K. Jill Ciccarelli, M.D.
16605 Kendle Road
Williamsport, MD 21795
P: 301-223-1241
F: 301-223-1240

Please complete ALL information so your claim can be processed efficiently. Please print clearly. Thank You!

Patient Information

Name:_____ DOB:_____ Age:_____
Last First Middle

Social Security #:_____ Sex:___M___F Marital Status:___S___M___D___W

Address:_____
Street / P.O. Box

_____
City / State Zip Code

Home Phone #:_____ Cell #:_____ Work #:_____

May we leave a message?:_____Yes _____No May we call work?_____Yes _____No Best time:_____

E-Mail address:_____

Emergency Contact Information

Name:_____ Relationship:_____

Address:_____
Street City / State Zip Code

Home phone #:_____ Cell/Work #:_____

Primary Insurance

Policy ID #:_____ Group #:_____
Insurance Company:_____ Phone #:_____
Address:_____
Policy Holder's Name:_____

Secondary Insurance

Policy ID #:_____ Group #:_____
Insurance Company:_____ Phone #:_____
Address:_____
Policy Holder's Name:_____

Often it is difficult to reach a patient to convey the physician's orders or test results. In this event, we require a signed authorization to release such information to a designated person and/or people. Please complete the section below.

I, _____, give the office of K. Jill Ciccarelli, MD permission to release any medical information to the following:

Name:_____ Phone:_____ Relation:_____

Name:_____ Phone:_____ Relation:_____

Signature:_____ Date:_____

I authorize the release of any medical information to my insurance company to process my claims by virtual, fax, internet and/or electronic billing. Also, I authorize any fax transmittal or mailing of medical records if necessary. I understand that the office of Jill Ciccarelli, MD reserves the right to charge a $25.00 fee for any missed appointments. A 24-hour notice is required to cancel appointments.

I acknowledge full financial responsibility for services rendered by the office of K. Jill Ciccarelli, MD and understand that payment of charges incurred is due at the time of service, unless other financial arrangements have been made. Any co-payments not paid at the time of service will incur a $10.00 service fee. I understand that I am financially responsible for all charges for services rendered, including the balance remaining after payment of possible insurance benefits. Our office provides a cash discount for patient paying cast at the time of service. All are welcome to have this discount, however, if one has insurance, one must choose between paying cash or using insurance. If one chooses to pay cash then that money may not be put toward your deductible. I understand that it is my responsibility to immediately notify the office of any changes in my insurance coverage, address or telephone numbers. I also understand that it is my responsibility to know my insurance benefits, including, but not limited to co-pays, benefit limits, deductibles and services not covered by my insurance.

There is a $10.00 fee for an extensive paperwork and/or forms that need to be filled out.

There is a $30.00 fee for any returned checks.

Signature:_____ Date:_____

MEDICARE PATIENTS ONLY

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or it's intermediaries or carriers, any information needed for this or any related Medicare claim. I permit a copy of this authorization to be used in place of the original request of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I also understand that I am responsible for the deductible, co-insurance and any non-covered services determined by Medicare.

Signature:_____ Date:_____

MEDICARE SUPPLEMENTAL INSURER'S MEDIGAP ASSIGNMENT OF BENEFITS

Section 4081 of t6he Omnibus Budget Reconciliation Act of 1987 provides an additional participation incentive for participating physicians by providing payment directly for assigned Medicare Supplemental (Medigap) insurance. I understand that my signature gives authorization for my physician to bill claims directly to my recognized Medigap insurance carrier as necessary. I understand that any deductibles, co-insurance and any non-covered services will be my responsibility.

Signature:_____ Date:_____

Notice of Privacy Practices
Your Health Information Rights

Although your health records is the physical property of the medical practice that compiled it, the information belongs to you.

You have the right to inspect or obtain a copy of your health records upon written request, except where restricted by law.

You have the right to request an amendment of information in your record that you believe is incorrect or incomplete. Any request for amendments to health information must provide the reason for the amendment.

You have the right to obtain an accounting disclosure of your health information. This is a list of disclosures we've made of medical information about you.

You have the right to request a restriction on certain uses and disclosures of you information; however, we are not required to agree to a requested restriction.

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can request that we only contact you at work or by mail.

You have the right to a complete paper copy of this notice upon request.

You have the right to revoke your authorization to use or disclose health information, except to the extent that action has already been taken. Any request must be made in writing.

Our Responsibilities

This practice is required to:

Maintain the privacy of your health information.

Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.

Abide by the terms of this notice.

Notify you if we are unable to agree to a requested restriction.

Accommodate reasonable requests you may have made to communicate health information by alternative means and/or alternative locations. We will not disclose your health information without your authorization, except as described in the full copy of this notice.

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 permitted by law, your health information will be shared with this exchange in order to provide faster coordination of care and assist provider 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 Monitoring Program (PDMP), will still be available to providers.

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used, disclosed and how you can get access to this information. Please review it carefully.

My signature below indicates that I acknowledge that I have received and reviewed a copy of the Privacy Practice guidelines.

_____

Signature of Patient/Legal Representative Date

_____

Printed Name

K. JILL CICCARELLI, MD

FAMILY MEDICINE
16605 Kendle Road
Williamsport, MD 21795
P: 301-223-1241
F: 301-223-1240

Authorization for Release of Medical Records

I,_____, hereby authorize Dr. Jill Ciccarelli's office to obtain from/release to:

_____

(Physician, Hospital, Attorney, Insurance Company, Self, etc)

_____

(Address) (City,State) (Zip)

The following health information from the medical records of:

Name of Patient:_____ Date of Birth:_____

Specific information to be disclosed:_____

The health information is needed for: Continuing Medical Care

I understand that the medical records to be released may contain information related to HIV status, AIDS, STD's, alcohol or drug abuse or mental health services and I hereby authorize the release of this information.

There is potential that information disclosed pursuant to the authorization is subject to redisclosure by the recipient and no longer protected by HIPAA.

Ability or inability to condition treatment, payment, enrollment or eligibility for benefits.

I understand that this authorization will automatically expire one year from the date of my signature and that I may revoke this authorization by sending a written notice to the person or entity authorized to make this disclosure described above. I authorize the release of the information as indicated above.

_____ _____

Signature of Patient, Parent or Guardian Date