Scoville Osteopathic Healthcare, P.C.
10325 Lloyd Road / Potomac, MD 20854 / 301-304-3330 / scovilleosteopathichealth.com

Patient Registration

(Please Print Clearly) Today's Date ____/____/_____

Patient's Full Name _____ Date of Birth ____/____/_____

Marital Status: S M D W Gender: M F NB Pronouns: _____

Address _____ City _____ State _____ Zip_____

Phone #s: Home ( ) _____ Work ( ) _____ Cell ( ) _____
Please circle which number is best to call home/work/cell May a private voice message be left for you? YES/ NO

Guardian for child _____ Relationship _____ Phone _____
Address (if different) _____

Patient's Employer _____ E-mail: _____
(Note that email generally and use of employer's email is not private.)
Address_____City_____State_____ Zip_____

Preferred method of contact: (circle one) phone call email USPS mail

Spouse's/Partner's Name _____
Spouse's/Partner's Employer_____ Daytime # ( ) _____
Emergency Contact _____ Phone # ( ) _____
(Other than Spouse/Partner)

Is there anyone you with whom you want us to share your medical information?

_____ _____
Name & relationship Name & relationship

Is there anyone with whom you do <u>not</u> want us to share your medical information ?

_____
(The Doctor is not required to honor your request if it is not in your medical best interests. Please discuss this with the doctor.)

<u>Financial Information</u>

Financially Responsible Person _____ Relationship_____
Address (if different) _____ City_____ State_____ Zip_____
Are you covered under Medicare? Y or N Medicare # _____

Primary Health Insurance Company:

_____
Identification # _____
Group # _____
Subscriber_____
Subscriber's Date of Birth ____/____/____
Effective Date _____

Secondary Health Insurance Company:

_____
Identification # _____
Group # _____
Subscriber_____
Subscriber's Date of Birth _____/_____/_____
Effective Date _____

Primary Care provider and phone number_____
Referred by: _____

Please continue onto next page and sign.

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Patient Registration (continued)

FINANCIAL POLICY: I certify that the information I have reported is correct. I acknowledge that it is the policy of this office to collect full payment at the time of each visit. I understand that I am financially responsible for services provided. This office does not participate with health insurance, including Medicare or Medicaid, or provide workers compensation or disability reports. In addition, I agree that in the event I do not pay for services provided, I will pay for the cost of collection, and/or court costs and reasonable attorney fees should this be required. I understand that in the absence of a payment plan, outstanding balances may accrue 1.5% interest per month after 30 days.

CONFIDENTIALITY: As your physician, it is necessary to communicate in writing, by phone, fax or electronic communication to your primary care physician, or other health care providers, health insurance companies, Medicare/Medicaid or health claims clearinghouses. Communication between your doctors is in your best interest as it helps coordinate your medical care. Furthermore, health insurance companies may require certain information about you be sent to them and you have agreed to release this information as a participating member. The practice will make its best efforts to protect your privacy. This includes nondisclosure of your personal health information for marketing and fundraising purposes.

I understand and agree that my personal health information may be transmitted by computer to laboratories and or consulting health care practitioners to facilitate my medical care. I acknowledge that I have had an opportunity to read the office's Notice of Privacy Practices and Health Care Disclosure Information that contains a description of the uses and disclosures of my personal health information. I understand that this information may be updated and I will be able to see the new information. The policy of this office is to strive to be in compliance with federal and state medical practice guidelines.
A copy of this form can be considered as valid as the original.

CONSENT TO TREATMENT: We understand that you have come here to seek specialized treatment and we will endeavor to assist you in a speedy recovery, but of course we cannot guarantee any specific result.

I have read and understand the above office policies and consent to treatment by Dr. Scoville and her staff.

X Signature of Patient_____ **Date** _____
or Authorized Guardian if under 18 years old

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of Scoville Osteopathic Healthcare, P.C.'s Notice of Privacy Practices.

Patient Name (Print): _____

X Patient Signature : _____ Date: _____

If signed by personal representative, please describe relationship to patient and authority to act on patients' behalf:

_____

FOR OFFICE USE ONLY

If acknowledgment not obtained, document reason: ☐ Emergency situation ☐ Patient refused to sign
Staff Initials: _____ *Date:* _____ ☐ Other: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Commitment to Your Privacy

Scoville Osteopathic Healthcare, P.C. is committed to protecting the privacy of health information. We are required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of Privacy Practices (Notice) of our legal duties and privacy practices regarding your PHI, and follow the terms of the Notice currently in effect.

This Notice tells you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of your health information.

The privacy practices described in this Notice will be followed by all members of the workforce at Scoville Osteopathic Healthcare, P.C., including health care professionals, employees, trainees, students, and volunteers. Additionally, third parties ("business associates") that provide services on our behalf will be required to comply with all applicable provisions.

How We May Use and Disclose Health Information About You

The following sections describe different ways we may use and disclose your health information. We abide by all applicable laws related to the protection of this information. Not every use or disclosure is listed. All of the ways we are permitted to use and disclose health information, however, will fall within one of the following categories:

Treatment.
We may use and disclose your health information to provide, coordinate, or manage your healthcare and related services. This includes consultation with other healthcare providers regarding your treatment and referral to another provider. For example, your primary care physician may share your health information with a specialist to coordinate your care.

Payment.
We may use and disclose your health information to obtain payment for services we provide. This includes billing activities, claims management, and collection activities. For example, we may send claims to your health insurance company containing certain health information to obtain payment for services we provided.

Healthcare Operations.
We may use and disclose your health information for our healthcare operations, which include internal administration and planning and various activities that improve the quality and cost-effectiveness of care. For example, we may use health information to evaluate the performance of our staff, assess the quality of care, or conduct training programs.

Other Uses and Disclosures We May Make Without Your Authorization:
As Required by Law. We may disclose health information when required by federal, state, or local law.

- **Law Enforcement**. We may disclose health information to law enforcement officials for law enforcement purposes as permitted by law.
- **Coroners, Medical Examiners, and Funeral Directors**. We may disclose health information to coroners, medical examiners, and funeral directors to carry out their duties.
- **Organ and Tissue Donation.** We may disclose health information to organizations involved in the procurement, banking, or transplantation of organs, eyes, or tissue.
- **Research**. We may use or disclose health information for research purposes when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of your information.
- **To Avert a Serious Threat to Health or Safety.** We may use or disclose health information when necessary to prevent a serious threat to the health or safety of you, another person, or the public.
- Specialized Government Functions. We may disclose health information for military, national security, protective services, or correctional institution purposes as authorized by law.
- **Workers' Compensation**. We may disclose health information as authorized by workers' compensation laws. Unless you say no, to anyone involved in your care or payment for your care, such as a friend, family member, or any individual you identify.

Substance Abuse Treatment.

We are required to protect the privacy and security of your substance use disorder patient records in accordance with 42 U.S.C. § 290dd–2 and 42 C.F.R. Part 2, the Confidentiality of Substance Use Disorder Patient Records ("Part 2"), in addition to HIPAA and applicable state law. In a civil, criminal, administrative, or legislative proceeding against an individual, we will not use or share information about your SUD treatment records unless a court order requires us to do so (after notice and an opportunity to be heard is provided to you, as provided in 42 CFR part 2) or you give us your written permission You may report suspected violations to the U.S. Attorney for the judicial district in which the violation occurs. Contact information for the U.S. Attorney office where we operate is below:

U.S. Attorney for the District of Maryland
Main office: 36 S. Charles Street 4th Fl., Baltimore, MD 21201; Phone: (410) 209-4800
Southern Division: 6406 Ivy Lane Suite 800, Greenbelt, MD 20770; Phone: (301) 344-4433

Suspected violations by an opioid treatment program may be reported to the Substance Use and Mental Health Services Administration (SAMHSA), Opioid Treatment Program Compliance Office by phone at 204-276-2700 or online at OTP-extranet@opiod.samhsa.gov.

Uses and Disclosures That Require Your Written Authorization:

We will obtain your written authorization before using or disclosing your health information for purposes other than those described above. Specifically, we will obtain your authorization before using or disclosing:

- Psychotherapy notes (with limited exceptions)
- Health information for marketing purposes
- Health information in a manner that constitutes a sale of PHI

Additionally, with certain limited exceptions, we are not allowed to sell or receive anything of value in exchange for your health information without your written authorization. If you provide us with authorization to use or disclose your health information about you, you may revoke your authorization, in writing, at any time.

However, uses and disclosures made before the revocation of your authorization are not affected by your action and we cannot take back any disclosures we may have already made with your authorization or that may have been made on reliance of your authorization.

Use of unsecure electronic communications.

If you choose to communicate with us via unsecure electronic communications, such as regular email or text message, we may respond to you in the same manner in which the communication was received and to the same email address or account from which you sent your original communication.

In addition, if you provide your email address or cell phone number to a health care provider, we may send you emails or text messages related to appointment reminders, surveys, or other general informational communications. For your convenience, these messages may be sent unencrypted.

Before using or agreeing to use of any unsecure electronic communication to communicate with us, note that there are certain risks, such as interception by others, misaddressed/misdirected messages, shared accounts, messages forwarded to others, or messages stored on unsecured, portable electronic devices.

By choosing to correspond with us via unsecure electronic communication, you are acknowledging and agreeing to accept these risks. Additionally, you should understand that the use of email or other electronic communications is not intended to be a substitute for professional medical advice, diagnosis, or treatment.

Your Rights Regarding Your Health Information

You have the following rights regarding the health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and obtain a copy of your health information that may be used to make decisions about your care, including medical and billing records. To inspect or copy your health information, submit a written request to our Privacy Officer. We may charge a reasonable fee for copying and mailing costs.

Right to Amend. If you believe that information in your record is incorrect or incomplete, you may request that we amend it. To request an amendment, submit a written request to our Privacy Officer that includes the reason for your request. We may deny your request in certain circumstances, and if we do, we will provide you with a written explanation.

Right to an Accounting of Disclosures. You have the right to receive a list of certain disclosures we have made of your health information. To request an accounting, submit a written request to our Privacy Officer specifying the time period for which you want the accounting (not to exceed six years). The first accounting in a 12-month period will be provided free of charge; subsequent requests may incur a reasonable fee.

Right to Request Restrictions. You have the right to request restrictions on how we use or disclose your health information for treatment, payment, or healthcare operations, or to restrict disclosures to family members or others involved in your care. We are not required to agree to your request except in one situation: if you pay for a service or item out of pocket in full, you can ask us not to share information about that service or item with your health insurer for payment or healthcare operations purposes, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. To request confidential communications, submit a written request to our Privacy Officer specifying how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice of Privacy Practices at any time. You may also obtain a copy of this Notice by visiting https://www.scovilleosteopathichealth.com/patient-forms-1 or by contacting our Privacy Officer at the address provided at the end of this Notice.

Right to Be Notified of a Breach. You have the right to be notified in the event that we discover a breach of your unsecured health information. Right to a Paper Copy of this Notice**.**

Changes to the Terms of This Notice.

We can change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request, in our facility, and on our web site.

Complaints.

If you have any questions about this Notice or our privacy practices, or if you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer at the address and phone number below. You will not be retaliated against for filing a complaint. you wish to exercise your HIPAA rights or make a complaint, please contact our Privacy Officer.

Contact Information

Privacy Officer: Katherine J. Scoville, D.O.

Address: 10325 Lloyd Road, Potomac, MD 20854

Phone: 301-304-3330

Email: info@scovilleosteopathichealth.com

To File a Complaint with HHS:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue,S.W.
Washington, D.C. 20201
Phone: 1-877-696-6775
Website: www.hhs.gov/ocr/privacy/hipaa/complaints/

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Office Policy

Welcome:

To help you get acquainted with the office, we have prepared this statement about our policies and fee schedules. Please sign below to indicate that you have read and understand our guidelines.

Office Hours:

In Potomac: Mondays 1-8:30pm; Tuesdays 8:30am-4:30pm; Wednesdays 9am-5pm; Fridays 10am-4pm or at *8609 Second Avenue, Suite 405B, Silver Spring, MD 20910*: Thursdays 12:30-8:30pm

Your Appointment:

Your appointment is time set aside for you to see the Doctor. We have a ***twenty-four (24) hour cancellation policy***. If you cancel an appointment less than 24 hours prior to its scheduled time, you will be billed the full visit fee. A message may be left on our voice mail at any time to cancel your appointment. The earlier you can inform us of a change in your plans, the more efficient use we can make of our time. We also respect your time and will make every effort to be punctual for your appointment.

Children:

Children *must be supervised by their caretaker and remain in the waiting area* unless they are being seen by the doctor.

Fragrances:

Some of our patients are allergic to environmental pollutants such as perfumes and hair sprays; we would appreciate it if you would refrain from wearing these to the office.

Fees & Payments:

For all patients, we require payment for services at the time they are provided. We do not participate with private insurance carriers, but we supply a standard, itemized receipt that you may submit to your non-Medicare insurance company to request reimbursement. Our practice also does not participate with Medicare or Medicaid. Because Dr. Scoville has opted out of Medicare, Medicare patients will need to sign a Private Pay Contract, which the doctor will explain prior to treatment. The Contract affirms that the patient accepts responsibility for all treatment costs, and will not seek Medicare reimbursement.

The parent or guardian of a minor patient is responsible for payment.

Checks returned from the bank will incur a $30.00 “returned check” fee to your account.

Thank you for taking the time to read this policy sheet. If you have any questions about our policy please ask them now.

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Name: _____ Date: _____

HISTORY OF CURRENT ISSUE

What problem(s) lead you to consult the doctor today? (Describe symptoms in detail.)

_____

_____

_____

When did symptoms begin? _____

Do you know what caused them? If so please explain. _____

_____

How often are symptoms present? _____

How long do symptoms last? _____

What time of day are symptoms more prominent? _____

Does the child appear to have pain? ___ If so, has it increased or decreased? _____

What makes symptoms better? _____

What makes symptoms worse? _____

Has the child had any of these problems in the past? _____

What type of treatment, medical or non-medical, has the child received for this issue? _____

_____

_____

What previous diagnostic tests or studies have been done? Results? _____

_____

_____

Has this issue affected the child developmentally or socially? If so, how? _____

_____

_____

Name: _____ Date: _____

PAST MEDICAL HISTORY

Please list all past illnesses/hospitalizations:

_____ Date _____
_____ Date _____
_____ Date _____

Please list any operations:

_____ Date _____
_____ Date _____
_____ Date _____

Please list current medications:

Name	Dose	Taking Since	Effect

Please list any allergies and type of reaction:

_____
_____
_____

Please list any traumas/accidents/injuries:

_____
_____
_____

PRENATAL & BIRTH HISTORY

(Please circle appropriate choices when given.)

___ of___ siblings; Pregnancy welcomed /planned: Yes No ; Prenatal care?_____

Medicines/ caffeine /tobacco/alcohol/substances used during pregnancy:_____

_____

Complications with Pregnancy: _____

Gestational age/weeks pregnant at delivery: _____Type of delivery_____

Time of ruptured membranes_____

Name: _____ Date: _____

Hours of Labor/Problems: _____

Time Pushing: _____Medicines used:_____

Epidural: Yes No Pitocin augmentation: Yes No Forceps or vacuum: Yes No

C-Section: Yes No Reason: _____

Presentation: Vertex Breech Transverse ; APGAR scores_____/_____

First Cry: strong weak Birth weight: _____ Birth length:_____

Complications Mother:_____

Complications Baby: _____

Feeding:

Immediately to breast? Yes No Breast/Bottle ; Suck strong: Yes No ; Spit-up: Yes No

Vomit: Yes No ; Failure to thrive: Yes No ; Formula name_____ changed? Yes No

Colic: Yes No ; Sleeps well: Yes No ; Start solids: Yes No ; Feed self: Yes No

Personality_____

Was baby placed on belly as infant? Yes No

DEVELOPMENTAL HISTORY

Milestone:	**Age:**	**Milestone:**	**Age:**
Chest up in prone (often approximately 2m)		**Coos, Smiles (2m)**	
Up on hands, rolls front/back (4m)		**Reaches, laughs, vocalizes after speaker (4m)**	
Rolls back/front, lifts head (5m)		**Smiles in mirror, object hand to mouth, mimic (5m)**	
Sit supported (6m)		**Babbles, strangers, looks to floor for fallen object**	
Sits unsupported (7m)		**Bangs/shake, toy, feet to mouth, (7m)**	
Gets into sitting position (8m)		**Peek-A-Boo**	
Pulls to stand, creeps, grasp with fingertips (9m)		**Words have meaning**	
Walk with hands held, pincer grasp (10m)		**Look at picture in book (10m)**	
Stands alone (11m)		**Looks for person named, First word (11m)**	
Walks (12m)		**2 words (12m**	
Climbs stairs (16m)		**5-10 words, tower of 3 cubes, fetches (16m)**	
Throws Ball		**10-25 words, Points to self, scribbles (18m)**	
Walks up stairs(20-22)		**2 word combination (20-22m)**	

Is the child toilet trained? Yes. No. At what age or stage? _____

If the child is in school, what grade? _____ Any learning problems? _____

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Name: _____ Date: _____

SOCIAL HISTORY

What is the child's home environment like? _____

Is the child adopted? ____ What family members live in the home? _____

Is there any smoking in the home? _____ Other environmental exposures? _____

Does the child do sports or exercise? _____ If so, what type? _____

What are the child's hobbies or interests? _____

FAMILY HISTORY

Please list any family illnesses:

Relative	Age if Living	Health Problem	Age of Onset	Age of Death	Cause of Death
Paternal GM					
Paternal GF					
Maternal GM					
Maternal GF					
Father					
Mother					
Brothers					
Sisters					

REVIEW OF SYSTEMS

Please check any of the following issues if present:

___Weight gain/loss
___Energy change
___Fever/chills
___Rashes
___Skin sores/growths
___Skin color changes
___Head trauma
___Headaches
___Head flattening
___Vision issues
___Red eye(s)
___Eye tearing/discharge
___Lazy eye
___Ear infections
___Hearing trouble

___Balance issues
___Nasal discharge
___Nasal obstruction
___Frequent colds
___Snoring/mouth breather
___Sore throat
___Large tonsils
___Dental issues
___Shortness of breath
___Coughing
___Sputum
___Chest pain
___Palpitations
___Heart murmur
___Congenital heart issue

___High blood pressure
___Blue hands/feet
___Swelling
___Feeding issues
___Suck/swallow issues
___Nausea/Vomiting
___Constipation
___Reflux/Spitting up
___Urinary infections
___Bed wetting
___Urinary reflux
___Paralysis/weakness
___Seizures
___Loss of consciousness
___Tremor

___Numbness/Tingling
___Memory/concentration
___Joint pain/swelling
___Stiffness
___Low muscle tone
___Scoliosis
___Depression
___Anxiety
___Autism Spectrum
___Abuse
___Thryroid problem
___Diabetes
___Anemia
___Bleeding issues
___Swollen lymph nodes

For Physician's use:

_____

_____