PATIENT REGISTRATION FORM
Please Print Clearly
Please provide insurance card and a photo I.D.

1027 Memorial Drive
Oakland, MD 21550
301-533-3300

INFORMATION

Patient's Last Name: ______________________________ **First:** _______________________________ **Middle:**______________

Patient's Date of Birth: _____ /_____ /__________ _____ Male _____Female Gender at Birth: ____________________

Mailing Address: ____ County: ____________________________

City: ____ State: __________ Zip Code: ___________

☐ Physcial Address is Same Religion: _________________________ Social Security #: __________________________

Physical Address: ____ County: ____________________________

City: ____ State: __________ Zip Code: ___________

Telephone: _______-_______-______ Cell Phone: _______-_______-_________ Marital Status: ______________________

Email Address: ___________________________________ **Prior PCP:** _______________________________________

Emergency Contact:______________________________ Emergeny Phone: ______________________________________

Race:
☐ American Indian
☐ Asian
☐ Asian/Pacific Islander
☐ Black/African American
☐ Hispanic/Latino
☐ Multiracial
☐ Native Hawaiian
☐ White (not Hispanic)

Employment Status:
☐ Full/Part Time
☐ Migrant Worker
☐ Seasonal Worker
☐ Not Employed
☐ Retired

Housing Status:
☐ Have Home
☐ Transitional
☐ Shelter
☐ Street
☐ Living with Someone Else

Relationship:____________

Do you speak English? ☐ Yes ☐ No

Is patient a student? ☐ Full ☐ Part

Veteran: ☐ Yes ☐ No

What is the highest level of school that you have finished?
☐ Less than high school degree
☐ High school diploma or GED
☐ More than high school
☐ I choose not to answer this question

Is your condition the result of a **work injury or auto accident**? ☐ Yes ☐ No

What is your main insurance?
☐ None/Uninsured
☐ Private Insurance
☐ Medicaid
☐ Medicare

Primary Insurance: ___________________________ **Policy #** __________________________ **Group #** _______________

Billing Address: ____

Name of Policyholder: ____________________________________ City/State/Zip: __________________________________

Birthdate of Policyholder: _____ /_____ /__________ Relationship to Patient:__________________________

Information

Employer Name: ____ ☐ Self Work Phone: _______-_______-_________

Employer Address: ______________________________________ City/State/Zip: ______________________________________

How were you referred to us? (Circle One)

ER/Hospital: ___________________

Family: _______________________

Insurance Company: ________________

Patient Referral: ______________________

Outreach/Event:______________________

Website: _______________________

Advertisement (Circle One) :
Facebook/Twitter/Instagram/Linked In/You Tube

Advertisement (Circle One) :
Newspaper/Radio/Billboard/Postcard/Town Planner

Responsible Party

Is someone other than the patient responsible for healthcare decisions? If yes, fill in below

Are you related to the patient: ________ Are you a Foster Parent: ________ How are you related: ________________

Parent/Guardian Full Name: ____ Social Security #: ____________________

Address (if different): ____ Telephone: _______-_______-_________

City: ________________________________ State: __________ Zip Code: _________ Guardian Birthdate: ____ /____ /______

Guardian's Employer: __________________________________ Employer Telephone: _______-_______-_________

Is Guardian a veteran? Yes ☐ No ☐

Number of persons in household: ______________________ Head of Household: ____________________________________

Annual household gross income: ________________________

Mountain Laurel Medical Center offers a sliding fee program for those patients who qualify. Are you interested in more information?

☐ Yes ☐ No ☐ Already enrolled

Assignment of Benefits

I authorize payment of insurance benefits to Mountain Laurel Medical Center for medical services rendered to me. I understand that I am responsbile for payment of fees for medical services rendered to me that are not covered by insurance or other third party payers, including copay, deductible and non-covered amounts. I am aware that without the proper insurance information, Mountain Laurel Medical Center is not able to accurately submit claims on my behalf. I attest that the information provided above is correct.

Signed:____ **Date:** ___________________________

Name: ______________________________ DOB: _______________

1. Does your family fall within the income guidelines for your household size? Yes______ No______ Decline to Answer _____

2. If yes, would you like to learn how you may qualify for a reduced rate for services? Yes______ No______

MOUNTAIN LAUREL
MEDICAL CENTER

Sliding Fee Schedule

Based on 2024 Federal Poverty Guidelines

	A		B		C		D		E	
Family Size	**Above**	**Below**	**Above**	**Below**	**Above**	**Below**	**Above**	**Below**	**Above**	**Below**
1	$0	$ 15,060	$ 15,060.01	$ 18,825	$ 18,825.01	$ 22,590	$ 22,590.01	$ 26,355	$ 26,355.01	$ 30,120
2	$0	$ 20,440	$ 20,440.01	$ 25,550	$ 25,550.01	$ 30,660	$ 30,660.01	$ 35,770	$ 35,770.01	$ 40,880
3	$0	$ 25,820	$ 25,820.01	$ 32,275	$ 32,275.01	$ 38,730	$ 38,730.01	$ 45,185	$ 45,185.01	$ 51,640
4	$0	$ 31,200	$ 31,200.01	$ 39,000	$ 39,000.01	$ 46,800	$ 46,800.01	$ 54,600	$ 54,600.01	$ 62,400
5	$0	$ 36,580	$ 36,580.01	$ 45,725	$ 45,725.01	$ 54,870	$ 54,870.01	$ 64,015	$ 64,015.01	$ 73,160
6	$0	$ 41,960	$ 41,960.01	$ 52,450	$ 52,450.01	$ 62,940	$ 62,940.01	$ 73,430	$ 73,430.01	$ 83,920
7	$0	$ 47,340	$ 47,340.01	$ 59,175	$ 59,175.01	$ 71,010	$ 71,010.01	$ 82,845	$ 82,845.01	$ 94,680
8	$0	$ 52,720	$ 52,720.01	$ 65,900	$ 65,900.01	$ 79,080	$ 79,080.01	$ 92,260	$ 92,260.01	$ 105,440
9	$0	$ 58,100	$ 58,100.01	$ 72,625	$ 72,625.01	$ 87,150	$ 87,150.01	$ 101,675	$ 101,675.01	$ 116,200
10	$0	$ 63,480	$ 63,480.01	$ 79,350	$ 79,350.01	$ 95,220	$ 95,220.01	$ 111,090	$ 111,090.01	$ 126,960
11	$0	$ 68,860	$ 68,860.01	$ 86,075	$ 86,075.01	$ 103,290	$ 103,290.01	$ 120,505	$ 120,505.01	$ 137,720
12	$0	$ 74,240	$ 74,240.01	$ 92,800	$ 92,800.01	$ 111,360	$ 111,360.01	$ 129,920	$ 129,920.01	$ 148,480
13	$0	$ 79,620	$ 79,620.01	$ 99,525	$ 99,525.01	$ 119,430	$ 119,430.01	$ 139,335	$ 139,335.01	$ 159,240
14	$0	$ 85,000	$ 85,000.01	$ 106,250	$ 106,250.01	$ 127,500	$ 127,500.01	$ 148,750	$ 148,750.01	$ 170,000
15	$0	$ 90,380	$ 90,380.01	$ 112,975	$ 112,975.01	$ 135,570	$ 135,570.01	$ 158,165	$ 158,165.01	$ 180,760
Each Additional Member Add	$5,380		$6,725		$8,070		$9,415		$10,760	
% Poverty	100%		125%		150%		175%		200%	
MEDICAL CODE*	**Slide A $20**		**Slide B $25**		**Slide C $30**		**Slide D $35**		**Slide E $40**	
PHARMACY CODE	**MLMC Lowest Cost**		**MLMC Lowest Cost + Admin Fee**		**MLMC Lowest Cost +Admin Fee +$5**		**MLMC Lowest Cost +Admin Fee +$10**		**MLMC Lowest Cost +Admin Fee +$15**	
CO-INSURANCE CODE	**Slide A $0**		**Slide B $3**		**Slide C $5**		**Slide D $10**		**Slide E $15**	

*** Patient Pays at a Minimum a $20 Nominal Fee for Medical Visits**

See the back of this form to see who may be counted in the "Family Size."

*Effective 1/12/2024

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.

☐ Food ☐Utilities ☐Clothing ☐Child Care ☐Phone ☐Medicine or any Healthcare ☐ I choose not to answer this question

☐No ☐Other: ____

Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? Check all that apply.

☐Yes, it has kept me from medical appointments or from getting my medications

☐Yes, is has kept me from non-medical meetings, appointments, work, or from getting things that I need

☐No ☐I choose not to answer this question

How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

☐Less than once a week ☐1-2 times a week ☐3-5 times a week ☐5 or more times a week ☐I choose not to answer this question

Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

☐Not at all ☐A little bit ☐Somewhat ☐Quite a bit ☐Very much ☐I choose not to answer this question

Do you feel physically and emotionally safe where you currently live?

☐Yes (safe) ☐No (not safe) ☐Unsure ☐I have not had a partner in the past year ☐I choose not to answer this question

In the past year, have you been afraid of your partner or ex- partner?

☐Yes ☐No ☐Unsure ☐I have not had a partner in the past year ☐I choose not to answer this question

****If you have concerns regarding safety, housing, lack of food/clothing ect., please make a staff member aware.****

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Signature:____ Date:___________________

1027 Memorial Drive
Oakland, MD 21550

104 Parkview Drive
Grantsville, MD 21536

Phone (301) 533-3300
Fax (301) 533-3299

Mountain Laurel Medical Center is dedicated to providing healthcare services to the residents of the local communities. Because physical and emotional problems often go together, we believe the best care is given when healthcare providers work together. MLMC patients may be referred to providers from other healthcare specialties either within the health center treatment team or to an external provider if needed.

Patients are seen by appointment and walk-in. Patients must call in advance if they cannot keep their appointment.

Information about a patient will not be given to anyone outside of MLMC, including family and friends, unless the patient (parent or legal guardian if a minor) gives written permission. However, we may release patient information to others without the patient's permission if 1) the patient poses a threat to him/herself or others 2) the patient is unable to protect him/herself from risk of harm; 3) the patient is in the legal custody of a government agency or facility; 4) there is evidence of child abuse; or 5) the patient's clinical records are requested under court order.
As part of the treatment team, patient's information is sent to any referring provider or consultant for proper coordination of care.

<u>Acknowledgement of Receipt of Notice of Privacy Practices</u>
I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operation such as quality assessments and physician credentialing. I am aware that your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information is available at my request. I understand Mountain Laurel Medical Center has the right to change the *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the above to obtain a current copy of the *Notice of Privacy Practices,* as required by law.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I have read or requested a copy of the *Notice of Privacy Practices* for Mountain Laurel Medical Center and understand the above information.

I hereby ask and agree to evaluation and treatment for myself and/ or my children, including any studies or procedures the MLMC professional staff decides are necessary.

Signature

Signature of Patient ____**Date** _____________________

Signature of Patient Representative _____________________________ **Date** _____________________
(Required if patient is a minor or an adult unable to sign this form)

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Please Print Clearly

Patient Name:____**Date of Birth:**_____/_____/______**Today's Date:**_____/_____/_____
Last, First, MI

Phone to be reached by MLMC:____________________________ **Phone to be reached by third party:** ________________________________

Authorization provided by: (circle one) Patient Parent Other Legal Guardian

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I HEREBY AUTHORIZE DISCLOSURE AND USE OF MY HEALTH INFORMATION TO THE FOLLOWING PEOPLE:

Name: (friends/ family only) Phone Relationship to patient May Leave Message? (Y or N)

1. ____

2. ____

3. ____

Mountain Laurel Medical Center may disclose the following protected health information: Place an "X" in the box

	Office Visit Notes		**Laboratory Tests/Results**		**Appointment Date/Time**		**Physical Exams**
	Diagnostics (x-ray, endoscopy, mammo, other)		**Immunization Records**		**Procedure Reports**		**Behavioral Health & Substance Abuse Records**
	Medications or Pharmacy Records		**Entire Medical Record (including behavioral health & substance abuse records)**		**Billing/Insurance Claims or Patient Statements**		**Newborn Summary**

List any information specifically ***excluded*** from disclosure: ____

Expiration of Authorization (1 year from date signed)________/__________/___________

Patient Authorization – Please Read Carefully

I authorize the use and/or disclosure of my PHI as described above. I authorize Mountain Laurel Medical Center to review my past twelve months of medication history. I understand that I retain the right to revoke this Authorization at any time, if I do so in writing. My signature below indicates my understanding of my rights and that I'm allowing the release of the information that I have initialed above for disclosure. I understand that when the information is disclosed pursuant to this Authorization to someone who is not required to comply with the federal or state privacy protection requirements, it may be subject to re-disclosure by the recipient and may no longer be protected and that Mountain Laurel Medical Center is hereby released from any legal responsibility or liability for such disclosure of to the extent indicated herein. I also understand that I have the right to inspect or copy my PHI to be used or disclosed pursuant to this Authorization, as permitted by law.

Patient/Parent/Legal Guardian Signature Date

Print Name of Parent or Legal Guardian Relationship to Patient

For Internal Office Use Only
Authorization verified and recorded
By_____________On: _________________

MOUNTAIN LAUREL
MEDICAL CENTER

Patient Code of Conduct

Welcome to Mountain Laurel Medical Center, your Patient Centered Medical Home. The staff at Mountain Laurel strive to provide excellent health care and service to our patients. It is important to maintain a therapeutic relationship with our patients and your provider of care.
To provide a safe and healthy environment for staff, visitors, patients and their families, Mountain Laurel Medical Center expects visitors to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

As a patient visiting our practice please consider the following:

- Please communicate all issues that you wish to discuss with the provider at the time your appointment is scheduled, so that an appropriate amount of time can be allotted. If you do not do this in advance, another visit may be necessary so that the provider can give all patients the quality of care they deserve.

- Our practice follows a zero-tolerance policy for aggressive behavior directed by patients against our staff.

- Please be courteous with the use of your cell phone and other electronic devices. When interacting with any of our staff, please put your devices away.

- Adults are expected to supervise their children.

The following behaviors are prohibited:

- Possessing any type of weapons

- Intimidating or harassing staff or other patients

- Making threats of violence through phone calls, letters, voicemail, email or other forms of written, verbal or electronic communication.

- Physically assaulting or threatening to inflict bodily harm.

- Making verbal threats to harm another individual or destroy property.

Any violations of the Code of Conduct will result in dismissal from our practice and reassignment to another healthcare provider outside of Mountain Laurel Medical Center.

MOUNTAIN LAUREL
MEDICAL CENTER

DEEMING NOTICE/FEDERAL TORT CLAIMS ACT

Mountain Laurel Medical Center, Inc., a Federally Qualified Health Center (FQHC), is deemed by the Bureau of Primary Health Care of the U.S. Department of Health and Human Services to be a federal employee for purposes of medical malpractice claims and, as such, qualified for protection under the Federal Tort Claims Act.

According to the FTCA requirements, medical malpractice claims against the Mountain Laurel Medical Center are reviewed and/or litigated by the U.S. Department of Health and Human Services. An individual who has a claim against the health center is to file an administrative claim with the U.S. Department of Health and Human Services at the following address:

Office of the General Counsel
General Law Division Claims and Employment Law Branch
330 Independence Avenue, SW, Suite 2600
Washington, DC 20201
Phone No: 202-233-0233
Fax No: 202-691-2035
Email: gcgl@hhs.gov