ALLDAY
Family Care
Primary Care | Behavioral Health

301-330-0006
301-330-0444
info@alldaymedicalcare.com
AllDayMedicalCare.com

702 Russell Avenue, Suite 100
Gaithersburg MD 20877

3915 Ferrara Drive
Silver Spring, MD 20906

3508 Worthington Blvd, Suite 101
Urbana, MD 21704

5525 Twin Knolls Road, Suite 323
Columbia. MD 21045

# Patient Intake Form

Patient Name:_____ Date of Birth:_____

Gender:_____ Email Address:_____

Primary Phone #:_____ Alt. Phone #:_____

Home Address:_____

_____

***Insurance Information***

Insurance Name:_____ ID #:_____

Group Number:_____

***Policy Holder Information***

Name:_____ Date of Birth:_____

Relationship to Patient:_____

***Secondary Insurance Information***

Insurance Name:_____ ID #:_____

Group Number:_____

***Policy Holder Information***

Name:_____ Date of Birth:_____

Relationship to Patient:_____

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# Patient Registration Form

Today's Date:_____ Home Phone:_____

Date of Birth:_____ Email Address:_____

Patient's Last Name:_____ Patient's First Name:_____

Driver's License #:_____ Address:_____

City:_____ State:_____

Zip Code:_____ Sex: Choose One Marital Status: Choose One

Social Security #:_____

Name of Person Responsible for Payment:_____

Emergency Contact:_____ Emergency Phone #:_____

# If Patient is a Minor, Please Complete the Following

Guardian First and Last Name:_____

Home Phone #:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Date of Birth:_____ Social Security #:_____

Emergency Contact:_____ Emergency Phone #:_____

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# ALL DAY MEDICAL CARE CLINIC: FINANCIAL POLICIES & AGREEMENT / TREATMENT CONSENT

Appointments are scheduled according to the individual providers recommendation. If there is an emergency during office hours, which requires immediate attention, please contact the office by phone 301-330-0006 or email customerservice@alldaymedicalcare.com. As protocol, we require a credit card on file for ALL of our patients.

***If an appointment cannot be kept, please contact the office at least 24 hours in advance. There will be a $100.00 fee for late cancellations and a no shows that are self-pay or private insurance.***

**INSURANCES**

Please check with our Billing Department to see if we participate with your insurance company. It is your responsibility to verify that we have your current address, phone number and insurance information on file.

If we participate with your insurance company, we will submit all services performed in our office for reimbursement unless we have received prior notification of non-covered services. All copays, deductibles, and overdue balances are your responsibility, and payment is expected at the time of each visit.

If we do not participate with your insurance company, you are responsible for payment in full at the time services are rendered.

Insurance companies often require pre-authorization as a condition of reimbursement – whether or not we participate with them. It is your responsibility to obtain any required insurance referrals or authorizations prior to your visit. If a required referral is not presented at the time of your visit, you may be required to reschedule your appointment.

**PAYMENT FOR SERVICES**

Payment for each visit is expected at the time of service. For your convenience, we accept all major credit cards, cash, or check. Returned checks will incur a $35 fee to each patient account affected. All patient payments including any outstanding balances are due at the time of service – unless prior arrangements have been made with the Office Manager, Billing Coordinator, and/or your clinician.

You will be charged for missed appointments if you fail to provide 24 business hours' notice. You are fully responsible for these charges because they are not covered by your insurance.

Overdue accounts may incur late fees at 18% per year. All balances that become 90 days past due may be sent to a professional collection agency. Should your account be sent to a collection agency, you will be financially responsible for a collection fee equal to 33% of the amount sent to the agency and any additional legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance. Your signature below authorizes All Day Medical Care Clinic to release information necessary for collection of past due accounts. Payment in full of any past due balance is expected prior to being seen in our office in the future. In addition, payment in full will be expected at the time of service for any future services.

**DISCHARGE**

Discharge procedures shall be followed to ensure patients are discharged effectively and efficiently, allowing for optimal utilization of available resources. An authorized practice discharge shall only be made by an order from the primary consultant. However, a patient may discharge himself/herself against medical advice. The Consultant or his designee shall document discharge instructions in the patient's medical record at the time of anticipated discharge. A Discharge Summary shall be prepared. The discharge summary shall contain: The reasoning behind the discharge. The provider shall be responsible for completing the discharge checklist and explaining the discharge summary to the patient. All the patients are provided with a discharge summary at the time of discharge.

**SELF-PAY**

In order to address the needs of our patients without insurance and patients with coverage limitations, we offer a discount off our standard fees. This discount reflects the lower cost involved in billing and collections when a claim does not need to be submitted to a third-party payer. In order to qualify, payment needs to be made in **FULL** prior to the visit.

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**Fees:**

| Behavioral Health Treatment | Price | Medical Treatment | Price |
|---|---|---|---|
| Psychiatric Nurse Practitioner Initial Visit | $220 | Initial Visit with PCP | $150 |
| Psychiatric Nurse Practitioner Follow-Up | $175 | PCP Follow-Up | $120 |
| Therapist Initial Visit | $220 | Health Assessment | $160 |
| Therapist Follow-Up | $120 | Suture Placement 2.5< | $90 |
| | | Suture Placement 2.6-7.5 | $110 |
| | | Suture Placement 7.6-12.5 | $130 |
| | | Suture Placement 12.6-20.0 | $180 |
| | | Suture Removal | $20 |
| | | EKG | $60 |
| | | Venipuncture + Labs | $5 + Lab Costs |

**Lab Fees:**

| Lab Type | Price | Lab Type | Price |
|---|---|---|---|
| AFP, Serum, Tumor Marker | $75 | Genital Culture, Routine | $50 |
| Amylase | $97 | Glucose | $17 |
| Antinuclear Antibodies Direct | $62 | Glucose, Plasma | $17 |
| Basic Metabolic Panel (7) | $55 | hCG, Beta Subunit, Qnt | $35 |
| Basic Metabolic Panel (8) | $55 | hCG, Beta Subunit, Qual | $35 |
| Beta Strep Gp A Culture | $30 | HCV Antibody | $45 |
| C Difficile Toxins A+B, EIA | $69 | Helicobacter pylori, IgM Ab | $60 |
| Calcium | $17 | Hemoglobin A1c | $25 |
| CBC w/ Differential/Platelet | $30 | Hepatic Function Panel (6) | $25 |
| CEA | $40 | Hepatic Function Panel (7) | $25 |
| Comp. Metabolic Panel (14) | $35 | Hepatitis Panel (4) | $60 |
| C-Reactive Protein, Quant | $30 | HIV Ab/p24 Ag with Reflex | $85 |
| Creatine Kinase, Total | $20 | Magnesium | $17 |
| Creatinine, Urine | $20 | Measles Antibodies, IgG | $38 |
| Influenza A/B ab, Quant | $45 | Measles/Mumps/Rubella Immunity | $108 |
| Iron and TIBC | $25 | Prostate-Specific Ag | $50 |
| Lipase | $25 | TSH | $40 |
| Lipid Panel w/ LDL/HDL Ratio | $40 | Urinalysis, Complete | $20 |
| Lyme Disease Serology w/ Reflex | $90 | Vitamin B12 | $30 |
| Digoxin, Serum | $30 | Vitamin D, 25-Hydroxy | $85 |
| Electrolytes Panel | $20 | | |

**Combo Pricing:**

1. Physical Exam + EKG + Venipuncture + Labs (CBC, CMP, Lipid Profile, TSH, Urinalysis) = $395 **Discounted Price: $355**
2. Physical Exam + Venipuncture + Labs (CBC, CMP, Lipid Profile, TSH, Urinalysis) = $355 **Discounted Price: $300**

**INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS/CONSENT TO TREATMENT**

I UNDERSTAND THAT CERTAIN INFORMATION MAY BE REQUIRED BY THIRD PARTY SOURCES FOR THE PURPOSE OF TREATMENT, PAYMENT (INCLUDING COLLECTIONS OF PAST DUE ACCOUNTS) AND HEALTH CARE OPERATIONS. I HEREBY CONSENT TO ALL DAY MEDICAL CARE CLINIC RELEASING MY HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS. I HEREBY ASSIGN TO THE PRACTICE ALL BENEFITS/PAYMENTS FOR SERVICES RENDERED TO MY DEPENDENTS AND/OR MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL AMOUNTS NOT COVERED BY MY INSURANCE. MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE BEEN PROVIDED ALL DAY MEDICAL CARE CLINIC'S NOTICE OF PRIVACY PRACTICES.

**Printed Name of Patient:**_____ **Date:**_____

**Signature of Party Financially Responsible/Parent/Guardian:**_____

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# CREDIT CARD AUTHORIZATION FORM

**Patient Name:**_____ **Date of Birth:**_____

The purpose of this form is to authorize Family Care Associates (DBA All Day Medical Care Clinic) to retain a valid credit card number on file for you as our patient. This form will be kept confidential and only authorized staff will have access to the information. ***If patient declines to provide credit card authorization a fee of $220 (for psychiatric services), $220 (for counseling services) and $250 (for medical services) is due at the time of each visit (self-pay and private insurance). A claim will be filed with the insurance. If patient responsibility is less what was paid a refund will be issued to patient. If patient owes balance statement will be sent out.***

***Your supplied credit care will be charged ONLY under the following circumstances:***

1. Family Care Associates (DBA All Day Medical Care Clinic) reserve the right to charge the credit card listed below for all current patient balances, including co-pays (following insurance payments), co-insurances and deductibles. A receipt will be kept in your patient chart, unless directed to send the receipt directly to you. This notice serves as your consent to being charged for all current patient balances on your account.
2. If you, as the patient, miss a scheduled appointment without 24-hour notice to cancel or reschedule, Family Care Associates (DBA All Day Medical Care Clinic) reserves the right to charge the credit card listed below $100.00 for our standard no-show fee. A receipt will be kept in your patient chart. This notice serves as your consent to being charged for any and all no-shows and cancellations. *As is customary, a representative from Family Care Associates (DBA All Day Medical Care Clinic) will call the phone number on file to remind you of your scheduled appointment. This reminder is usually done 24 hours prior to your scheduled appointment. It is the patient's responsibility to ensure we have a correct, current telephone number on file.*
3. If we receive notice that a payment is returned to us for any reason, Family Care Associates (DBA All Day Medical Care Clinic) reserves the right to charge the credit card listed below *a $35.00 returned check fee*. A receipt will be kept in your patient chart. This notice serves as your consent to being charged for any returned payments.
4. If you, as the patient, request paper records we will provide to you, upon written request, a paper copy of your medical record. Family Care Associates (DBA All Day Medical Care Clinic) reserve the right to charge the current medical records copying fees as set forth by the Maryland Board of Physicians. *As of 2023 the current fee is $0.76 per page of the medical record and the actual cost of postage and handling of no more than $22.88.* The office will provide you with a copy of your record. This notice serves as your consent to being charged for medical records request. Other than the conditions mentioned above, under NO circumstance will Family Care Associates (DBA All Day Medical Care Clinic) charge your credit card for anything not discussed personally with you. In conjunction with HIPPA regulations, all credit card information will be confidentially kept within your medical chart in our office. Only authorized staff will be able to access this information.

**Acknowledged, Agreed & Accepted**
*Having read this form and talked with the staff, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged accordingly for the conditions listed above.*

Card Holders Name:_____

Credit Card Number:_____ Expiration Date:_____ CVV:_____

Patient Signature:_____ Date:_____

**If patient is a Minor, Parent/Guardian signature below**

Parent/Guardian Signature:_____ Date:_____

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# AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

This consent form allows All Day Medical Care Clinic to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This information may be used or disclosed to carry out treatment, payment, or health care operations.

**Information Release for:**_____ **Patient's Date of Birth:**_____

I hereby authorize All Day Medical Care Clinic to communicate with the individual(s) listed below only for purposes of 1) collecting payment due on my account(s) at All Day Medical Care Clinic and 2) answering questions specific to billing and payment collections on said account(s).

Authorized communication can include only the following information: date/time (if applicable) of any provided services (or no-shows/late cancellations); type/level of services; name of All Day Medical Care Clinic provider(s); and fees due or paid for any rendered services, missed appointments, or cancelled appointments with less than 24 (business) hours' notice.

This authorization **DOES NOT** apply to issues beyond those noted above. This authorization is specific for this request only and is not a universal authorization.

I understand that once information is disclosed in accordance with this authorization, it may be redisclosed by the recipient(s) and no longer protected by HIPAA Privacy Rules. I further understand that All Day Medical Care Clinic does not have any ability to prevent subsequent disclosures of my information by the recipient(s).

I authorize communication, restricted to the purposes and information as stated above, with the following:

Name:_____ Relationship to Patient:_____

Phone Number:_____ Alt. Phone Number:_____

Mailing Address (Address, City, State, and Zip):_____

_____

Name:_____ Relationship to Patient:_____

Phone Number:_____ Alt. Phone Number:_____

Mailing Address (Address, City, State, and Zip):_____

_____

**THIS AUTHORIZATION TO DISCLOSE MAY BE REVOKED BY ME AT ANY TIME EXCEPT TO THE EXTENT THAT ALL DAY MEDICAL CARE CLINIC HAS ALREADY DISCLOSED INFORMATION BY HAVING ACTED ON MY PRIOR CONSENT.**

I understand I may cancel this authorization at any time by providing to the Office of All Day Medical Care Clinic written communication that includes the date this authorization will end.

Printed Name of Patient:_____ Date:_____

Signature:_____

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# All Day Medical Care Clinic Patient Rights and Responsibilities Form

**Patients have the right:**

1. To be treated humanely, with dignity, and respect.
2. To not be discriminated against due to race, religion, ethnicity, gender, sexual orientation, or disability.
3. To receive treatment appropriate to their mental health condition.
4. To have diagnosis and treatment explained in understandable terms.
5. To participate in the formulation and revision of the treatment plan.
6. To refuse treatment, request another provider, or seek a referral outside of the practice.
7. To receive services that adhere to the principles of confidentiality and privacy except for the following specialized circumstances:
    a. When circumstances place the patient's welfare or that of others in immediate danger.
    b. When disclosures made by the patient raise the suspicion of the child's physical, mental, or sexual abuse or neglect, or if an adult discloses an allegation of abuse in their childhood. In this situation, the law requires a report be made to the appropriate agency, usually Social Services.
    c. When a court order requires testimony or release of patient's records.
    d. In a circumstance where the provider determines that consultation within the practice is needed in order to provide optimal treatment, in which case the utmost discretion will be used to insure privacy.
8. To access your medical record as deemed appropriate by the provider.

**Patients have the responsibility:**

1. To know the benefits and exclusions of your insurance coverage and to provide us with current insurance information.
2. To make regular and prompt payments for services rendered.
3. To keep scheduled appointments. Patients will be charged for missed appointments or cancellations for which 24-hour notice has not been given.
4. To follow the mutually agreed upon treatment plan.
5. To be open and honest in sessions.
6. To report any safety concerns or abuse allegations to your provider.
7. To discuss with your provider any concerns about treatment, including the desire to terminate treatment.

Printed Name of Patient:_____ Date:_____

Signature:_____

# Mental Health Intake

1. **Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?**

- (●) No
- ( ) Yes

If **YES**, previous: ☐ Therapist ☐ Practitioner: _____
Name of Provider(s)

2. **Are you currently taking any prescription medication?**

- (●) No
- ( ) Yes

If **YES**, please list:_____

_____

3. **Are you currently experiencing overwhelming sadness, grief, or depression?**

- (●) No
- ( ) Yes

If **YES**, for approximately how long?_____

4. **Are you currently experiencing anxiety, panic attacks or have any phobias?**

- (●) No
- ( ) Yes

If **YES**, when did you begin experiencing this?_____

5. **Are you currently experiencing any chronic pain?**

- (●) No
- ( ) Yes

If **YES**, please describe:_____

6. **Do you drink alcohol?**

- (●) No
- ( ) Yes

If **YES**, how often:_____

7. **Do you engage in recreational drug use?**

- (●) No
- ( ) Yes

If **YES**, for how long?_____

8. **Are you currently in a romantic relationship?**

- (●) No
- ( ) Yes

If **YES**, for how long?_____ On a scale from 1-10, how would you rate your relationship?_____

9. **What significant life changes or stressful events have you experienced recently?**

_____

_____

**10. What is your legal history, if any?**

**11. What are your treatment goals?**

## Additional Information

**1. Are you currently employed?** ◉ No ○ Yes

If **YES**, name and address of your employer:

**2. Do you enjoy work? Is there anything stressful about your current work?**

**3. What do you consider to be some of your strengths?**

**4. What do you consider being some of your weaknesses?**

5. **What would you like to accomplish out of your time in therapy?**

_____

_____

6. **Do you have suicidal thoughts?**

(•) No
( ) Yes

If **YES**, do you have a plan? (•) No ( ) Yes

## MINORS

1. **Do you enjoy school?**

(•) Yes
( ) No

If **NO**, please explain: _____

_____