BAY COMMUNITY HEALTH

Date:_____

Legal Name *Last*	*First*	*Middle Initial*	*Maiden Name (if Married)*
Legal Sex: ☐ Male ☐ Female	**Date of Birth** Month Day Year / /	**Social Security #**	

Please be aware that the name & sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. Your answers to the following question will help us reach you quickly & discretely with important information

Home Phone ( )	**Cell Phone** ( )	**Work Phone** ( )	**Best number to use:** ( ) Home ( ) Cell ( ) Work
Please indicate if BCH may leave a message for you on the following numbers: ( ) Home ( ) Cell			
Local Address	City	State	Zip
Billing Address (if different from above)	City	State	Zip
Email Address		☐ Do not have email address ☐ Prefer not to share email address	
Responsible Party Name	**Phone Number**	**Relationship to you**	
Responsible Party Address	City	State	Zip
Emergency Contact's Name	**Phone Number**	**Relationship to you**	

This information is for Bureau of Primary Health Care reporting purposes and ensures federal funding to serve our patients. We respect that this is personal and confidential information. Your cooperation in completing this section is appreciated.

1) **Which category best describes your current annual income?**
- ☐ < $15,000
- ☐ $15,001-$25,000
- ☐ $25,001-$35,000
- ☐ $35,001-$50,000
- ☐ >$50,001

2) **Family Size:** _____
Total # of family members residing in the same house

3) **Marital Status**
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated
- ☐ Partnered

4) **Employment status:**
- ☐ Full Time
- ☐ Part Time
- ☐ Not Employed
- ☐ Self Employed
- ☐ Retired

5) **Student status:**
- ☐ Student Full Time
- ☐ Student Part Time
- ☐ Not a Student

6) **Racial Group(s)**
- ☐ Asian
- ☐ Black/African American
- ☐ American Indian/ Alaska Native
- ☐ Native Hawaiian/ Other Pacific Islander
- ☐ White/Caucasian

7) **Ethnicity**
- ☐ Hispanic/Latino/Latina
- ☐ Not Hispanic/Latino/Latina

8) **Language(s)**
- ☐ English
- ☐ Spanish
- ☐ Other: _____

9) **Require translation services**
☐ Yes ☐ No

10) **Veteran Status**
- ☐ Veteran
- ☐ Not a Veteran

11) **Seasonal Worker?**
☐ Yes ☐ No

12) **Migrant Worker?**
☐ Yes ☐ No

13) **Homeless since January this year?**
☐ Yes ☐ No

14) **Public housing Resident?**
☐ Yes ☐ No

15) **How did you learn about BCH:**
- ☐ Friend/Family
- ☐ Other Doctor's Office
- ☐ Insurance Company
- ☐ Postcard/Mailing
- ☐ Hospital/ER
- ☐ Internet Advertising
- ☐ Capital
- ☐ Bay Weekly
- ☐ Chesapeake Family
- ☐ Other: _____

16) **Do you think of yourself as:**
- ☐ Straight
- ☐ Lesbian/Gay
- ☐ Bisexual
- ☐ Something else
- ☐ Don't Know
- ☐ Choose not to disclose

What gender do you identify with?
- ☐ Male
- ☐ Female
- ☐ Choose not to disclose
- ☐ Trans Male
- ☐ Trans Female
- ☐ Other: _____

Please Turn Over

BAY COMMUNITY HEALTH

Date:_____

Please indicate below if you have a preferred pharmacy for filling prescriptions:

Preferred Pharmacy:		**City**	

Payment/Insurance Information

PLEASE PROVIDE YOUR INSURANCE CARD AT THE TIME OF REGISTRATION. A list of insurance we accept is available on our website. Our registration staff can also assist you.

METHOD OF PAYMENT

I understand and acknowledge that payment is due at the time service is rendered. This includes all co-payments and co-insurance responsibilities. Any variation to this policy must be pre-arranged through our Accounting Department, prior to being seen. We accept Cash, Checks, Money Orders, Visa, MasterCard, American Express, and Discover.

INSURANCE AUTHORIZATION, ASSIGNMENT AND PAYMENT OF SERVICES

I request that payment of authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to Bay Community Health (BCH) for any services furnished me by that party who accepts assignment/clinical provider. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to be released in order to process payment of such services. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for treatment. I also understand that it is my responsibility to be knowledgeable of my insurance benefits and requirements. I understand that based on my health insurance policy, there may be services that the Clinical Provider of BCH may deem necessary that may not be covered by my health insurance, and I shall be held responsible for the payment of such services. I understand and acknowledge that payment is due at the time service is rendered. This includes co-payments, patient responsibility percentage of office visit/procedural charge and any previous back charges. Any variation to this policy must be pre-arranged through our Accounting Department, prior to being seen.

AUTHORIZATION TO TREAT

Permission is hereby given to the Clinical Providers of BCH, to administer such diagnostic, operative, or treatment procedures to the above named patient that are deemed necessary. This includes accessing information from an Carequality/Commonwell Health Information exchange and online pharmacy database about medications that I may be taking for the purpose of continued treatment.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of this provider's *Notice of Privacy Policies*, detailing how my information may be used and disclosed as permitted under federal and state law.

ADVANCE DIRECTIVE

I acknowledge receipt of "Advance Directives" pamphlet/form. This information was given to me *as* part of my "New Patient" documents. I fully intend to read this pamphlet, and should I decide to choose the use of the advance directives, I will complete the form and will return the signed document back to OPC to maintain with my medical records.

The below signature acknowledges your agreement to the above disclosures:

X _____ **Date:** _____

_____ _____

BAY COMMUNITY

BAY COMMUNITY HEALTH
Medical History Form

Name _____ **Date of Birth** _____

Address _____ **Home Phone #** _____

_____ **Work Phone #** _____

Social Security # _____ **Occupation** _____ **Cell Phone #** _____

HOSPITALIZATION/SURGERY

Date	Reason

IMMUNIZATIONS

Hepatitis B	YES	NO	When _____
Pneumovax	YES	NO	When _____
Flu	YES	NO	When _____
Tetanus	YES	NO	When _____

DRUG ALLERGIES

_____

_____

_____

MEDICATION LIST

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

MEDICAL HISTORY

____ Ringing in Ear
____ Ear Infections-Frequent
____ Dizziness/Fainting
____ Failing Vision
____ Eye Infections
____ Nose Bleeds
____ Sinus Trouble
____ Sore Throats-Frequent
____ Hayfever/Allergies
____ Pneumonia
____ Bronchitis/Chronic Cough
____ Asthma/Wheezing
____ Chest Pain
____ High Blood Pressure
____ Heart Murmur
____ Swollen Ankles
____ Leg Pain- walking
____ Varicose Veins/Phlebitis
____ Loss of Appetite
____ Difficulty Swallowing
____ Indigestion or Heartburn
____ Persistent Nausea/Vomiting
____ Peptic Ulcers
____ Abdominal Pain-Chronic
____ Gall Bladder Trouble
____ Jaundice/Hepatitis
____ Change in Bowel Habits
____ Diarrhea
____ Constipation
____ Diverticulosis
____ Crohn's/Colitits

____ Bloody or Tarry Stools
____ Hemorrhoids
____ Hernia
____ Urine Infections-Frequent
____ Blood in Urine
____ Kidney Stones
____ Venereal Disease
____ Urethral Discharge
____ Chronic Fatigue
____ Weight Loss-Recent
____ Anemia
____ Bruise Easily
____ Cancer
____ Diabetes
____ Thyroid Disease
____ Convulsions/Seizures
____ Stroke
____ Tremor/Hands Shaking
____ Muscle Weakness
____ Numbness/Tingling Sensations
____ Headaches-Frequent
____ Arthritis/Rheumatism
____ Osteoporosis
____ Back Pain-Recurrent
____ Bone Fracture/Joint Injury
____ Gout
____ Foot Pain
____ Cold Numb Feet
____ Rashes/Hives
____ Psoriasis
____ Eczema

____ Nervousness
____ Depression
____ Memory Loss
____ Moodiness-Excessive
____ Phobias
____ Mental Illness
____ Lactose Intolerance
____ Prostate Disease
____ Sexual Menstruation Dysfunction
____ Frequent Infections
____ Diphtheria
____ Tetanus
____ Chicken Pox
____ Polio
____ Mumps
____ Measles
____ Rubella
____ Rheumatic Fever
____ Scarlet Fever
____ Tuberculosis
____ Herpes

URINATION

____ Overnight > than twice
____ Painful
____ Loss of Control
____ Decrease in Force/Flow

____ Other _____
____ Other _____
____ Other _____
____ Other _____

BAY COMMUNITY HEALTH
Medical History Form

PLEASE TURN FORM OVER

FEMALES (Please Complete)

Pregnant YES NO
Planning Pregnancy YES NO
Pain/Bleeding during or after sex YES NO

Menstrual Flow: ____ Regular ____ Irregular ____ Pain/Cramps
Days of Flow _____
Length of Cycle _____

Number of:
____ Pregnancies
____ Miscarriages
____ Abortions
____ Live Births

Birth Control Method _____
Name of Birth Control Pill _____

Do you have your Well Woman Exam (PAP and Breast Exam) done at Bay Community Health? *Yes* *No*

Are you:	Test	Provider/Organization Name	Date Last Done
21 yrs or older (females only)	**Pap Smear**		/ /
40 yrs or older (females only)	**Mammogram**		/ /
50 yrs or older (female & male)	**Colonoscopy**		/ /

FAMILY HISTORY

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

	Which Family Members	Approx. when Diagnosed
Alcoholism		
Asthma		
Bleeding Disorder		
Cancer		
Diabetes		
Glaucoma		
Epilepsy/Convulsions		
Heart Disease		
High Blood Pressure		
Kidney Disease		
Mental Illness		
Migraine		
Osteoporosis		
Stroke		
Thyroid Disease		
Other _____		
Other _____		

HABITS

____ Alcohol Type _____ Amount _____ How Long _____
____ Smoke Daily Qty _____ How Long _____
____ Coffee Cups Daily _____

PREVENTION

Do you wear seatbelts?	YES	NO	If no, why not? _____
Do you wear a bike helmet?	YES	NO	N/A
Do you have a working smoke detector?	YES	NO	N/A
If there is a gun in your home, is it out of children's reach and unloaded?	YES	NO	
Do you wish to be tested for AIDS?	YES	NO	
Have you ever worked with chemicals, paints, asbestos, or other hazardous material?	YES	NO	If yes, explain _____

BAY COMMUNITY HEALTH

BAY COMMUNITY HEALTH
Notice of Privacy Practices
Effective Date: January 1, 2013

This notice describes how health information about you may be used and disclosed and how you can get this information. PLEASE READ IT CAREFULLY.

Our Pledge to You about Protecting Your Health Information We at Bay Community Health (BCH) understand that health information about you and your health care is personal. We are committed to protecting this most private information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by this health care practice, whether made by your personal doctor or health care practitioner or others working in this office. This notice will tell you about the ways we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and certain obligations we have to use or disclose it. LAW REQUIRES US TO:

- Make sure that health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy with respect to your health information; and
- Follow the terms of this notice currently in effect

How We May Use and Disclose Health Information About You ***For Treatment*** We may use health information about you to provide you with health care treatment or services. We may disclose information about you to doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our office, at the hospital if you are hospitalized under our supervision, or at another doctor's office, lab, pharmacy, or other health care provider to whom we may refer you for consultation, to take x-rays, to perform lab tests, to have prescriptions filled, or other reasons. The information is needed by these professionals in order to know what treatments you will need. They will record actions taken in the course of your treatment and note how you respond. In the event of a disaster, we may also disclose health information about you to another organization assisting in disaster relief so that your family can be notified about your condition, status and location. ***Communications with Family*** Using our best judgment, we may disclose to a family member, personal representative, or any other person you identify, health information about you related to that person's involvement in you care if you do not object, or in the event of an emergency. ***Appointments*** We may use your information to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may be of interest to you. ***For Payment*** We may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payer, such as an insurance company or health plan. The bill may contain information that identified you, your diagnosis, and treatment or supplies you received in the course of care. ***For Health Care Operations*** We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of medical staff, risk or quality improvement personnel, and others to:

- Evaluate the performance of our staff;
- Assess the quality of care and outcomes in your case and similar cases;
- Learn how to improve our facilities and services; and
- Determine how to continually improve the quality and effectiveness of the health care we provide.

Health Information Exchanges We may participate in various health information exchanges to facilitate the secure exchange of your electronic health information between and among several health care providers or other health care entities for your treatment, payment, or other healthcare operations purposes. We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide health information exchange. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and prevent searching of your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org.

Health Care Oversight Activities We may disclose health information to a health oversight agency for activities authorized by law. These activities include, for example, audits, investigations, inspections, and licensure. They are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. ***As Required by Law*** We may use and disclose information about you as required by law. For example, we may disclose information for the following purposes:

- For judicial and administrative proceedings;
- To assist law enforcement officials in their duties, and
- To report information related to victims of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

To Avert a Serious Threat to Health and Safety We may use or disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of another person or the public. Any disclosure, however, would only be made to someone able to help prevent the threat. ***For Public Health*** We may use or disclose your health information for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report reactions to medications or problems with products;
- To notify people of recalls for products they may be using, and
- To notify a person who may have been exposed to disease or may be at risk for contracting the disease or condition.

Military or Veterans If you are a member of the armed forces or separated/discharged from military service, we may release health information about you as required by military command authorities or the Department of Veteran Affairs. We may also release health information about foreign military personnel to the appropriate foreign military authorities. ***Workers Compensation*** We may disclose health information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness. ***Coroners, Health Examiners and Funeral Directors*** We may release health information to a coroner or health examiner. For example, this may be necessary to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties. ***Inmates*** If you are an inmate of a correctional institution or under custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release may be necessary for the institution to provide you with the health care, to protect your health and safety or that of

others, or for the safety and security of the correctional institution. ***Government Functions*** We may release health information to specialized government functions such as protection of public officials (President of the United States and others), or reporting to various branches of the armed services, authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. ***Lawsuits and Disputes*** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Your Health Information Rights The health and billing records we maintain are the physical property of Bay Community Health. The information in them, however, belongs to you. You have a right to: ***Inspect and Copy*** You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records. This does not include psychotherapy notes. To inspect and/or copy health information you must request this in writing using the form that we will provide to you upon request. Medical Record copies may be processed by an independent company, and a fee by this company or by Bay Community Health is billed to the patient. The fee varies based on the individual's medical records and specifics of the request, and the request will be processed within 2 to 3 weeks of date of the request. We may deny your request to inspect and copy your health information in very limited circumstances. If you are denied access to your health information, you may request a review of the denial. The person conducting the review will
not be the same one that denied your request. We will comply with the outcome of this review. ***Right to Amend*** If you feel that health information we have about you is incorrect or incomplete; you may ask us to amend the information. To request an amendment you need to submit your request in writing, on one page of paper, legibly handwritten or typed to Bay Community Health, HIPAA Officer, 134 Owensville Road, West River, MD 20778. In addition, you must provide the reason for wanting to amend the information. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information that you would be permitted to inspect and copy; or
- Is accurate and complete.

Any amendment we make to your health information will be disclosed to those with whom we share information as previously described. ***Right to an Accounting of Disclosures*** You have the right to request a list of accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, or health care operations, as previously described. To request a list of disclosures, you must submit your request in writing to Bay Community Health, HIPAA Officer, 134 Owensville Road, West River, MD 20778. Your request must state a time frame that may be no longer than six (6) years and may not include dates prior to April 13, 2003. The first list you request within a twelve-month period will be free. For additional lists, we will charge you the cost of providing the list. We will notify you of the cost involved and you may choose to modify or withdraw your request at that time and before the costs are incurred. We will mail you a list of disclosures in paper form within 30 days of your request, or notify you if we are unable to supply the list within that time period and the date by which we can supply the list, but this date will not exceed a total of 60 days from the date you made the request. ***Right to Request Restrictions.*** You have the right to request a restriction of limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment of your care, such as a family member or friend. ***We are not required to agree to your request for restrictions if we are not able to ensure our compliance or if we believe it will negatively impact the care we may provide you.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request in writing to Bay Community Health, HIPAA Officer, 134 Owensville Road, West River, MD 20778. In your request, you must tell us what information you want to limit and to whom you want the limits to apply. ***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. For example; you can ask that we only contact you at work or by mail to a post office box. To request confidential communications, you must make your request in writing to Bay Community Health, HIPAA Officer, 134 Owensville Road, West River, MD 20778. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must tell us how or where you wish to be contacted. ***Right to a Paper Copy of this Notice.*** You have the right to obtain a paper copy of this notice at any time. To obtain a copy, please request it from Bay Community Health, HIPAA Officer, 134 Owensville Road, West River, MD 20778.

Changes to this Notice We reserve the right to change this notice. We reserve the right to make revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain the effective date on the first page.

Complaints
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 Bay Community Health, HIPAA Officer, 134 Owensville Road, West River, MD 20778. All complaints must be submitted in writing. ***You will not be penalized for filing a complaint.***

Acknowledgement of Receipt of this Notice
We will request that you sign a separate form or notice acknowledging that you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name and date the acknowledgement form. This acknowledgement will be filed with your records.

Bay Community Health sincerely respects your privacy rights, and will make every reasonable attempt to protect your health information. It is important that you read this notice carefully, and if you have questions or concerns regarding this notice, please contact:

Bay Community Health
Attention: HIPAA Officer
134 Owensville Road
West River MD 20778
410-867-4700

BAY COMMUNITY
HEALTH

Bay Community Health

Notice of Privacy Practices Acknowledgement

Effective Date: January 1, 2013

I have been provided a paper copy of the Notice of Privacy Practices effective as of the date above.

_____
Patient's Name

_____
Patient's Signature

_____
Date

TO BE RECORDED IN PMS/SCANNED IN EPR

BAY COMMUNITY HEALTH

BAY COMMUNITY HEALTH
Patients' Bill of Rights & Responsibilities

Bay Community Health is committed to providing quality health care. A well-informed patient that participates in treatment decisions and communicates openly with their healthcare professionals is a patient that will ultimately benefit greatly in their continued healthcare.

You have the Right to …

- To considerate and respectful treatment from your first phone call throughout your office visit and follow-up care.
- To know the names and professional status of the people serving you.
- To privacy/confidentiality concerning your own health care program and medical records.
- To participate in choosing a form of treatment.
- To consent to or refuse any care or treatment.
- To examine and receive an explanation of all charges
- To receive full information and counseling or the availability of known financial resources for your health care.
- Timely resolution of any questions, complaint or problem regarding OPC services and/or procedures.

You have the Responsibility …

- To be honest about your medical history.
- To follow health advice and instructions.
- Report any significant changes in symptoms or failure to improve.
- Maintain and have available an updated detailed medication list.
- Provide sufficient time in making "Follow-Up" and "Annual" appointments to ensure appointment availability.
- To keep appointments or provide 48 hours advance notice for cancellation.
- **To insure you obtain prescriptions at the time of your office visit. If a prescription refill must be called in, allow a minimum of 48 hours notice.**
- **Allow 3-5 working days for specialty referrals.**
- **Allow 5-7 working days for completions of forms. Forms must be completed/signed by patient; some forms will require an appointment and some forms may incur a patient fee.**
- Be knowledgeable and well-informed about your health insurance coverage, especially in regard to:
    1. Prescription/Medication formularies
    2. Preferred Lab Providers
    3. Specialty-Care providers, policies and procedures
    4. Non-Covered medical services
- To turn-off cellular phone while in the building.
- To be respectful of all other patients, visitors and staff.

BAY COMMUNITY HEALTH

Bay Community Health
Patient Information Sheet

Bay Community Health welcomes you and your family, and we appreciate the opportunity to provide your health care services! We provide Primary Care and Behavioral Health Care services at all Bay Community Health Locations. Please read the following information, which is provided to help meet your needs and answer questions about our practice.

Office Hours	West River		Shady Side	
	Medical	Behavioral Health	Medical	Behavioral Health
Monday	8:00 am – 5:00 pm	8:00 am – 5:00 pm	8:00 am – 5:00 pm	Closed
Tuesday	8:00 am – 5:00 pm	8:00 am – 7:00 pm	8:00 am – 5:00 pm	Closed
Wednesday	8:00 am – 5:00 pm	8:00 am – 7:00 pm	8:00 am – 5:00 pm	8:00 am – 5:00 pm
Thursday	8:00 am – 7:00 pm	8:00 am – 7:00 pm	8:00 am – 5:00 pm	Closed
Friday	8:00 am – 4:30 pm	8:00 am – 4:00 pm	8:00 am – 4:00 pm	Closed
Saturday	Closed	8:00 am – 2:00 pm	Closed	Closed
Sunday	Closed	Closed	Closed	Closed

Appointment Scheduling

- Established patients should arrive 15 minutes prior to appointment time / New patients should arrive 30 minutes prior
- Sick visits are typically scheduled for the same day or within 48 hours of appointment request
- Same-day and walk-in appointments are granted based on availability
- Follow-up office visits are scheduled at check-out
- Physical exams/well exams are usually scheduled within 2 to 6 weeks of appointment request
- Our providers may occasionally be running late, and your visit may be delayed. Our staff will try to inform you if this occurs.
- 48-hour advance notice on all cancellations is requested

Return Telephone Messages

Our providers and/or medical support staff attempt to return all messages in a timely fashion. Return calls are often made during the lunch or late afternoon hours and sometimes on the following day.

Prescriptions

Our providers believe that patients should be evaluated prior to being prescribed new medications. Prescription refills should be made through the pharmacy, which requires patients to inform their pharmacy with 48 hours advanced notice. "Controlled substance" medications will not be prescribed on Fridays or on the day before a Federal holiday and in most cases will require an appointment with the primary provider. Some written prescriptions need to be picked up at the office and cannot be called in to a pharmacy. To avoid delays with medication refills, please review medication needs at each office visit.

Medical Referrals

You may require a medical referral for specialty and/or urgent care. Bay Community Health requests 5 working days to process these referrals. In many cases an office evaluation will be requested to determine the referral's necessity. Urgent care and/or emergency department visits may also require prior authorization. Please contact the office within 48 hours of an urgent care or emergency department visit to determine whether it has been authorized. Please remember that there are many health insurance companies many more individual policies. It is the patient's responsibility to know and abide by the regulations of his or her insurance coverage.

BAY COMMUNITY HEALTH

Medical Records/Medical Forms

In order to obtain a copy of Bay Community Health medical records patients must complete a "Request for Medical Records" form and allow a minimum of 5 working days for processing. The processing fee varies depending on the size of the medical chart, but the basic fee is typically $25.00. There is no charge to obtain copies of immunization records or records pertaining to State of Maryland Workman's Compensation. Depending on the form, there may be a charge applied to the patient bill for this processing. It may also be necessary for the patient to be evaluated in the office prior to form completion.

BAY COMMUNITY HEALTH

Bay Community Health
134 Owensville Road
West River MD 20778
Phone: 410 867-4700 / Fax: 410 867-4934

Patient Name _____ **DOB:** _____

Patient preferred telephone number to be contacted: _____

Please indicate additional persons with whom we may contact on your behalf and indicate their relationship to you:

Name	Relation to Patient	Telephone #	Phone Type
			H W C
			H W C
			H W C
			H W C
			H W C

Patient additional comments: _____

Signature: _____ **Date:**_____

Print Name: _____

BCH Employee Initials: _____

Authorization for Release of Medical Records

Bay Community Health
134 Owensville Road
West River, Md. 20778
(T) 410-867-4700 (F) 855-772-1468

I authorize the following protected health information to be released from the medical record of:

Last Name _____ First Name _____ Today's Date _____

Birthdate _____ Email Address _____ Phone Number _____

Release Records
- ☐ **To**
- ☐ **From**

Bay Community Health
134 Owensville Road
West River, Md. 20778
(T) 410-867-4700
(F) 410-867-4934

Release Records
- ☐ **To**
- ☐ **From**

Name/Organization _____

Address _____

City / State / Zip _____

Phone _____ Fax _____

☐ **Please mail my records** ☐ **Please call when my records are ready for pick up** ☐ **Please fax my records**
☐ **Other:** _____

I understand that to the extent that any recipient of this information, as identified above, is not a "covered entity" under Federal or Maryland privacy law, the information may no longer be protected by Federal and Maryland privacy laws once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.

TO BE RELEASED	**Date of Service / Provider**	**TO BE RELEASED**	**Date of Service / Provider**
☐ Chart Summary	_____	☐ Immunizations	_____
☐ Office visit & lab	_____	☐ Physical Therapy notes	_____
☐ GYN visit & lab	_____	☐ Radiology reports	_____
☐ Urgent Care visits	_____	☐ Entire Record	_____
☐ Lab work	_____	☐ Other	

➔ Note: If specific dates to be released or a specific provider are not indicated, all records in the category marked will be released.

Indicate the PURPOSE for this disclosure:_____
I understand the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
I understand I have the right to revoke this authorization I must do so in writing and in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition_____.
If I fail to specify and expiration date, event or condition, this authorization will expire in six months of dated signature. I understand that authorizing the disclosure of this phi is voluntary. I need not sign this for in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact BCH Privacy Officer.
I understand that I may incur a charge for the copying or inspection of patient records. A minimum clerical fee of $_____and per page fee of $_____.

Signature of Patient or Patient Representative _____ Printed Name/Relationship of Patient Representative _____ Date _____

If documents are being picked up at BCH, from someone other than the patient. This authorization form must indicate this accordingly

Signature of person picking up documents _____ Printed Name/Relationship _____ Date _____