Friday, and can accommodate urgent walk in situations only as able. I understand if I have a life-threatening emergency, I must seek care through a hospital emergency department or other health care provider.

Consent to Share Medical Records:
I understand Access Carroll, Inc. is a strategic partnership of local network providers including the Carroll County Health Department, Carroll Hospital, and Carroll Health Group. I understand that to better coordinate my health care services, my health information will be a part of this shared network of providers that includes an electronic health record as further explained on the Health Information Portability and Accountability Act (HIPAA) acknowledgment.

I understand Access Carroll is a participant of the Chesapeake Regional Information System for our Patients (CRISP), a statewide health information exchange. As permitted by law, I understand my health information will be shared through the CRISP exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. I understand I may "opt out" and disable access to my health information through CRISP by calling 1-877-952-7477 or by completing and submitting an Opt-Out form to CRISP by mail, fax, or through their website at www.crisphealth.org. I further understand public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

Consent for Medical Insurance Authorization and Assignment:
I understand all charges are due at the time services are provided. I authorize Access Carroll, Inc. and all integrated entities to provide information to my insurance carriers concerning my illness and treatments. I authorize payment of medical benefits from my insurance carriers for services rendered to Access Carroll, Inc. I understand I am responsible for any amount not covered by insurance, including co-pays and fees. I understand I may be eligible for financial assistance through a sliding fee scale and must provide all necessary eligibility documents in order to determine eligibility.

Patient Responsibilities:

- I understand my health is my responsibility.
- I will inform Access Carroll, Inc. if I change my address or telephone number. If I decide not to return to Access Carroll, Inc., I will seek care from another care provider.

I understand it is my responsibility to notify the clinic when I will not be able to keep a scheduled appointment, **at least 24 hours in advance**. If I fail to give adequate notice, it will be considered a failed appointment. I realize after three such failed appointments, I may not be allowed to return to the clinic for a period of no less than one year from the last failed date.

- I voluntarily agree to have Access Carroll, Inc. integrated health care services. I understand I may withdraw this consent at any time by request in writing.

This Consent for Services is valid for **one year** from the signature date.

Date: _____ Client Signature: _____

I have reviewed the above information with the client.

Date: _____ Staff Signature: _____

2005-03-21; revised 2008-03-26, revised 2013-07-24, revised 2016-11-30 TB

Access Carroll, Inc.
Notice of Privacy Practices

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Understanding Your Health Record and Health Information

Access Carroll, Inc. is committed to protecting your health information. Each time you visit a health care provider, a record of your visit is made. This information is often referred to as your health or medical record. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. Your health record is a legal document and may be used for a variety of purposes including planning your care and treatment, communicating to other health professionals who contribute to your care, providing data for medical research, and educating other health professionals. Access Carroll, Inc. will follow the policies described in this notice, though we reserve the right to change our privacy practices and the terms of this notice at any time.

How Access Carroll, Inc. Uses and Discloses Your Protected Health Information

Access Carroll, Inc. will only use your health information when doing their jobs. Your information will be entered into an Electronic Health Record. Only staff working directly with you or that have administrative responsibilities will have access to those records. No information will be released to any other agency without your written consent. For uses beyond what Access Carroll, Inc. normally does we must have your written authorization unless the law permits or requires it. The following are permitted disclosures for treatment, payment, and health care operations that do not require patient authorization.

- Treatment: Access Carroll, Inc. may use or share your health information to approve, deny treatment and to determine if your medical treatment is appropriate, including health services provided by network providers of the Carroll County Health Department, Carroll Hospital, and Carroll Health Group. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- Health Care Operations: Access Carroll, Inc. may use and share your records to evaluate the quality of services provided, or to local, state or federal auditors as required.
- Payment: Access Carroll will use your health information for payment. A bill may be sent to you or a third-party payer. Presenting insurance information at the time of service provides us with the authorization to release personal information to your insurance carrier. This includes, but is not limited to, social security number, full name, and date of birth, as well as the diagnosis pertaining to the service provided.
- Appointment Reminder Calls: We may contact you to remind you of your appointment for treatment or medical care. We will ask you to sign in when you come for care so we can prepare for your visit and call you when your caregiver is ready to see you.
- Health Care Oversight and Quality Assurance and Peer Reviews: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, inspections, investigations, and licensure requirements. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- Family and Friends Involved in Your Care: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. During a disaster, we may share information with a disaster relief organization so that your family can be notified of your condition, status, and location.
- Patient Satisfaction Surveys: Access Carroll, Inc. conducts patient satisfaction surveys to ensure we are providing the best possible care for you and our community.
- Food and Drug Administration (FDA): As required by law, Access Carroll, Inc. may disclose health information concerning adverse events with the respect to food, supplements, product defects or post-marketing surveillance information.
- Public Health Activities: Access Carroll, Inc. may disclose health information when Access Carroll, Inc. is required to collect or report information disease or injury, or to report vital statistics to public health authorities.
- Coroners, Medical Examiners, Funeral Directors and Organ Procurement Programs: Access Carroll, Inc. may disclose health information relating to a death to coroners, medical examiners or funeral directors, and to authorized organ procurement programs.
- Research Purposes: In certain circumstances Access Carroll, Inc. may disclose health information to assist medical research.
- Avert Threat to Health or Safety: In order to avoid a serious threat to health or safety, Access Carroll, Inc. may disclose health information as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

- Abuse and Neglect: Access Carroll, Inc. will disclose your health information to appropriate authorities if we reasonably believe you are a possible victim of abuse, neglect, domestic violence, or some other crime. Access Carroll, Inc. may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- Specific Government Functions: Access Carroll, Inc. may disclose health information of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government benefit programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.
- Worker's Compensation: Access Carroll, Inc. may disclose health information to worker's compensation programs providing benefits for work-related injuries or illnesses without regard to fault.
- Patient Directories: You will not be identified to an unknown caller or visitor without authorization.
- Lawsuits, Disputes and Claims: If you are involved in a lawsuit, a dispute, or a claim, Access Carroll, Inc. may disclose your health information in response to a court or administrative order, subpoena, discovery request, investigation of a claim filed on your behalf, or other lawful process.
- Law Enforcement: Access Carroll, Inc. may disclose your health information to a law enforcement official for purposes required by law or in response to a subpoena.
- Homeless Database: If you are at risk for or are identified as homeless, Access Carroll, Inc. will provide limited demographic information into a county database, Community Service Point, as required by the US Department of Housing and Urban Development (HUD) for the purposes of coordinating emergency and housing services.

Your Health Information Rights

Although your health record is the physical property of the health care provider and facility that compiled it, the information belongs to you.

- Request Restrictions: You have a right to request a restriction or limitation on the health information Access Carroll, Inc. uses or discloses about you. Access Carroll, Inc. will accommodate your request if possible, but is not legally required to agree to the requested restriction. If Access Carroll, Inc. agrees to a restriction, Access Carroll, Inc. will follow it except in emergency situations.
- Request Confidential Communications: You have the right to ask Access Carroll, Inc. to send you information at an alternative address or by alternative means. Access Carroll, Inc. must agree to your request as long as it is reasonably easy for us to do so.
- Inspect and Copy: You have the right to see your health information upon your written request. If you want copies of your health information, you may be charged a fee for copying, depending on your circumstances. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.
- Request Amendment: You may request in writing that Access Carroll, Inc. correct or add to your health record. Access Carroll, Inc. may deny the request if Access Carroll, Inc. determines the health information is: (1) correct and complete; (2) not created by us and/or not part of our records; (3) not permitted to be disclosed. If Access Carroll, Inc. approves the request for amendment, Access Carroll, Inc. will change the health information and inform you and tell others needing to know about the change in the health information.
- Accounting of Disclosures: You have the right to obtain a list of the disclosures made of your information; however, we are not required to agree to a requested restriction.
- Notice: You have the right to receive a paper copy of this notice and/or an electronic copy by e-mail upon request.

_____ _____

Patient or Authorized Representative Date

If unable to get acknowledgement, specify why:

_____

Signature of Access Carroll, Inc. Representative

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Discount Application Form

Fee Determination Data Sheet

Date of Intake_____ Renewal Date_____ Renewal Date _____

Patient Name _____

Name of wage earners in household _____

Billing Address _____

City _____ State _____ Zip Code _____

Phone Numbers: Cell _____ Other: _____

Place of employment _____

Driver's License No._____ SS# _____

Occupation/Trade _____ No. of Family Members _____

Combined Annual Income _____ Age _____ Race _____ Sex _____

Documents provided by patient to prove income _____

_____

The Financial Counselor has explained to me my financial responsibility. My percentage of discount from Access Carroll's full fee is ____ % based on my current income and family size. My one year period of eligibility starts on _____. I will need to be re-determined for this program on my anniversary date which is_____. I understand I must bring in more current documentation at the point of my annual anniversary.

I understand that the fee on Access Carroll's Laboratory fee schedule has already been discounted by Access Carroll's reference Lab and will not be discounted any further. Lab fees will be paid in full by me before lab specimens are drawn.

Patient / Guardian Signature _____ Date: _____

Financial Counselor Signature _____ Date: _____

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Phone: 410-871-1478 FAX: 410-871-3219

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: _____ **Birth Date:** _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

   _____
   _____
   _____
   (please include full name of physician or organization, address, phone, and FAX number)

3. The type and amount of information to be used or disclosed is as follows :
   Dates of specific services: _____

   - ☐ History and Physical
   - ☐ Progress Notes
   - ☐ Laboratory and Pathology Reports
   - ☐ Radiology Reports
   - ☐ Consultation Reports
   - ☐ Psychiatric Reports
   - ☐ All Records
   - ☐ Face Sheet
   - ☐ Emergency Department Record
   - ☐ Operative Report
   - ☐ Problem List
   - ☐ Medication List
   - ☐ Most Recent Discharge
   - ☐ Other _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or humanimmunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.
5. This information may be disclosed to and used by the following organization for continuity of healthcare:

   ACCESS CARROLL, INC.
   10 DISTILLERY DRIVE, SUITE 200
   WESTMINSTER, MD 21157
   Phone: 410-871-1478
   FAX: 410-871-3219

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization previously given permission to disclose my records (named above in item 2). This authorization will expire in three months.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential or an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

NOTE to Recipient of Information: This information has been disclosed to you from records whose confidentiality is protected by Federal and State law. Federal and State regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. Anyone who receives information covered by these regulations, whether obtained legally or not, is prohibited from using that information for any criminal or civil investigation, or prosecution of the patient. (Federal Regulation 42CFR part 2: N.J.S.A. 26:5C–11) (N.J.A.C. 10:37-6.79 (a) 3).

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DENTAL HEALTH HISTORY

Date: _____

Patient Name:_____ Age:_____ Date of Birth:_____

Social Security Number:_____ Circle one: Male or Female

Home phone number:_____ Cell phone number:_____

Address:_____ City_____ State_____ Zip Code: _____

Primary Care Physician:_____ City/State:_____ Physician Phone:_____

Allergies (Patient):

Are you allergic to Latex: YES or NO

Are you allergic to any medications: YES or NO If yes, please list all medications: _____

Medical History (Patient) Please check if you have had or currently have any of the following

- ☐ Asthma
- ☐ Angina
- ☐ Anemia
- ☐ Blood Disorder
- ☐ Hemophilia
- ☐ Heart Problems
- ☐ ADD
- ☐ ADHD
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Developmental Problems
- ☐ Breathing Problems
- ☐ COPD
- ☐ Emphysema
- ☐ Diabetes
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Easy Bruising or Bleeding
- ☐ Clotting Disorders
- ☐ Epilepsy/Seizures
- ☐ Arthritis
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Sexually Transmitted Diseases
- ☐ HIV
- ☐ AIDS
- ☐ Kidney Disorder
- ☐ Dialysis
- ☐ Liver Problems
- ☐ Hepatitis, Please circle: A B C
- ☐ Stomach/Bowel Problems
- ☐ Glaucoma
- ☐ Spina Bifida
- ☐ Stroke
- ☐ Fainting Spells
- ☐ Joint Replacement
- ☐ Vascular Disease
- ☐ History of Substance Abuse
- ☐ History of Alcohol Abuse
- ☐ Consume 3 or more Alcoholic Drinks Per Day

If you answered yes to any of the above questions please explain:

_____

_____

Have you been hospitalized in the past five years? Circle one: YES or NO **If yes, please give date(s) and reason(s) for hospitalization:**_____

_____

Family Medical History: Please check if yes for immediate family members (i.e. siblings, parents, grandparents)

- ☐ Diabetes
- ☐ Cancer
- ☐ Anemia/Blood Disorder
- ☐ Clotting Disorders
- ☐ Stroke
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Tuberculosis
- ☐ Vascular Disease
- ☐ Heart Problems
- ☐ Kidney Disorder/Dialysis
- ☐ Bleeding Disorder/ Hemophilia

If you answer yes to the following, please list how often:

Do you (patient) use/smoke/chew tobacco? Yes No How often? _____

Do you regularly use alcohol? Yes No How many per Day? _____

Do you or have you ever used street drugs? Yes No How often? _____

Are you currently in a Substance Abuse Treatment Program? Yes No If Yes, which one? _____

Do you want help with current Substance or Alcohol Abuse? Yes No If Yes, which one?_____

LIST MEDICATIONS YOU (PATIENT) CURRENTLY TAKE: (include "as needed" and over-the-counter)

Name of Medication, Dose, Times per Day	Name of Medication, Dose, Times per Day

If you are taking any blood thinners, Aspirin, Plavix, or Coumadin or others, you must contact your doctor to see whether or not you must discontinue the product before dental surgery and when you can restart taking the drug.

DENTAL HISTORY

Why are you here today? _____

Do you have any previous dental records? _____ Date of last visit to the dentist: _____

Reason for last dental visit:_____

Please answer the following questions:

Do any of your teeth hurt?	__ Yes __ No
Are your teeth sensitive to hot, cold, sweets, or pressure?	__ Yes __ No
Are any of your teeth loose?	__ Yes __ No
Are there any sores or growths in your mouth?	__ Yes __ No
Are you wearing a removable dental appliance (dentures/retainer)?	__ Yes __ No
Have you ever had orthodontic treatment (braces/ retainer)?	__ Yes __ No
Have you ever had a problem after extraction (bleeding/dry socket)?	__ Yes __ No
Have you ever had abnormal bleeding?	__ Yes __ No
Have you ever had an allergic/adverse reaction to dental treatment?	__ Yes __ No
Have you ever fainted in the dental office?	__ Yes __ No
Have you ever had to take an antibiotic prior to dental treatment?	__ Yes __ No
Do you have pain and/or clicking in the jaw joint around your ear?	__ Yes __ No
Do your gums bleed?	__ Yes __ No
Do you grind your teeth or clench your jaws?	__ Yes __ No
Do you have any other dental complaints?	__ Yes __No

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or a change in medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I CONSENT to services provided by a supervised SENIOR DENTAL STUDENT in Access Carroll Dental:

Patient/ Guardian Signature: _____ Date: _____

Emergency Contact: _____ Phone Number: _____

Provider Signature: _____