CalvertHealth
Medical Group

Plastic & Reconstructive Surgery
New Patient Information

❑Mr. ❑Mrs. ❑Miss ❑Ms. ❑Dr. Today's Date: _____

Patient Name: _____ SSN#: _____

Address: _____

DOB: _____ Age: _____ ❑ Male ❑ Female Marital Status: _____

Home Phone: _____ Referring Doctor/Person: _____

Work Phone: _____ Primary Doctor: _____

Cell Phone: _____ Email Address: _____

Emergency Contact: _____ Relationship to Patient: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient's Employer/School: _____ Occupation: _____

Address: _____

Primary Health Insurance Company: _____

Insured's Name: _____ DOB: _____ Employer: _____

Patient's Relationship to Insured: ❑Self ❑Spouse ❑Child ❑Other: _____

Secondary Health Insurance Company: _____

Insured's Name: _____ DOB: _____ Employer: _____

Patients Relationship to Insured: ❑Self ❑Spouse ❑Child ❑Other: _____

Photography Policy: I hereby authorize the physician and his associates to take pre-operative, intra-operative and post-operative photographs of the area being treated, if needed for use in my treatment. I authorize the photographs to be sent to my health insurance company to approve treatment and/or payment for rendered services as necessary. I understand and agree that my photographs may be shown to future patients in order to illustrate surgical results. If the photographs any distinguishing marks as indicated by me the photographs will not be shown to future patients without my written approval. I authorize the physician and his associates to send the photographs to my primary and other physicians involved in my treatment. I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of the photographs or my interview. I further understand that neither I nor anyone accompanying me, may record, video tape or take any photographs during my visit and/or procedure. I understand I may get a copy of the photographs upon signing a medical release and paying a fee for each copy. I understand photographs will not be loaded to the internet or used in any advertising unless I provide my written approval.

_____ _____ _____
Signature of Patient or Responsible Party Relation to Patient Date

CalvertHealth
Medical Group

New Patient Information

Patient Name: _____ **DOB:** _____

Male ❑ Female ❑ Last Menstrual Period: _____
Reason for visit: _____ Work Related? ❑Yes ❑No Trauma Related? ❑Yes ❑No
Primary Care Provider: _____ Referring Provider: _____
Do you see a cardiologist? ❑No ❑Yes Physician Name: _____ Last Appt: _____
Pharmacy: _____

Permission to release medical records: I hereby authorize CalvertHealth Medical Group to release and receive any medical information required in the course of my examination, evaluation, history taking and treatment. I permit this to be done by mail/fax to any physician, hospital, radiology office, laboratory or any other health care organization involve at any time in my care.

Signature: _____ Date: _____

Medical History: Please circle all that apply

Cardiovascular
- Hypertension
- Chest Pain
- MI/CAD
- Palpitations/Arrhythmia
- Pacemaker/AIDC
- Valvular Disease
- Coronary Stent
- A-Fib
- PVD
- Hyperlipidemia

Pulmonary
- Asthma
- COPD
- Cough
- Shortness of breath
- Sleep Apnea
- Wheezing
- Bronchitis
- C-PAP: ❑Yes ❑No

GI Endocrine
- Hernia
- Reflux
- Hepatitis, Type: _____
- Liver Disease
- Thyroid Disease
- Obesity
- IBS
- Ulcers
- Gastritis
- Diverticulitis
- Diabetes, Type: _____

Neuromuscular
- TIA or Stroke
- Seizures
- Cerebrovascular Disease
- Dementia
- Osteoarthritis
- Rheumatoid Arthritis
- Psychiatric Disorder
- Anxiety
- Depression
- Neuromuscular Disease
- Syncope

Hematologic
- Anemia
- Sickle Cell
- Bleeding Disorder
- Chemotherapy
- HIV/AIDS
- Factor V Liden
- Cancer, Type: _____

GU
- Prostate Problems
- Vasectomy
- Stones
- Urinary Incontinence
- Blood in Urine

Miscellaneous
- Cataracts
- Glaucoma
- Glasses/Contacts

Conditions not listed: _____

Prior Hand/Wrist/Arm Surgery or Trauma: _____

Surgical/Hospitalization History

Surgery	Date	Hospitalization	Date

Have you ever experienced bleeding problems during or after surgery? ❑No ❑Yes: _____
Have you ever experienced problems with anesthesia in the past? ❑No ❑Yes: _____

CalvertHealth
Medical Group

New Patient Information

Patient Name: _____ **DOB:** _____

Family History: **Clotting Disorder:** _____
Anatomic/Body Birth Differences: _____

Mother					
Diabetes	Lung Disease	Heart Disease	Cancer _____		Other _____
Living	Deceased; If so, was it cause of death?		No	Yes	Age of death _____
Father					
Diabetes	Lung Disease	Heart Disease	Cancer _____		Other _____
Living	Deceased; If so, was it cause of death?		No	Yes	Age of death _____
Siblings					
Diabetes	Lung Disease	Heart Disease	Cancer _____		Other _____
Living	Deceased; If so, was it cause of death?		No	Yes	Age of death _____
Grandparents					
Diabetes	Lung Disease	Heart Disease	Cancer _____		Other _____
Living	Deceased; If so, was it cause of death?		No	Yes	Age of death _____

Allergies: Please list any drug, food or contact allergies: _____

Do you see a pain management specialist? ☐ **Yes** ☐ **No**

Current Medications:

Medication Name	Dosage	# Times per day

Do you use non-prescribed drugs? ☐ **No** ☐ **Yes:** _____

Social History:

Marital Status: Single Married Separated Divorced Widowed

Occupation: _____

Do you use tobacco?	No	Yes	Former	Type _____	How much? _____ per day week (circle one)
Do you vape?	No	Yes	If former, age stopped: _____		Years used: _____
Do you drink alcohol?	No	Yes	Type: _____		How much? _____ per day week (circle one)
Do you consume caffeine?	No	Yes	Type: _____		How much? _____ per day week (circle one)

Are you a recovered substance abuser ☐ No ☐ Yes: _____

CalvertHealth™
Medical Group

Patient Financial Policy

Patient Name: _____ DOB: _____

Thank you for choosing CalvertHealth Medical Group (CMHG) as your health care provider. We are committed to building a successful provider-patient relationship with you and your family. Please understand that payment of your bill is part of your care. This Patient Financial Policy is intended to help avoid misunderstandings by detailing your financial obligations.

Insurance: Please confirm your provider is enrolled with your insurance carrier prior to scheduling your visit.
We participate in most insurance plans, including Medicare. If you are not insured by a plan we accept, or if you choose to submit your claim yourself, payment in full is expected at each visit. We will provide you with appropriate documentation so that you can submit a claim to your insurance company.

If we do participate in your plan, but you do not have a **current insurance card** or the **designated primary care provider** is not a CHMG provider, payment is required in full for each visit until we verify coverage. Alternatively, if we do not participate in your insurance plan and you choose to see our providers, or if you do not have insurance and choose to see our providers, you will be considered 'self-pay' subject to the terms defined later in this document.

Proof of Insurance: If you have insurance and we submit claims on your behalf, we require a copy of your driver's license or other government issued photo ID and your current insurance card at each visit. This information must be provided prior to seeing a provider (physician, nurse practitioner or physician assistant).

Claims Submission: Your insurance benefit is a contract between you and your insurance company, and the charges for any services provided are your responsibility. We will submit claims to your insurance (primary and secondary or supplemental) company on your behalf. In order to submit claims, we require the patient's name, address, and date of birth, as well as the policyholder's name, address, and date of birth. This information must match exactly what your insurance company has on file for you, including exact name, address, and policy number. Any missing or incorrect information provided may result in claims being denied or reimbursement being delayed, in which case you may become responsible for the full amount of the services provided.

Coverage Changes: Please notify us before your scheduled appointment if any of your insurance information has changed. This includes changes of employer, insurance provider, address, policy number, covered dependents, etc. Not having up-to-date information may result in claims being denied or delays in reimbursement in which case you will become responsible for the whole amount of the services provided.

Co-Payments: If your insurance company requires co-payments, those co-payments must be paid at the time of service. We collect co-pays during appointment check in.

Deductibles and Out-Of-Pocket Expenses: We will bill you for any outstanding balance once your insurance company has processed your claim and made payment to us. This balance may include your contracted deductible or other out-of-pocket expense as determined by your insurance policy. Payment for outstanding balances is expected within 30 days of the statement date and/or at your next appointment.

Referrals: It is your responsibility to obtain any necessary referrals from your primary care provider prior to receiving treatment. Patients who elect to receive service without a proper referral will be required to sign a waiver and will be expected to pay for the service prior to treatment.

Payment: We accept payment by cash, debit card, check, VISA, MasterCard, Discover, and American Express. All outstanding balances must be paid at time of service unless prior arrangements/payment plans have been set up. As a convenience to our patients, all CHMG practices are able to collect payments for all other CHMG practices.

Returned Check Fee: We charge a $25.00 fee for returned checks. In the event a check has been returned the patient must pay by credit card or cash. If a second check is returned, in addition to the returned check fee, you will be asked to pay by cash, money order, cashiers' check, or credit card for all future visits.

CalvertHealth
Medical Group

Patient Financial Policy

Self-Pay: A Self-Pay patient is any patient who does not have health insurance; chooses to submit their own claims, see a CHMG provider who does not participate in their health insurance plan, receive a service that requires a referral from their insurance company or primary care provider when they do not have the referral with them or receives a treatment, they know is not covered by their insurance company.

Financial Assistance: The Practice has payment plans, financial assistance, and sliding fee scale, to uninsured and others with self-pay balances. Please ask the office assistant for further information.

Non-Payment: If a balance remains unpaid past 90 days your account will be transferred to a collection agency or collection attorney. In the event your accounts remain in delinquent standing with the collection agency, you may be terminated from the medical group.

Minor Patients: Any adult (parent or guardian) accompanying a minor child to their appointment is responsible for payment for all services rendered to the minor child at the time of the appointment.

Physicals: Department of Transportation (DOT), 500, sports, camp and work physicals are not usually covered by any insurance companies. Payment for these services are expected at the time of service.

Personal Injury Claims: CHMG will bill the current health insurance for treatment covered by the insurance company. All applicable co-pays will be collected at time of service.

Account Consultation: Providers (physicians, nurse practitioners, physician assistants) are not trained to discuss financial issues with patients. Only CHMGs billing staff is trained to discuss your account, including charges, fees, payments, and payment arrangements. If you have questions about any of the financial issues related to your account, please contact the **billing office at 410-414-4555**.

Worker's Compensation: Prior authorization is required from your employer before service can be provided. We require the following information for each claim submitted on each date of service: state where injury occurred (i.e., Maryland); date of injury; exact location on the body where the injury occurred and that is covered by the claim. If the claim is denied and you do not have health insurance, the charges will become your responsibility.

CHMG Billing Contact Information:

Physical Address
CHMG Billing Office
Prince Frederick, MD 20678
Billing Phone Number: 410-414-4555

Mailing Address
CalvertHealth Medical Group
P.O. Box 11759
Newark, NJ 07101-4759

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our financial and payment policy.

My signature below certifies that I have read, understand, and agree to the terms of this Patient Financial Policy.

Patient Signature: _____ Today's Date: _____

Patient Name: _____ DOB: _____

AMB.FINPOL

CalvertHealth™
Medical Group

Consent to Care and Treatment

Patient Name: _____ DOB: _____

As a patient, you have the right to be informed about the state of your health and any recommended medical, diagnostic or surgical procedure that will be used in the course of your care at this practice so that you may make informed decisions as to whether or not to undergo any recommended treatment.

If you have been a patient of this practice prior to signing this consent, any medical conditions and/or treatment plans have already been discussed with you and you consent to the ongoing care and treatment that has been defined.

If you are a new patient with this practice, no specific treatment plan has yet been recommended.

This consent form gives us your permission to examine you and perform the evaluations necessary to evaluate your health and identify any conditions that may be affecting it. It also gives us your consent to recommend appropriate treatment for any conditions identified during the course of your care and treatment.

By signing this consent, you are giving us your permission to perform reasonable and necessary medical examinations and testing in order to assess your health and recommend treatment. You authorize this practice, your assigned physician and/or advanced practice clinician (Nurse Practitioner or Physician Assistant), and any employee working under the direction of the physician or other advanced practice clinician, to provide medical care to you. This medical care may include services and supplies related to your health and may include but not limited to preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment, or review of physical or mental status/function of the body and the prescribing of drugs, devices, equipment, or other items required to diagnose and treat a medical condition. This consent includes contact and discussion with other health care professionals who may be consulted regarding your care and treatment.

You are also indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain fully effective until it is revoked in writing.

You have the right at any time to discontinue services. You have the right to discuss the purpose, potential risks and benefits of any test ordered for you in the course of your treatment plan with your physician or health care provider. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

If additional testing, invasive or interventional procedures are recommended, you will be asked to read and sign additional consent forms specific to the test(s) or procedure(s) to be performed.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____	_____
Patient Signature (or Guardian if signing for another person)	Date
_____	_____
Name of Guardian	Relationship to Patient
_____	_____
Witness	Witness Name (please print)

CalvertHealth™
Medical Group

No-Show and Late Cancellation/Reschedule Policy

Patient Name: _____ DOB: _____

Thank you for choosing CHMG as your health care provider. We are committed to building a successful provider-patient relationship with you and your family. We understand there are times when you must miss a scheduled appointment or cannot cancel or reschedule in a timely manner; however, when you do not call to cancel a scheduled appointment at least 24 hours prior to the appointment or miss a scheduled appointment without notice, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise when another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

To help avoid misunderstandings, we are providing you with our No Show and Late Cancellation/Reschedule Policy. For purposes of this policy, a late cancellation is when a patient cancels or reschedules a scheduled appointment but provides less than 24 hours' notice. Late cancellations will be treated as a 'no-show' per CHMG policy.

The following policies will apply to 'no-shows' and late cancellations/reschedules, combined, on a rolling 12 month period.

'No-Shows' and late cancellations/reschedules for Office Visits:

- First offense will prompt a warning letter to the patient regarding their no-show or late cancellation/ reschedule occurrence and a notation will be made in the patient's chart.
- Second offense will prompt a phone call from the practice to the patient and 2nd warning letter will be sent to the patient.
- Third offense will prompt the patient to be discharged from the practice. The patient will receive a letter of discharge by certified mail and the patient portal.

'No-Shows' or late cancellations/reschedules for Procedure:

- Patient will automatically be charged a $100 'no-show' or late cancellation/reschedule fee. The practice staff will print a copy of the signed No-Show and Late Cancellation/Reschedule Policy along with the fee ticket, and mail to the patient.

Additional Information:

The No-Show and Late Cancellation/Reschedule Policy is not provider specific but applies across all CHMG practices, such that a no-show or late cancellation/reschedule for one provider could impact the patient's ability to schedule appointments with another CHMG provider. **For a listing of all CalvertHealth Medical Group providers and practices, please go to CalvertHealthMedicalGroup.org.**

All applicable no-show and late cancellation/reschedule fees must be paid prior to scheduling future appointments with any CHMG provider.

My signature below certifies that I have read, understand, and agree to the terms of the No Show and Late Cancellation/Reschedule Policy.

Patient Signature: _____ Today's Date: _____

CalvertHealth™
Medical Group

Patient Portal Access

The CalvertHealth Medical Group Patient Portal is a key component of managing your health. The Patient Portal is a secure, online tool that lets you communicate with your healthcare team and manage your health information.

Using the Portal, you can:

- Review lab results.
- Review your medical history.
- Request medication refills.
- Request appointments.
- Request Referrals.
- Pay your CHMG bill.
- Send your provider or practice questions.

THE PATIENT PORTAL IS THE PRIMARY METHOD CHMG AND YOUR PROVIDER USE TO SHARE IMPORTANT INFORMATION WITH YOU!

We will send you secure communications through the portal to:

- ❑ Remind you of upcoming appointments
- ❑ Notify you of new providers
- ❑ Notify you of departing providers
- ❑ Notify you of changes to office opening and closing times (i.e., for inclement weather)

We no longer send notifications by regular mail. All communications will be by portal message, text message or telephone.

Patients who do not sign up for and activate their Patient Portal access will miss out on key communications and not be able to take advantage of this secure, online access to your medical records, medication refills, lab results, and provider communications.

When you check in for your appointment, we will ask for your email address and give you a token that you will use to activate your access. You will have 30 days from the date you receive it to go online to nextmd.com to enter the token and activate your access.

WE ENCOURAGE YOU TO ACTIVATE YOUR PORTAL ACCESS AS SOON AS YOU GET HOME.

Once you have activated your portal access, you can click on 'My Chart' then 'Request Health Records' to start downloading your medical records into your portal.

The Patient Portal is a convenient, secure way to communicate with your provider, manage your medications and monitor your health records. Please sign up and activate your portal access today.

CalvertHealth
Medical Group

Informed Risk of Nicotine/Marijuana for Wound Healing

This informed risk statement is to ensure that you understand the use of tobacco/nicotine and marijuana can inhibit wound healing, contribute to scars, skin necrosis (wound break down), cancer, and is not limited to just these complications and risks. Please inform Dr. Ehrmantraut if you use and or have used tobacco, nicotine, or marijuana. You are advised to discontinue the use of tobacco, nicotine, and any marijuana products. If you are scheduled for a surgery, you MUST stop all forms of tobacco, any marijuana products, vaping (e-cigarettes), and nicotine four (4) weeks prior to your surgery and for at least four (4) weeks after your surgery. *This means complete abstinence from all forms of tobacco, nicotine, and any marijuana, including but not limited to nicotine gum, nicotine patch, e-cigarettes, edibles, weed pens, vape pens, marijuana gummies, etc.*

If you need assistance, you are advised to contact your family physician, CalvertHealth Medical Center, or the Calvert County Health Department for a smoking cessation program.

If you currently use tobacco, nicotine, or any marijuana products, you will be given an order to undergo urine nicotine and or cannabis testing which you must perform two (2) weeks prior to your scheduled surgery date. If the results of your nicotine and or cannabis test show an unacceptable level of nicotine and or cannabis in your system, your surgery will be canceled. If you need emergency surgery, please discuss this with Dr. Ehrmantraut.

I have read the above information and understand the risks associated with tobacco/nicotine and marijuana use, that there are many complications that can result due to the use of tobacco/nicotine and marijuana. I understand that I am responsible for seeking a smoking cessation program. If I am scheduled for surgery, I agree to stop the use of tobacco/nicotine and marijuana four (4) weeks prior to my surgery and to not use tobacco/nicotine and marijuana for at least four (4) weeks after my surgery. I agree to undergo a urine nicotine/marijuana test before my surgery. Furthermore, I verify that the information provided on this form is true and accurate to the best of my knowledge.

_____ _____

Print Patient Name Date

_____ _____

Patient Signature Date