Prime Medicine, LLC.
Board Certified Internal Medicine

Patient Registration Form

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Date:_____ Home Phone:_____ Cell Phone:_____
Name:_____SSN:_____
Address:_____City: _____
State:_____ Zip Code:_____Email:_____
Sex: M / F Age:____ Date of Birth:_____
Martial Status:Married / Widowed / Single / Minor/ Separated / Divorced / Partnered for ___ years
Preferred method of communication?_____
Do you authorize consent to receive email/text/voice communication? Yes / No
Preferred Pharmacy_____

Patient Employer/School:_____ Occupation: _____
Employer/School Address:_____
Employer/School Phone:_____ Employer/School Fax:_____
Whom should we thank for referring you?_____
In case of Emergency, who should be notified?_____ What is the relationship to you?_____ _____ Phone:_____
Is there anyone that can have access to your medical records? Yes / No
If yes, What is the persons full name/relationship to you?_____

Person responsible for account:_____Relation to Patient:_____
Insurance Company:_____ ID:_____Group:_____
Name(s) of other dependents(s) covered under this plan: _____
_____
Is this patient covered by additional insurance? Yes / No
Insurance Company: _____ ID_____ Group Number: _____

I certify that I, and/or my dependent(s) have insurance coverage with_____
And assign directly to Prime Medicine, LLC all insurance benefits, if any other wise payable to me for service rendered. I understand that I am basically responsible for all charges whether or not paid by insurance. I authorize the use my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to insurance benefits or the benefits payable for related services.

Signature:_____ Date:_____
(Signature of Patient, Parent, Guardian, or Legal Personal Representative)

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PRIME MEDICINE, LLC

Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

Prime Medicine, LLC appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approval period, you will be responsible for your balance in full. There will be a $35.00 fee for any checks returned for non- payment in addition to the check amount. We make many efforts to assist our patients with managing their medical bills. Please contact us if you are having difficulty with payments. Accounts that are not paid in a reasonable amount of time will be sent to an external collection agency. **Should the account be referred to a collection agency or an attorney for past due amounts you agree to reimburse the fee of any collection agency, which may be based on a percentage at a maximum of 25% of the debt, and all cost, and expenses , including reasonable attorney fees, we incur in such collection efforts.**

I have read the above policy regarding my financial responsibility to Prime Medicine, LLC, for providing rehabilitative services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Prime Medicine, LLC, and the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____
(If Guarantor is not the patient)

Consent for Treatment and Authorization to Release Information

I hereby authorize Prime Medicine, LLC, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriated assessment and treatment procedures. I further authorize Prime Medicine, LLC, to release to appropriate agencies, any information acquired in the course of my or the above named patients examination and treatment.

Patient/Guarantor Signature _____ Date _____

Co-pay and Cancellation/No show Policy

Some health insurance carriers require the patient to pay co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment or there will be an additional fee assessed of $25.00. I understand if I do not show for three appointments or cancel for a total of four appointments, I may be discharged from care. The Prime Medicine, LLC, will notify you in writing, via certified mail, if you are discharged from care. I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature _____ Date _____

PRIME MEDICINE, LLC.

Patient acknowledgement and Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Prime Medicine, LLC, to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Prime Medicine, LLC, describes such used and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent and have been provided the opportunity to review it. Prime Medicine, LLC, reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the attention of the Privacy Officer, at the practice address.

By signing this form, I am consenting to allow Prime Medicine, LLC, to use and disclose my Protected Health Information to carry out Treatment, Payment, and Health Care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Prime Medicine, LLC, may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Print Name if Legal Guardian

_____ _____

Print Patients' Name Date

For Office Use Only:

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement and Consent, but was unable to do so as documented below:

Date: Initials: Reason:

NAME:_____ DATE:_____

Patient Health Questionnaire-2 (PHQ-2)

Instructions:

Please respond to each question.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Give answers as 0 to 3, using this scale:

0=Not at all; 1=Several days; 2=More than half the days; 3=Nearly every day

1. **Little interest or pleasure in doing things**

☐0 ☐1 ☐2 ☐3

2. **Feeling down, depressed, or hopeless**

☐0 ☐1 ☐2 ☐3

Instructions

Clinic personnel will follow standard scoring to calculate score based on responses.

Total score: __

Reminder Checklist

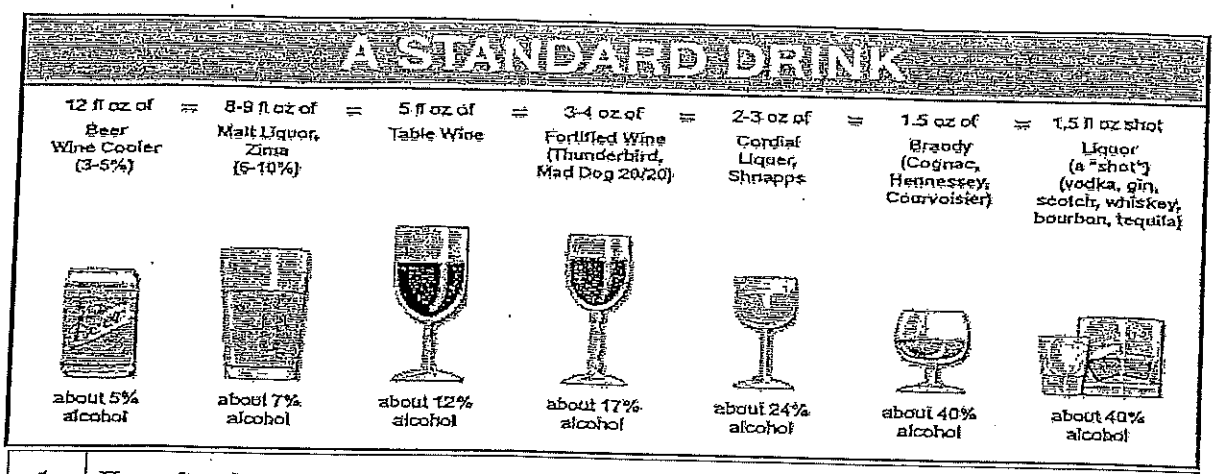
Please remind your doctor if you are due for any of these tests

Name: ..... **DOS:** .....

- ❑ Yearly Physical Exam +BW/UA/EKG (once a year)
- ❑ Prostate exam and PSA (males after age 40)
- ❑ Female exam and PAP smear (up to age 75)
- ❑ Mammogram (after age 40-74)
- ❑ Screening Colonoscopy (after age 50-85)
- ❑ Stool OB Kit (once a year)
- ❑ Bone density (after menopause)
- ❑ Carotid doppler, AAA, 2D-echo, ABI
- ❑ CXR if smoker or CT of chest if smoked >30 pack years(55-77 years)
- ❑ PFT (Asthma or chronic smoker)
- ❑ Urine Microalbumin (Diabetic and HTN)
- ❑ Hepatitis C (if born between years 1945-1965)
- ❑ Ophthalmology/ Retinal exam
- ❑ Dental exam
- ❑ Pneumovax (age 65 and 5 years after) + Prevnar (age 65)
- ❑ Shingles Vaccine (age 50) // Check Varicella titer if not sure about chickenpox
- ❑ Tdap Vaccine (every 10 years)
- ❑ Flu Vaccine
- ❑ Depression screening // Anxiety screening (if applies)
- ❑ ETOH screening / Tobacco Use
- ❑ Fall Screening (above age 65)
- ❑ Discuss Daily Aspirin, ACE/ARB, Statins (in certain conditions)

Name:_____ Date:_____

ADULT SBIRT SCREENING QUESTIONNAIRE



1.	How often do you have a drink containing alcohol?				
	Never	Monthly or less	Two to four times a month	Two to three times per week	Four or more times a week
2.	How many drinks containing alcohol do you have on a typical day when you are drinking?				
	1 or 2	3 or 4	5 or 6	7 or 9	10 or more
3.	How often do you have six or more drinks on one occasion?				
	Never	Less than monthly	Monthly	Two to three times per week	Four or more times a week
	0	1	2	3	4

4.	In the past 12 months have you used: Yes ☐ No ☐ (If Yes: Circle all that apply)					
	Marijuana	Crack/ Cocaine	Spice/ K-2	Heroin	Molly/ Ecstasy	Other
	If others please list the names:_____					

5.	In the past 12 months have you used prescriptions medications for non-medical reasons? Yes ☐ No ☐ (If Yes: Circle all that apply)							
	Percocet	Valium	Vicoden	Ativan	Oxycontin	Xanax	Klonopin	Other
	If others please list the names:_____							

*If all of the patients points on the AUDIT-C are from Question #1 only (Question #2 and #3 are zero), it can be assumed that the patient is drinking below recommended limits.
Recommended that provider review the patient's alcohol intake over the past few months to confirm accuracy

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Name:_____

Date:_____

Risk Stratification Tool for Adults

Age

- 19-55 years.....Score 0
- 56-74 years.....Score 1
- 75 years and older.....Score 2

Have you been hospitalized in the past 12 months?

- 0-1time.....Score 0
- 2 times.....Score 1
- 3 or more times.....Score 2

Have you had ER visits in the past 12 months?

- 0-1 time.....Score 0
- 2 times.....Score 1
- 3 or more times.....Score 2

How many total office visits (except pregnancy visits) have you had in the past 12 months?

- 1-2 visits.....Score 0
- 3-6 visits.....Score 1
- 7 or more.....Score 2

How many prescription medications (including oxygen) do you take?

- 0-2 medications.....Score 0
- 3-6 medications.....Score 1
- 7 or more medications.....Score 2

Which one describes your social and self-management status?

- Stable income. Independent. Stable residency. Family/other support. Adequate medical insurance.....Score 0

- Receive some support to meet social needs. Some medical insurance. Live alone and I need some assistance with adult daily living tasks.....Score 1

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- Live in a nursing home/assisted living. Home bound. Homeless. Unsafe home environment.Unemployed.No family or financial support that affects my care. Transportation barrier. No medical insurance.....Score 2

Language and Literacy

- Primary language is English. Carries out plan of care. Understands health care needs well. Independently seeks health information.....Score 0
- Limited English. Hearing impaired. Carries out some plan of care. Requires some reinforcement.....Score 1
- Always requires interpreter. Unable to carry out to plan of care without continued reinforcement. Require routine reinforcement and education.....Score 2

Chronic Disease (except mental health diagnoses)

- No chronic disease. Borderline disease or at risk for disease. Non smoker. BMI 18.5-25.....Score 0
- 1-3 Chronic illnesses. 1-15 years of tobacco use history. BMI <18.5or >25.....Score 1
- 4 or more Chronic illnesses. More than 15 years of tobacco smoking history . BMI >35.....Score 2

Chronic Disease Qualifier

- N/A.....Score 0
- 1 or more chronic conditions not on target (Mildly controlled).....Score 1
- 1 or more chronic conditions severely uncontrolled.....Score 2

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Mental and Behavioral Health (including dementia, substance, alcohol, autism, eating disorders, developmental delays, and more)

- No diagnosis. Stable for long term with medications.....Score 0
- 1-2 diagnosis. Routine follow up with provider or mental health provider. 1-2
  - significant life stressors (divorce, death, job loss, moving, etc).....Score 1
- 3 or more diagnosis. 3 or more significant life stressors(divorce, death, job loss, Moving, etc).....Score 2

Mental and Behavioral Health Qualifier

- N/A.....Score 0
- 1 or more mental conditions not quite controlled.....Score 1
- 1 or more mental conditions severely uncontrolled .....Score 2

This section is for office use only.

Total Score

- 0-3.....Low risk
- 4-9.....Moderate risk
- 10-13..... .....High risk
- 14-18 .....Extremely high risk

Complex Care Coordinator Referral.....Yes / No

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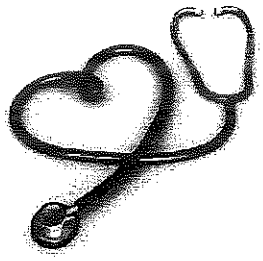

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General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name:_____
Address:_____
_____
Phone_____ Date of Birth_____ SSN_____

I authorize the custodian of the records of Dr._____ to disclose/release the following information (Check all that apply)

- ☐ All records
- ☐ Labs/ Pathology
- ☐ Radiology
- ☐ Billing Records
- ☐ Abstract/Summary
- ☐ Pharmacy/Prescriptions records
- ☐ Other (Please specify)_____

These records are for services provided on the following date(s):_____

Please send the records listed above to:
Name:_____
Address:_____
Phone:_____ Fax:_____

The information may be used/disclosed for each of the following purposes:

- ☐ At my request (only the patient can check this box)
- ☐ For my health
- ☐ Insurance purposes
- ☐ Employment purposes
- ☐ Other_____

The authorization shall expire no later than: ___/___/___or upon the following event_____ (whichever is sooner), and may not be valid for greater than one year from the date of the signature for Maryland medical records.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Signature of patient (or patients representative)_____
Print Name of Representative_____
Representative's authority to sign for patient, (i.e. parent, poa)_____
Date_____

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