WELCOME TO

INTERNAL MEDICINE SPECIALISTS OF FREDERICK, LLC

Please PRINT the information below to help us serve you better.

Patient's name: _____ Today's date: _____

Patient's address: _____

Phone #'s: Home: _____ Work: _____ Cell: _____

Last 4 digits of SS# _____ Date of Birth: _____ Age: _____

Please CIRCLE: Male/Female Married/Single/Divorced/Separated Race: _____ Ethnicity: _____

Dominate Hand: _____ Language Spoken: _____

Patient's occupation: _____ Employer: _____

Employer's address: _____ Emp phone: _____

If patient has a Power of Attorney, please notify the doctor.

Spouse's name: _____ Occupation: _____

Spouse's employer & Address: _____

_____ Phone: _____

Your primary care physician: _____ Other important physicians: _____

Who referred you? _____ If not your MD, may we thank him/her? _____

IN CASE OF EMERGENCY, PLEASE NOTIFY: _____

Relationship: _____ Address: _____

Home/Work/Cell phone: _____ Patient's mother's maiden name: _____

Other close relative/friend who does not live with you (Name, Address, Phone #): _____

_____

INSURANCE INFORMATION

Please submit your insurance card with this form to be copied.

Primary Insurance Carrier: _____ ID# _____ Group# _____

Policy Holder's Name _____ Patient's relationship to Subscriber _____

Secondary Insurance Carrier: _____ ID# _____ Group# _____

Policy Holder's Name _____ Patient's relationship to Subscriber _____

Pharmacy: _____

If you do not have insurance, please be prepared to discuss payment options.

KINDLY ALLOW US TO COPY YOUR DRIVERS LICENSE—THE PICTURE HELPS WITH IDENTIFICATION

This information may be used in an attempt to collect a debt and any information obtained may be used for that purpose.

PATIENT HISTORY FORM

Today's date: _____

Name: _____ Date of Birth: _____

Occupation: _____ Date of Last Physical Exam: _____

Please list the names of other providers from whom you have received care in the past year (including physicians, chiropractors, counselors, acupuncturists, naturopaths or psychiatrists):

_____

What is the main reason for your visit today? (Explain specific symptoms, how they started and what happened).

_____

_____

PAST MEDICAL HISTORY: Do you have or have you had in the past, any of the following conditions (please circle):

Anxiety	Heart Disease	Rheumatoid Arthritis
Asthma	Hepatitis	Seizure Disorder
Depression	High Blood Pressure	Stroke
Diabetes	High Cholesterol	Thyroid Disease
GERD	Kidney Disease	Tuberculosis
Heart Attack	Osteoporosis	STD
Cancer (type) _____	Other: _____	

Please list any prior injuries and the date of injury: _____

_____

SURGICAL HISTORY: Please list any surgeries you had have with the dates performed:

_____ _____ _____

_____ _____ _____

MEDICATIONS: Please list any prescription and over the counter medications you take (including vitamins) and the dosage:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES: Have you ever had a reaction to any medication? Is so, which med and what happened?

ALLERGIES: Food?
Environmental?

DIET: Are you on a special diet? Is yes, please explain.

_____

FAMILY HISTORY:

Are there any illnesses (cancer, diabetes, heart disease or depression) that run in your family? Y N

If so, which illnesses? _____

Health status of your family:

Relationship	Living	Age	Significant Health Problems
Mother	Y N	____	_____
Father	Y N	____	_____
Sibling	Y N	____	_____
Sibling	Y N	____	_____
Sibling	Y N	____	_____
Paternal Grandfather	Y N	____	_____
Paternal Grandmother	Y N	____	_____
Maternal Grandfather	Y N	____	_____
Maternal Grandmother	Y N	____	_____
Children	Y N	____	_____
_____	Y N	____	_____
_____	Y N	____	_____

Do You:

Currently smoke tobacco? Y N If yes, how much? _____ For how long? _____

Have you been a smoker in the past? Y N

If yes, how long? _____ Packs/day? _____ Last quit date? _____

Drink alcohol? Y N If yes, how much? _____

Drink caffeinated beverages? Y N If yes, how much? _____

Use any recreational or "street drugs" (ex: marijuana, cocaine, LSD, ecstacy, methamphetamine) Y N

If yes, which type? _____ If yes, how much? _____

Ever inject drugs? _____ If yes, how often? _____

Wear seatbelts? Y N If yes, how often? _____

Are you sexually active? Y N If so, with men? _____ with women? _____

Have an HIV concern? Y N If yes, why? _____

Exercise regularly? Y N If yes, what type and how often? _____

Travel outside the U.S.? Y N If so, where? _____

Where were you born? _____

Have you:

Had a tetanus shot in the last 10 years? Y N If so, when? _____

Ever had a pneumonia vaccine? Y N If so, when? _____

Ever had a flu shot? Y N If so, when? _____

Been tested for colon cancer? Y N If so, when? _____

WOMEN:

Date of last pap smear? _____ Date of last mammogram? _____

Date of last menstrual period? _____ Is your period predictable? _____

Birth control method? _____

Number of pregnancies: _____ Number of births: _____ Number of miscarriages: _____

Internal Medicine Specialists of Frederick, LLC
70 Thomas Johnson Drive, Suite 101
Frederick, Maryland 21702
(301) 668-9393
Communication Form

Patient name_____ Date of Birth_____

I _____give Internal Medicine Specialists of Frederick permission to discuss the following:

- Diagnosis, prognosis, and/or treatment information
- Test results
- Scheduling Information
- Billing Information
- Other (please specify):_____

With the following people:

_____ relationship:_____ phone #_____
_____ relationship:_____ phone #_____
_____ relationship:_____ phone #_____

I also authorize Internal Medicine Specialists of Frederick to:

- Leave messages on my home answering machine
- Leave messages on my cell phone
- Leave messages on my work answering machine/voicemail
- Leave messages with my family members or others residing in my household

Signature_____ Date_____
Patient

Signature_____ Date_____
Parent or legal guardian

This form must be filled out completely in order for us to ensure the patient's confidentiality of our patients' protected health information. The instructions on this form will be considered current communication authorization supersedes them. It is the patients' responsibility to file a new form with us if there are household changes. We are not responsible for undesired communications resulting from the failure of a patient communication authorization form.

AUTHORIZATION

This is authorization for Dr. Kane, to apply for benefits on my behalf. I request that any payments for services rendered to me under any insurance plan, Medicare, Medical Assistance, etc. be made directly to Dr. Kane/Internal Medicine Specialists of Frederick, LLC until such time as I revoke this authorization in writing. I further authorize the release of any medical information for any claim to my insurance carrier that may be transmitted electronically.

I authorize Dr. Kane, to send a letter to my referring physician or health care provider summarizing his findings, treatment, and recommendations. I further authorize any and all communication between Dr. Kane, and my health care providers to facilitate optimal patient care when felt to be in my best interest by Dr. Kane. I understand that I need to complete a formal "Release of Information" form for my chart to be copied and forwarded to another health care provider. A charge may apply for copying of records. I may be contacted with appointment reminders, replies to inquiries, messages regarding test results or treatment, via answering machine or voicemail messages, letters, or email.

If my family (spouse, parents, siblings, adult children) should inquire of Dr. Kane, regarding my medical care, treatment issues, etc., I authorize such communication providing Dr. Kane, feels such to be in my best interest. PLACE AN "X" OVER THOSE PERSONS, IF ANY, THAT YOU WISH INFORMATION WITHHELD FROM.

I acknowledge that I am responsible for payment of the total bill incurred. I promise to pay my bill in a timely manner as determined by Dr. Kane/Internal Medicine Specialists of Frederick, LLC and/or office policy. I acknowledge and accept financial responsibility for any and all expenses, direct and indirect, related to collection of my financial obligation, including court costs, attorney fees, collection agency fees, rebilling and administrative fees, loss of wages/salary, etc. **I may be held financially responsible for office or procedure appointments not canceled with at least 2-business days notice.**

I understand that Dr. Kane may recommend further testing, procedures, future appointments, consultations with other health care providers, treatments, etc. I accept full and complete responsibility if I fail to obtain such recommended testing, procedure(s), consultations, follow-up evaluations, etc., or fail to follow Dr. Kane's, recommendations and advise; I release Dr. Kane and their staff from any consequences that may result.

I understand that I should not take any medication if there is any possibility that I may be or could become pregnant without discussing with Dr. Kane as such could seriously harm my unborn child. Likewise, if there is any possibility that I could be pregnant at the time of an X-ray examination or any other examination, test, or procedure, I need to inform Dr. Kane. I accept any and all responsibility if I fail to take appropriate precautions or so fail to inform Dr. Kane. **Prescriptions will be refilled during regular business hours; please allow 48-hours notice.**

I understand that it is Dr. Kane's policy to generally acknowledge all testing and lab results, pathology reports, etc., including normal results. If I should not receive such an acknowledgment within a reasonable amount of time, generally 14 days, I understand that it is my responsibility to contact the office to verify that Dr. Kane, did receive my results.

I understand and agree to the above, which shall remain in effect until revoked in writing. I may request a copy of this Authorization.

Signature of patient / responsible party: _____

Date: _____

Internal Medicine Specialist of Frederick, LLC

Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our financial policy, which we require you read and sign prior to any treatment.

- **PAYMENT IS DUE AT TIME OF SERVICE**
- **WE ACCEPT CASH, CHECKS, VISA OR MASTERCARD**

REGARDING INSURANCE

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If you have insurance coverage with one of the plans we participate with, we will bill your insurance company along the guidelines of our contract. However, we require that **ALL COPAYS OR DEDUCTIBLES** ***be paid at the time of service***. If you have an insurance with which we do not participate, we ask that payment be made at the time services are rendered and your insurance company will reimburse to you any amount due based on your policy. As a courtesy to our patients, we will submit a claim to your insurance company. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

You will be required to show a copy of your insurance card at the time of service. If you do not have your insurance information or we are unable to verify your coverage, you will be required to pay for the services rendered to you that day. Please be advised that any payment plan should be made *in advance* with our business office. If a check is returned to us by your bank, you will be responsible for charges relating to that return. *Information obtained may be used in an attempt to collect a debt and any information obtained may be used for that purpose.*

MINOR PATIENTS

The parent, or guardian, who presents the child for medical treatment is the responsible party. Any legal agreement between the parents has nothing to do with this practice. The law states the parent seeking or authorizing medical treatment is responsible for the bill.

MISSED APPOINTMENTS

Unless canceled at least 2 business days in advance, our policy is to charge for missed appointments. If the appointment is for a procedure, we require 4 business days notice to avoid a charge. Please help us serve you better by keeping scheduled appointments, including procedure appointments.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy. I guarantee payment of all charges incurred for the account of the below patient. I further agree to pay any attorney's fee, court costs, and related collection fees incurred.

Patient Name (print) **Responsible Party (signature)** **Date**

CONFIDENTIAL

ADULT IMMUNIZATION RECORD

Date _____ SS/HIC/Patient ID# _____

Patient Name _____ Date of Birth _____

Vaccine	Date Given	Dose	Route[1]	Site[2]	Lot Number	VIS Date[3]	Manufacturer	Side Effects	Given By
Hepatitis A									
Hepatitis A									
Hepatitis B									
Hepatitis B									
Hepatitis B									
Influenza									
Influenza									
Influenza									
Influenza									
Influenza									
MMR									
MMR									
Meningococcal (polysaccharide)									
Pneumococcal (polysaccharide)									
Pneumococcal (polysaccharide)									
Tetanus/Diptheria									
Tetanus/Diptheria									
Varicella									
Varicella									
Other									
Other									
Other									
Other									

Route[1]	SC=Subcutaneous IM=Intramuscular PO=Per Os
Site Given[2] O=Oral	RA=Right Arm LA=Left Arm RT=Right Thigh LT=Left Thigh
VIS Date[3]	VIS=Vaccine Information Statements

Consent

I have been provided information regarding the diseases and vaccines listed above. All my questions have been answered to my satisfaction. I believe that I have adequate knowledge regarding the risks and benefits of the vaccines upon which to base an informed consent for me or the person for whom I am authorized to give this consent. I understand that vaccines, like any medication, are capable of causing serious side effects, although the risk is very small. I acknowledge that no guarantees have been made to me concerning the results of the proposed vaccination.

Signature of Patient, Parent, Guardian or Personal Representative _____ Date _____

Please print name of Patient, Parent, Guarian or Personal Representative _____ Relationship to Patient _____

Consent for Subsequent Immunization _____ Date Subsequent Vaccine Given _____

Consent for Subsequent Immunization _____ Date Subsequent Vaccine Given _____

Vaccine Administration Record for Adults

Patient name: _____

Birthdate: _____ Chart number: _____

Clinic name and address

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

Vaccine	Type of Vaccine[1]	Date given (mo/day/yr)	Funding source (F,S,P)[2]	Route[3] & Site[3]	Vaccine		Vaccine Information Statement (VIS)		Vaccinator[5] (signature or initials & title)
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Tetanus, Diphtheria, Pertussis (e.g., Td, Tdap) Give IM.[3]									
Hepatitis A[6] (e.g., HepA, HepA-HepB) Give IM.[3]									
Hepatitis B[6] (e.g., HepB, HepA-HepB) Give IM.[3]									
Human papillomavirus (HPV2, HPV4) Give IM.[3]									
Measles, Mumps, Rubella (MMR) Give SC.[3]									
Varicella (VAR) Give SC.[3]									
Pneumococcal (e.g., PCV13, conjugate; PPSV23, polysaccharide) Give PCV13 IM.[3] Give PPSV23 IM or SC.[3]									
Meningococcal (e.g., MenACWY, conjugate; MPSV4, polysaccharide) Give MenACWY IM.[3] Give MPSV4 SC.[3]									

See page 2 to record influenza, Hib, zoster, and other vaccines (e.g., travel vaccines).

How to Complete This Record

1. Record the generic abbreviation (e.g., Tdap) or the trade name for each vaccine (see table at right).
2. Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
3. Record the route by which the vaccine was given as either intramuscular (IM), subcutaneous (SC), intradermal (ID), intranasal (IN), or oral (PO) and also the site where it was administered as either RA (right arm), LA (left arm), RT (right thigh), or LT (left thigh).
4. Record the publication date of each VIS as well as the date the VIS is given to the patient.
5. To meet the space constraints of this form and federal requirements for documentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and titles.
6. For combination vaccines, fill in a row for each antigen in the combination.

Abbreviation	Trade Name and Manufacturer
Tdap	Adacel (sanofi pasteur); Boostrix (GlaxoSmithKline [GSK])
Td	Decavac (sanofi pasteur); generic Td (MA Biological Labs)
HepA	Havrix (GSK); Vaqta (Merck)
HepB	Engerix-B (GSK); Recombivax HB (Merck)
HepA-HepB	Twinrix (GSK)
HPV2	Cervarix (GSK)
HPV4	Gardasil (Merck)
MMR	MMRII (Merck)
VAR	Varivax (Merck)
PCV13, PPSV23	Prevnar 13 (Pfizer); Pneumovax 23 (Merck)
MenACWY	Menactra (sanofi pasteur); Menveo (Novartis)
MPSV4	Menomune (sanofi pasteur)

Technical content reviewed by the Centers for Disease Control and Prevention

For additional copies, visit www.immunize.org/catg.d/p2023.pdf • Item #P2023 (4/14)

This form was created by the Immunization Action Coalition • www.immunize.org • www.vaccineinformation.org

Vaccine Administration Record for Adults

Patient name: _____

Birthdate: _____ Chart number: _____

Clinic name and address

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

Vaccine	Type of Vaccine[1]	Date given (mo/day/yr)	Funding Source (F,S,P)[2]	Route[3] & Site[3]	Vaccine		Vaccine Information Statement (VIS)		Vaccinator[5] (signature or initials & title)
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Influenza (e.g., IIV3, trivalent inactivated; IIV4, quadrivalent inactivated; RIV, recombinant inactivated; LAIV4, quadrivalent live attenuated) Give IIV and RIV IM.[3] Give LAIV IN.[3]									
Hib Give IM.[3]									
Zoster (Zos) Give SC.[3]									
Other									

See page 1 to record Tdap/Td, hepatitis A, hepatitis B, HPV, MMR, varicella, pneumococcal, and meningococcal vaccines.

How to Complete This Record

1. Record the generic abbreviation (e.g., Tdap) or the trade name for each vaccine (see table at right).
2. Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
3. Record the route by which the vaccine was given as either intramuscular (IM), subcutaneous (SC), intradermal (ID), intranasal (IN), or oral (PO) and also the site where it was administered as either RA (right arm), LA (left arm), RT (right thigh), or LT (left thigh).
4. Record the publication date of each VIS as well as the date the VIS is given to the patient.
5. To meet the space constraints of this form and federal requirements for documentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and titles.

Abbreviation	Trade Name and Manufacturer
LAIV (Live attenuated influenza vaccine)	FluMist (MedImmune)
IIV (Inactivated influenza vaccine), RIV (recombinant influenza vaccine)	Afluria (CSL Biotherapies); Agriflu (Novartis); Fluarix (GSK); Flublok (Protein Sciences Corp.); Flucelvax (Novartis); FluLaval (GSK); Fluvirin (Novartis); Fluzone, Fluzone Intradermal, Fluzone High-Dose (sanofi pasteur)
Hib	ActHIB (sanofi pasteur); Hiberix (GSK); PedvaxHib (Merck)
ZOS (shingles)	Zostavax (Merck)

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