



10 Distillery Drive • Suite 200 • Westminster, MD 21157
Phone: 410-871-1478 Fax: 410-871-3219

OFFICE USE ONLY

Today's Date:

Keyed By:

Patient Data Sheet

Printed Name: Last: _____ First: _____ MI: _____			Date of Initial Visit: _____		
Address: Apt#: _____		City: _____		Zip Code: _____	
Phone: ☐ Home ☐ Mobile		Date of Birth: _____		Age: _____	Assigned Birth Sex: Male _____ Female _____
Email: _____			Pronouns: He/Him _____ She/Her _____ They/Them _____		
Sexual Orientation: Heterosexual _____ Homosexual _____ Bisexual _____ Other: _____		Gender Identify: Male _____ Female _____ Transgender _____ Other: _____			
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? Yes _____ No _____ 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 _____ 6. Other: _____	
Employment Status (circle): Full time _____ Part time _____ Seasonal _____ Temp Agency _____ Retired _____ None _____					
If Employed, Employer Name: _____			Work Phone: _____		
Insurance (circle) Commercial Yes _____ No _____ Pending _____ Medicare Yes _____ No _____ Pending _____ Medicaid Yes _____ No _____ Pending _____ Veterans Yes _____ No _____ Pending _____				Additional Insurance Information: 	
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/have served in the Military			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: How did you hear about Access Carroll, Inc? _____			Phone: _____		Relationship: _____

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

CONSENT FOR INTEGRATED SERVICES



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 (mental 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 daily, 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 LifeBridge, 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 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.

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 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

Grievance Procedures:

If you feel at any time that you are being treated unfairly as a client of the program, or if you do not agree with termination procedures or if you have any other complaints of any kind, please bring the matter to the attention of the Business Operations Manager at Access Carroll (410-871-1478).

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

Date Patient/Client Signature PRINTED Patient/Client Name

I have reviewed the above information with the client.

Signature of Witness Date

Access Carroll, Inc.

Notice of Privacy Practices



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.
- 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.

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 Witness

Date

SLIDING FEE DISCOUNT APPLICATION

It is the policy of Access Carroll to provide essential health services regardless of the patient's ability to pay at the time of service. We offer a Sliding Fee Discount to patients who have household incomes at or below 200% of the Federal Poverty Level, with the sliding fee discount fee based on household size and household income. The discount level will apply to all services received at this facility by Access Carroll, but not those services or equipment purchased from outside entities, including reference laboratory testing, medications, radiology services, and specialty care services. Please completely fill out both sides of this application, sign the form and return with proof of eligibility documents.

Please note that the information provided on this application is valid for up to one year.

Patients are responsible for completing a new application annually, prior to the expiration of their current application.

Applicant Full Name Printed: _____

Applicant Date of Birth: _____ Patient Identification Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone Number: _____ Email: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Please list all household members and applicable incomes, as defined on
Access Carroll FORM: Proof of Eligibility Documents List & How to Report Your Household Size & Income.

Full Names of Household Members	Relationship to Applicant	Birthdate	Yearly Income
	SELF		
Total Household Size: _____		Total Household Income: _____	

Insurance Coverage: ☐ Uninsured ☐ Medicaid ☐ Medicare ☐ Other: _____

(You will not have to pay both the insurance co-pay and the sliding fee scale. You will pay whichever amount is less.)

BE SURE TO COMPLETE BOTH SIDES OF THE FORM

Proof of Income (POI) is required from everyone in the household who is 18 or older AND is the patient's dependent. Only your first visit will receive a discount based on verbal claims or partial information. All following appointments will be charged the 100% FULL FEE rate until discount eligibility is verified with proof of income documents (see **Proof of Eligibility Documents List**).

The Access Carroll Staff Member has explained to me my financial responsibility. I understand I must provide necessary documentation to continue to receive discounted services at Access Carroll.

_____ By initialing I confirm that my household proof of income was provided to Access Carroll today

OR

_____ By initialing I confirm that my household proof of income is not required because I have Medicaid coverage

OR

_____ By initialing I confirm that no household proof of income was provided to Access Carroll today. My TEMPORARY Good Faith Estimate (GFE) is only good for my initial visit. Future appointments will be charged 100% FULL FEE until my proof of income documents are provided.

I certify that the information provided on this application is true and complete and may be checked for accuracy. I understand that willful falsification and/or omission of information contained in this application will result in denial of financial assistance.

I understand that the Sliding Fee Discount level determination will be applied to all members of the household for all service lines at Access Carroll until the expiration of my current Good Faith Estimate (GFE).

I understand that I am responsible for completing a new application annually, prior to the expiration of my current application, as noted on my Good Faith Estimate (GFE).

Signature of Applicant: _____ Date: _____

DO NOT WRITE BELOW - THIS SECTION COMPLETED BY STAFF

☐ Patient instructed to bring in any required POI/eligibility documents at next appointment or 100% full fee will be charged until received. Notes: _____

☐ Proof of Income (POI) Documents Received Eligibility Documents Verified: ☐ Yes ☐ No

Received by Staff Name: _____ Initial Application Date: _____

NOTE: Upon receipt, POI verification and GFE level determination will be noted on GFE level form. A copy of the GFE form will be given to the applicant and uploaded into their EHR and will serve as their Sliding Discount Level for a period not to exceed 12 months.

PROOF OF ELIGIBILITY DOCUMENTS LIST

INCOME:

- Tax Return (most recently filed) – this is usually Form 1040 (This is not needed from patient/clients that are on Medical Assistance)
- Pay Stubs – The most recent 1-month worth of pay stubs (four weekly; two biweekly; or one monthly)
- Proof of Income (POI) Employer Letter – When pay stubs cannot be obtained, client/patients can ask their employer for a verification of income letter.
- Tax Statements such as – W-2, 1099
- Social Security Benefit Verification Letter (you can get a benefits letter by logging into [mysocialsecurity.gov](https://my.socialsecurity.gov))
- Unemployment Award Notice
- Access Carroll's Verification of No Income (VONI) Form

IDENTITY:

- Driver's license issued by a State or Territory with a photo or other identifying info
- Identification card or official document issued by federal, state or local government with a photo or other identifying info
- Military Dependent's Identification Card
- Casa de Maryland Identification Card
- School Identification Card with a photo
- US Military Card or Draft Record
- US Coast Guard Merchant Mariner Card
- Clinic, doctor, hospital or school record for children under 19
- Finding of identity from a Federal or State governmental agency
- Two documents containing consistent information that corroborates an applicant's identity (e.g. employer identification cards, high school and college diplomas [including high school equivalency diplomas], marriage certificates, divorce decrees and property deeds or titles)

CARROLL COUNTY RESIDENCY:

- Homeowners insurance bill
- Lease
- Mortgage statement
- Property tax bill
- Utility bill
- Maryland Safe at Home Address Confidentiality Program (ACP) Authorization Card or signed copy of Notice of ACP Participation form
- Form DHR/FIA 1130 Verification of Living Arrangements

SOCIAL SECURITY NUMBER (SSN):

- Social Security Card
- Tax form(s)
- Benefit or income statement from Social Security containing your SSN
- Pending application for an SSN
- Letter from Social Security stating that you're not eligible for an SSN or are only eligible for a non-work SSN
- Letter stating that you refuse to obtain an SSN for established religious objections

HOW TO REPORT YOUR HOUSEHOLD SIZE & INCOME

When you apply for health coverage through Access Carroll's Sliding Fee Discount Application, you'll enter information about your household size and income to see if you may qualify for lower costs.

HOUSEHOLD SIZE:

Who to include (even if they are not seeking coverage):

- Yourself
- Your spouse
- Your children who live with you, even if they make enough money to file a tax return themselves
- Your unmarried partner
- Anyone you include on your tax return as a dependent, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

HOUSEHOLD INCOME:

Your household income includes income for:

- You and your spouse
- Any dependents who make enough money to be required to file a tax return, per current IRS guidelines

The income types used to determine your Sliding Fee Scale level includes:

- Income from your job
- Net income from any self-employment
- Unemployment income
- Social Security Benefits (with the exemption of Supplemental Security Income (SSI) which is NOT included as household income)
- Alimony
- Retirement income
- Investment income
- Pension income
- Rental income

The income types not included in household income:

- Gifts
- Supplemental Security Income (SSI)
- Veterans disability payments
- Child support
- Proceeds from loans (like student loans, home equity loans, or bank loans)
- Worker's compensation



10 Distillery Drive * Suite 200 * Westminster, MD 21157
Phone: 410-871-1478 FAX: 410-871-3219

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Printed 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 human immunodeficiency 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 of 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).