UNIVERSITY of MARYLAND
CHARLES REGIONAL MEDICAL GROUP

REGISTRATION FORM

Please Print Clearly

Date Completed: _____ ***Form Completed By:*** _____

PATIENT DEMOGRAPHICS

Last Name: _____ First Name: _____ Middle: _____

Alias/ Nickname: _____

Social Security #: _____ Gender: _____ Date of Birth: _____ Age: ____

Permanent / Physical Address (Required) – *If PO Box is used for mailing please list as Confidential Address*

Street Address:_____

City: _____ State:_____ Zip Code:_____ County:_____

Temporary Address ☐ **Confidential Address** ☐ (Not Required) Start Date:_____ End Date: _____

Address: _____

City: _____ State:_____ Zip Code:_____ County:_____

Contact Phone Numbers: Home: _____ Work: _____

Cell / Mobile: _____ Email: _____

GENERAL INFORMATION

Interpreter Needed? Yes ☐ **No** ☐ Preferred Language: _____

Marital Status: _____ Spouse's Name: _____

Religion: _____

Hispanic / Latino Ethnicity? Yes ☐ NO ☐ Country of Birth: _____

Check all Race Categories the patient self-identifies as:

- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White / Caucasian
- ☐ Declined to Answer

REFERRING PHYSICIAN

Name: _____ Phone Number: _____

Location: _____

PRIMARY CARE PHYSICIAN

Name: _____ Phone Number: _____

Location: _____

Approximate start date of care:_____

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EMPLOYMENT STATUS (Please Check One)

Employed: Full Time ☐ Part Time ☐ Self Employed ☐ Active Military ☐

Occupation: _____ Employer: _____

Address: _____

Student: Full Time ☐ Part Time ☐

Retired: ☐ (Date) _____ Company:_____

Disabled: ☐ (Date) _____

EMERGENCY CONTACTS

Contact #1 Name: _____ Relationship: _____

Home: _____ Work: _____ Cell / Mobile: _____

Contact #2 Name: _____ Relationship: _____

Home: _____ Work: _____ Cell / Mobile: _____

GUARANTOR OF ACCOUNT (required if patient is a minor)

☐ Mother ☐ Father ☐ Legal Guardian ☐ Other_____

Last Name: _____ First Name: _____ Middle: _____

Alias/ Nickname: _____

Social Security #: _____ Gender: _____ Date of Birth: _____ Age: ____

Billing Address: _____

City: _____ State:_____ Zip Code:_____ County:_____

INSURANCE INFORMATION

Primary Insurance:_____

Subscriber's Name:_____ Relationship to Patient:_____

Date of Birth:_____ SS#_____ Employer:_____

Patient Policy #: _____ Subscriber Policy #: _____

Group # (if applicable) _____

Secondary Insurance:_____

Subscriber's Name:_____ Relationship to Patient:_____

Date of Birth:_____ SS#_____ Employer:_____

Patient Policy #: _____ Subscriber Policy #: _____

Group # (if applicable) _____

UNIVERSITY of MARYLAND
CHARLES REGIONAL MEDICAL GROUP

UNIVERSITY OF MARYLAND CHARLES REGIONAL MEDICAL GROUP CONSENT FOR TREATMENT, FINANCIAL RESPONSIBILITY AND HEALTHCARE OPERATIONS

UNIVERSITY OF MARYLAND CHARLES REGIONAL MEDICAL GROUP (UM CRMG), for the purposes of this consent, includes all hospitals, physician offices and other facilities providing healthcare services, which are part of UM CRMG.

REQUEST, AUTHORIZATION AND CONSENT FOR TREATMENT: I voluntarily request, authorize, and consent to care including medical and/or surgical treatment and diagnostic, radiology, and laboratory examinations and procedures by physicians, residents, nurses and other technical staff of **UM CRMG**. I understand and agree that healthcare professionals in training, which may include but are not limited to residents, fellows, medical/nursing/dental students may assist or participate in providing hospital and/or medical care to me. I understand that these professionals in training work under the direction or supervision of my physician or other healthcare professional and may perform or observe some of the health services I receive and specifically consent to.

I understand that the extent and severity of my injury or illness is not known at this time. I further understand and agree that the practice of medicine is not an exact science and that no guarantees have been made as to the results of either hospital care and medical and/or surgical treatment or examinations. If applicable, I give **UM CRMG** permission to appropriately dispose of any specimens/tissue (such as blood samples, PAP smears, skin tags, etc.) taken from my body. Once disposed of, these specimens/tissues cannot be retrieved. I hereby authorize **UM CRMG** to retain, preserve and use for scientific or teaching purposes or dispose of at their convenience, any specimens or tissues taken from my body during any hospital/clinic procedure(s).

EMERGENCY CARE: I acknowledge that the treatment rendered to me on an emergency basis is not intended to be comprehensive in scope and it may be necessary to select another physician for a further diagnosis and continuation of treatment after my discharge from **UM CRMG**.

INDEPENDENT CONTRACTORS: I acknowledge that not all healthcare providers are either employees, servants or agents of UM CRMG. Some are independent contractors who have been granted the privilege of using the UM CRMG facilities for the care and treatment of their patients. I understand that if the employment status of an individual is important to me in making treatment and other healthcare decisions, I may inquire as to that individual's employment status. I further understand that UM CRMG is not liable for the care and treatment decisions of these independently contracted healthcare providers. _____ (Patient/Responsible Party initials)

INSURANCE CERTIFICATION AND ASSIGNMENT: I hereby certify that the information given by me in applying for payment under titles XVIII and XIX of the Social Security Act and/or by any other third party payers is correct. I assign to **UM CRMG** all benefits for care due to me under the terms of said policies and programs but not to exceed the regular charges for similar services. I assign payment to the physician(s) rendering medical services and I assign payment for the unpaid charges of the physician(s) for whom the **UM CRMG** is authorized to bill in connection with its services. I understand that I am responsible for payment of any health insurance deductibles, coinsurance, or any other expenses incurred which are not paid by any insurers or other third party payers.

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MEDICARE AUTHORIZATION: I request payment of authorized Medicare benefits be made on my behalf for any service furnished me by **UM CRMG**, including physician services. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

PHOTOGRAPHY and/or Video Record: The persons caring for you may need to photograph and/or record you to document a medical condition, help with the diagnosis and/or treatment of a condition, and/or to help plan the details of surgery. Photographs and/or recordings taken for these clinical reasons do not require your written permission.

PRIVACY OF INFORMATION: (please check √ one)

_____ - I ACKNOWLEDGE receipt of a copy of the Notice of Privacy Practices which explains how UM CRMG may use and disclose protected health information; or

_____ - I REFUSE receipt of a copy of the Notice of Privacy Practices which explains how UM CRMG may use and disclose protected health information.

USE AND DISCLOSURE OF SUBSTANCE USE DISORDER PATIENT RECORDS: If I receive treatment for a substance use disorder at a program within **UM CRMG**, I consent to the program disclosing these records to others within **UM CRMG** and to other affiliates of University of Maryland Medical System that treat me for purposes of my treatment, quality improvement and other healthcare operations and care coordination. This consent will expire one year after I am no longer a patient of **UM CRMG** or other affiliates of University of Maryland. I may revoke this consent at any time except to the extent that the program, **UM CRMG**, or other University of Maryland Medical System affiliates have already acted in reliance on my consent.

PERSONAL PROPERTY/VALUABLES: I understand that **UM CRMG** recommends that all personal belongings shall be sent home with a family member or friend and that **UM CRMG** will not be responsible for the theft, loss or damage of my personal property which includes but is not limited to money, jewelry, eyeglasses, dentures, hearing aids, garments or other articles of unusual value. I understand that there may be storage options available for my use. I assume full responsibility for all of my personal property and valuables and release **UM CRMG** from responsibility and liability for such items.

GUARANTEE OF ACCOUNT: I acknowledge responsibility for this account and assume and guarantee payment of all hospital and physician charges, including copayments and deductibles and non-covered charges rendered to me during this visit. Should this account be referred to an attorney for collection, I agree to pay attorney fees of twenty-five percent (25%), collection expenses, and interest at the highest rate authorized by law. I understand that I may be billed separately for services provided to me or on my behalf during this period of treatment by independent professional groups or hospital based physician services (radiology, anesthesiology, emergency, pathology etc.).

WIRELESS COMMUNICATION: I expressly consent and authorize **UM CRMG** and its agents to:

UNIVERSITY of MARYLAND
CHARLES REGIONAL MEDICAL GROUP

a. Contact me at any telephone number, including wireless numbers, email addresses, or unique electronic identifiers or modes that I provided to **UM CRMG** at any time associated with me or my account;
b. Communicate with me using any current or future means of communication, including but not limited to, automated telephone dialing systems, artificial or pre-recorded messages, SMS text messages, or other forms of electronic messages; for any reason related to the services received at **UM CRMG** or services received at **UM CRMG** in the future, including operations and quality matters, such as patient satisfaction surveys, and collection of amounts owed on my account; and
c. Leave answering machine and voicemail messages, in compliance with applicable laws, for any reason related to the services provided by **UM CRMG** or services to be provided by **UM CRMG** in the future, including operations and quality matters, such as patient satisfaction surveys, and collection of amounts owed on my account.

I further promise to immediately notify **UM CRMG** if any telephone number, email address or other unique electronic identifiers or modes that I provided to **UM CRMG** change or are no longer used by me.

I CERTIFY THAT I HAVE READ THIS CONSENT AND AM THE PATIENT OR THE PARENT OR GUARDIAN OF THE PATIENT OR AM 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 IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____
PRINT PATIENT NAME

_____ _____
PRINT RESPONSIBLE PARTY NAME RELATIONSHIP TO PATIENT

_____
SIGNATURE

_____ _____ _____
DATE TIME WITNESS NAME & SIGNATURE

FORM NOT SIGNED:

_____ REFUSED _____ UNABLE (if unable proceed to verbal consent)

TO BE USED FOR VERBAL CONSENT:

ON _____ AT _____ O'CLOCK,
DATE TIME

_____
PRINT NAME OF PERSON GIVING CONSENT

THE TERMS OF THIS CONSENT WERE REVIEWED WITH THE PATIENT, PARENT OR GUARDIAN OF THE PATIENT OR THE DULY AUTHORIZED AGENT OF THE PATIENT VERBALLY AND SUCH INDIVIDUAL PROVIDED VERBAL CONSENT TO THE TERMS SET FORTH HEREIN.

_____ _____
PRINT WITNESS NAME WITNESS SIGNATURE

UNIVERSITY of MARYLAND
CHARLES REGIONAL MEDICAL GROUP

The University of Maryland Charles Regional Medical Group complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The University of Maryland Charles Regional Medical Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The University of Maryland Charles Regional Medical Group provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you believe that the University of Maryland Charles Regional Medical Group has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Corporate Compliance and Business Ethics Group, 900 Elkridge Landing Road, First Floor, Linthicum, MD 21090, 410-328-4141, compliance@umm.edu. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Compliance Director is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-868-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html