ROCKVILLE MEDICAL CARE

Janna Lachtchinina, MD

2401 Research Blvd., Suite 360 Rockville, MD 20850 p: 240.449.8900

Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name		Middle Name	Last Name (as it appears on insurance card or ID)
Sex	Marital Status	Date of Birth (Age)	Social Security Number

Street Address	City	State	Zip

Home Phone	Mobile Phone	Email Address

Referred by	Primary Care Physician	Primary Care Physician Phone

Pharmacy	Pharmacy Phone	Pharmacy Address

Patient Employer/School Information

Employer/	Occupation	Employer/School Phone

Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Phone Number	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company		Plan
Plan Number	Group Number	Insured's Employer/School

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

	City	State	Zip

Insured's Social Security Number	Insured's Birthdate	

Secondary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient

Address	City	State	Zip

_____ _____

Signature of Patient or Authorized Guardian Date

Janna Lachtchinina, MD 2401 Research Blvd., Suite 360 Rockville, MD 20850 p: 240.449.8900

Reason for Visit

What brings you you to the office today?

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other conserns you would like to address?

Current Medications

What medication are you currently taking?

Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction
Name	Reaction

Past Medical History

☐ Alcoholism ☐ Back Problems ☐ Ear Problems
☐ Allergies ☐ Bleeding Disorder ☐ Eating Disorder
☐ Anemia ☐ Blood Disease ☐ Epilepsy
☐ Anxiety Disorder ☐ Blood Transfusion ☐ Glaucoma
☐ Arthritis ☐ Cancer ☐ Gout
☐ Asthma ☐ Diabetes ☐ Heart Disease
☐ AIDS / HIV ☐ Depression ☐ Heart Problems
☐ Hepatitis - A, B, or C ☐ Measles ☐ Skin Disorder
☐ High Blood Pressure ☐ Migraines ☐ Stomach Ulcer
☐ High Cholesterol ☐ Osteoporosis ☐ Substance Abuse
☐ Joint Disorder Kidney ☐ Pneumonia ☐ Thyroid Disorder
☐ Disorder Liver ☐ Polio ☐ Tuberculosis
☐ Disorder ☐ Rheumatic Fever ☐ Venereal Disease
☐ Lung Disease ☐ Stroke

Hospitalizations & Surgeries

Reason	Date
Reason	Date

Women Only:

of Pregnancies # of Miscarraiges # of Abortions Last # of Living

Pap Smear Last Mammogram Birth Control Method

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism ☐ Cancer ☐ Joint Disorder Kidney
☐ Allergies ☐ Depression ☐ Disease Liver Disorder
☐ Alzheimer's ☐ Diabetes ☐ Lung Disease
☐ Anemia ☐ Epilepsy ☐ Migraines Psychiatric
☐ Anxiety ☐ Genetic Disorder ☐ Disorders
☐ Arthritis ☐ Glaucoma ☐ Osteoporosis Stroke
☐ Asthma ☐ Heart Disease ☐ Substance Abuse
☐ AIDS/HIV ☐ Hepatitis ☐ Thyroid Disorder
☐ Bleeding Disorder ☐ High Cholesterol ☐
☐ Blood Disorder ☐ High Blood Pressure ☐

Details:

Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year _____

Do you wished to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much allcohol do you drink per week?

drinks/week _____

How much coffeine do you drink per day?

drinks/day _____

How often do you exercise?

times/week _____

Patient Registration Form Disclosures & Contents

Patient Name: _____ **Date of Birth:** _____
First Name M.I. Last Name

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Rockville Medical Care, LLC or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Rockville Medical Care, LLC is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Rockville Medical Care, LLC or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the Rockville Medical Care, LLC Patient Information Privacy Policy. I hereby authorize Rockville Medical Care or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Rockville Medical Care, LLC representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to restrict this authorization at any time by notifying Rockville Medical Care, LLC to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my Rockville Medical Care, LLC physician or his or her designee.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARANTOR SIGNATURE: _____ **DATE:** _____
(If different from patient)

GUARANTOR NAME (Please Print): _____

ROCKVILLE
MEDICAL CARE
Janna Lachtchinina, MD

Rockville Medical Care, LLC

Notice Of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:

Rockville Medical Care, LLC 2401 Research Blvd. Suite 360, Rockville MD 20850 phone: 240.449.8900

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process, crime, or the description, identity or location of the perpetrator).

5. Optional: Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Optional: Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Optional: Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authoriza-tion to use your PHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:

(A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improp-er use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justi-fication for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

(B) The research could not practicably be conducted without the waiver,

(C) The research could not practicably be conducted without access to and use of the PHI.

8. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circum-stances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10.National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may dis-close your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforce-ment official. Disclosure for these purposes would be necessary: (a) for the institu-tion to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Rockville Medical Care, LLC 2401 Research Blvd. Suite 360, Rockville MD 20850 phone: 240.449.8900** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **Rockville Medical Care, LLC 2401 Research Blvd. Suite 360, Rockville MD 20850 phone: 240.449.8900**

Your request mustdescribe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must sub-mit your request in writing to **Rockville Medical Care, LLC 2401 Research Blvd. Suite 360, Rockville MD 20850 phone: 240.449.8900** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **insert Rockville Medical Care, LLC 2401 Research Blvd. Suite 360, Rockville MD 20850 phone: 240.449.8900 .**You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permit-ted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your informa-tion to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Rockville Medical Care, LLC 2401 Research Blvd. Suite 360, Rockville MD 20850 phone: 240.449.8900.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **iRockville Medical Care, LLC 2401 Research Blvd. Suite 360, Rockville MD 20850 phone: 240.449.8900.**

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact

Rockville Medical Care, LLC 2401 Research Blvd. Suite 360, Rockville MD 20850 phone: 240.449.8900. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note:* We are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Rockville Medical Care, LLC 2401 Research Blvd. Suite 360, Rockville MD 20850 phone: 240.449.8900.**

HIPAA Privacy Notice Acknowledgment.
We are required by law to provide individuals with this notice of our legal responsibilities and privacy practices with respect to Protected Health Information.
Signature bellow is only acknowledgment that you have received this Notice of our Privacy Practices.

Print Name_____

Sginature_____

Date_____

ROCKVILLE
MEDICAL CARE
Janna Lachtchinina, MD

Patient Rights and Responsibilities Acknowledgment

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

You have the right to:

- A personal clinician who will see you on an on-going, regular basis.
- Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- A second medical opinion from the clinician of your choice, at your expense.
- A complete, easily understandable explanation of your condition, treatment and chances for recovery.
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Be free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan.
- Have your pain evaluated and managed.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
- The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

You are responsible for:

- Knowing your health care clinician's name and title.
- Giving your clinician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
- Signing a "Release of Information" form when asked so your clinician can get medical records from other clinicians involved in your care.
- Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
- Telling your clinician about any changes in your condition or reactions to medications or treatment.
- Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
- Paying copayments at the time of the visit or other bills upon receipt.
- Following the office's rules about patient conduct; for example, there is no smoking in our office.
- Respecting the rights and property of our staff and other persons in the office.

Patient initials: _____ Today's Date: _____

ROCKVILLE
MEDICAL CARE
Janna Lachtchinina, MD

Medical Record #: _____
Name: _____
DOB: _____

Adult Screening

Because we recognize that many issues in today's society are not openly discussed, Dr. Lachtchinina is routinely asking our patients to answer the following questions. The purpose of asking these questions is to help us give you the best care possible. This questionnaire is entirely voluntary and you may choose not to complete the form.

I do not wish to complete this form. Signed: _____ Date: _____

If your answer to any of the following questions is YES, please put a mark in this box ☐

Have you been feeling sad, "down" or depressed?
Have you lost interest in things you used to enjoy?
Has your appetite changed?
Has your sleep changed?
Have you had thoughts of dying or hurting yourself in some way?

If your answer to any of the following questions is YES, please put a mark in this box ☐

Do you often get tired easily?
Do you often feel irritable?
Do you often have problems falling or staying asleep?

If your answer to any of the following questions is YES, please put a mark in this box ☐

Do you think you're at risk for HIV, AIDS, or other Sexually Transmitted Diseases?
Have you ever had a blood transfusion?
Do you ever have sex without using a condom?
Have you had a Sexually Transmitted Disease such as syphilis, gonorrhea, or chlamydia?
Have you had sex with more than one partner within the past year?
Have you ever used needles to inject drugs (other than insulin or drugs ordered by your clinician)?
(This question is for women only.) Has it been longer than three years since the last time you had a Pap Test or have you ever been told that you had an abnormal Pap Test?

If your answer to any of the following questions is YES, please put a mark in this box ☐

Have you ever thought about cutting down on your alcohol or drug use?
Have you ever become angry when other criticized your alcohol or drug use?
Have you ever felt guilty about your drug or alcohol use?
Have you ever used alcohol or drugs as an "eye opener" first thing upon waking?
Has your drinking or drug use ever affected your relationships with your family, work, or school?

If your answer to any of the following questions is YES, please put a mark in this box ☐

In the past year, have you been threatened, or felt controlled by your spouse, partner, or caretaker?
Have you or your partner, spouse, or caretaker ever used physical force when you were arguing?
Has your partner, spouse, or caretaker ever destroyed things that you care about?
Are you ever afraid of your spouse, partner, or caretaker?

Please help us understand how much pain you experience by answering the following questions:

1. Do you experience pain or suffering? Never ☐ Some of the time ☐ Most of the time ☐ All of the time ☐
2. Are you currently taking medication(s) or using some type of treatment for pain relief? ☐ Yes ☐ No
3. How would you rate the severity of your pain? ***Circle*** the words below that best reflect your current level of pain.

   No Pain Hurts a little bit Hurts a little more Hurts a whole lot Hurts really bad

4. Do you want your doctor to talk with you about your pain? ☐ Yes ☐ No

****

☐ No intervention required ☐ Intervention recommended. ***See progress note.***

Clinician Signature: _____ Date: _____

ROCKVILLE
MEDICAL CARE
Janna Lachtchinina, MD

Medical Record #: _____
Name: _____
DOB: _____

PATIENT HEALTH QUESTIONNAIRE-PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "V" to indicate your answer or click it.)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0	1 ☐	2 ☐	3 ☐
3. Trouble falling or staying asleep, or sleeping too much	0	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1 ☐	2 ☐	3 ☐
8. Moving or speaking so slowly that other peoplecould have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1 ☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1 ☐	2 ☐	3 ☐

FOR OFFICE CODING 0 + _____ + _____ + _____

Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Financial Policy Notification Form

Thank you for coming to Rockville Medical Care, LLC. We believe that good care for you and your family starts with good communication, and we have created this policy to help our patients understand the responsibilities that they and their families have for payment of our fees. If at any time you have questions and problems with our fees, or payment process, please do not hesitate to contact our billing department at (contact #).

Insurance and Billing Process:

- We have made prior arrangements with many insurers and health plans to accept an assignment of the benefits. This means that we require that our patients promptly pay copay amounts and/or deductibles at the time of the service.
- We expect that all charges we present to you at a visit will be paid at the time of the visit. This includes, among other things, copay amounts, deductibles, earlier charges that remained unpaid, and charges for services that we believe are not covered by, or left over as your responsibility to pay after coverage by insurance or government programs.
- We may also present charges to you by written statement via the mail following a visit. If we do this, we expect that charge will be paid in full by return mail the first time it is presented to you.
- We or our agents may send you statements and reminders of charges made, or call you about the same. By accepting our services, you are consenting to receive these communications.
- If after **90 days** your balance remains unpaid, the account will be sent to a collection agency.
- For self-pay patients : fee schedule will be available at the time of the visit , or you can call in advance our office for fees and services.

"NO-SHOW" Policy:

- We recognize that you may need to cancel or change an appointment; however, we require you give a **24-hour notice** so we may offer that appointment to another patient who need to be seen.
- Failure to Provide our office with adequate notice will result in **$ 35** "no-show" or late cancellation fee.

Medical Record Fee:

-The patient will be charged for Medical Record unless otherwise noted. The fee is **$ 0.76** per page and fulfillment fee (cost of postage).
-A medical Record Being sent to another provider , flat fee of **$ 22.80** will be applied.

Phone Services after hours.

-After hours Provider will be available on the phone for patients who have true emergency (chest pain, shortness of breath, bleeding, etc.)
-If you do not have an emergency but still need to speak to provider there will be a **$ 25** fee assessed to your account per after hour call.
-If you feel it is an emergency and you have not heard from provider on call within 30 min, please go to nearest emergency room, or dial 911.

The following are not appropriate to discuss in a phone consult and require a follow-up appointment : STD results, Disability or Workers Compensation claims, or Mental health.

Any Letter or form that needs to be filled out by either staff or provider will require an office visit.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

PRINT NAME: _____

PATIENT SIGNATURE: _____ **DATE:** _____

ROCKVILLE
MEDICAL CARE
Janna Lachtchinina, MD

Notice of Privacy Practices

We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. 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 through 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.

CRISP
Connecting Physicians With Technology to Improve Patient Care in Maryland

Patient Name:_____

Signature:_____ Date:_____