Klein & Associates, M.D., P.A. **Registration Form**

Last Name _____First _____MI____

SSN # _____ DOB _____ Age _____ Sex M F

Home Address _____

City _____State _____ Zip _____

Cell ( ) _____ Home Phone ( ) _____

May we leave a detailed message on your voicemail for the numbers listed above? Yes _____ No _____

Primary Doctor's Name _____

Patient's Employer _____

Employer's Address _____

City _____State _____ Zip_____

Work Phone ( ) _____ (only if you are able to receive phone calls at work)

Marital Status: Single Married Separated Divorced Widowed

Spouse's Name _____DOB _____

SSN# _____ (only necessary if required for insurance claim)

Spouse's Employer _____

Spouse's Employer's Address_____

City _____State _____ Zip _____

Authorization to Release Information:

Name _____Relationship to Patient _____Phone ( ) _____

Name _____Relationship to Patient _____Phone ( ) _____

Name _____Relationship to Patient _____Phone ( ) _____

By signing this form, the patient agrees that the above information is accurate.

Signature _____Date _____

Payment Policy

The patient is responsible for payment at the time of service, unless prior arrangements have been made. Payments can be made either by cash, check or Visa/Master/Discover card. If we participate with your insurance company we will file the claim. All patients with insurance that Dr. Klein and Dr. Howell do not participate with, are responsible for payment at the time of service, unless prior arrangements have been made, or they have obtained an out of network authorization before the time of service.

The patient is responsible for any service that is not covered by his/her insurance as well as any co-pays, deductibles, and co-insurance. Co-pays are due at the time of service. We accept co-pays by cash, check or Visa/Master card.

All HMO and Managed Care plans require a referral for all services. **It is the patient's responsibility to obtain any necessary insurance referrals.** If you do not have a referral, your appointment will need to be rescheduled.

Each patient is responsible to make sure that lab studies, x-rays and scans are performed at a facility participating with their insurance.

If a response to a claim is not received from your insurance company within forty-five (45) days after billing, a statement will be sent to you. If your account becomes delinquent and becomes assigned to a collection agency, you agree to pay 35% collection agency fees, court costs, and attorney fees.

A $35.00 returned check fee will be assessed to the account for each check returned to the office as a result of insufficient funds.

We require at least a 24 hour notice to cancel an appointment. If you do not call at least 24 hours ahead of time **or** if you **no show** for an appointment, you will be charged a $50 fee that must be paid before another appointment is scheduled for you.

I hereby authorize Drs. Klein and Howell to furnish information to any insurance company or authorized agency specified concerning my medical care. I hereby assign and transfer any medical benefits due me to Drs. Klein and Howell for the services provided to me by this medical practice. I permit a copy of this authorization to be used in place of the original. Regulations pertaining to Medicare Assignment of Benefits apply, as applicable.

I have read, understand and agree to all of the terms described in the Payment Policy above. I understand and agree, accept where applicable under contract, that I am ultimately responsible for the balance on my account for any professional services rendered.

_____ _____

DATE SIGNATURE

Over →

Consent & Assignments

Medicare

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Finance Administration or its intermediaries or carriers of any information needed for this or a related Medicare claim (Title XVIII). I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party whom accepts assignment.

Blue Cross/Blue Shield Of Maryland

Dr. Steven Klein and Dr. Mary Howell are participating physicians of Blue Cross/Blue Shield of Maryland, Inc. I authorize release of any medical information necessary to process this claim. I understand that I am responsible for any deductible and/or co-payment.

Insurance Assignment

I authorize and assign payment directly to the physicians involved in my treatment and authorize release of medical information necessary to process the claim. I further understand I am financially responsible for charges not covered by my insurance.

Managed Care

I understand that without an authorization/referral form from my HMO/IPA/PPO or MCO I will be financially responsible for charges I incur.

****

Ultimately, you are responsible for payment to our physicians for services rendered. If your insurance company does not respond to our claim within 45 days, a statement will be sent to you. Your signature below acknowledges your understanding and your agreement to fulfill all financial obligations.

_____ _____

DATE **SIGNATURE**

KLEIN & ASSOCIATES, M.D., P.A.

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____, have received a copy of Klein & Associates, M.D., P.A.'s Notice of
Patient Name
Privacy Practices.

_____ _____
Signature of Patient Date

Over →

Rheumatology Consultants
Klein & Associates, MD, PA
Steven J. Klein, MD, FACR
Board Certified Specialist in Rheumatology
Mary P. Howell, MD
Devin Traynor, PA-C
Theresa Gillis, PA-C

The Osteoporosis & Clinical Trials Center
A Division of Rheumatology Consultants

Arthritis and Rheumatic Diseases • Connective Tissue Diseases • Osteoporosis • DXA Scanning for Bone Density • Clinical Drug Trials

We have chosen to participate in the Chesapeake Regional Information System (CRISP) for our patients, a regional health information exchange serving Maryland and D.C. as of March 2017. 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 disable access to 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 though their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

Receipt of Notice of PDMP Privacy Practices

I, _____, have received a copy of Klein & Associates, MD, PA notice of PDMP (Prescription Drug Monitoring Program) Privacy Practices.

This is a new requirement regarding prescriptions medications that providers must adhere to.

_____ _____
Signature of patient Date

The Professional Village
346 Mill Street • Hagerstown, MD 21740
301-791-6680 • Fax: 301-714-1506

Seton Drive Professional Building
921 Seton Drive • Suites C & D • Cumberland, MD 21502
301-724-4337 • Fax: 301-724-3276

E-mail: arthritis@rheumdocs.com
Web: www.rheumdocs.com