Patient Information

Name: _____
Last First Middle

Address: _____
Street City State Zip

Home: _____ Work: _____ Cell: _____

Date of Birth: _____ Sex: _____ Marital Status: _____

Social Security Number: _____

Email Address: _____

Emergency Contact: _____ Phone: _____

Relationship to Pt: _____

Referring Physician: _____ Phone: _____

Internist/Family Physician: _____ Phone: _____

Race: _____ Ethnicity: _____

Preferred Language: _____

Insurance Information

Primary Insurance: _____ Effective Date: _____

Name of Policy Holder: _____ Holder DOB:
_____

Relationship to Policy Holder: _____

Secondary Insurance: _____ Effective Date: _____

Name of Policy Holder: _____ Holder DOB:
_____

Relationship to Policy Holder: _____

I authorize the release of any medical information necessary to process my claims. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signature Date

Robert F. Hoofnagle, Jr., M.D., P.A.

Acknowledgement of Notice of Privacy Practices

I understand a copy of the Notice of Privacy Practices for this office can be made available at the time of my visit. I understand the Notice of Privacy Practices contains a complete description of the uses and disclosures of my health information. I understand this office has the right to change its Notice of Privacy Practices at any time and I may contact this office at any time and obtain a current copy.

Please select one of the following:

_____ I wish to receive a copy of the Notice of Privacy Practices.

_____ I do NOT wish to receive a copy of the Notice of Privacy Practices. (I understand there is a copy in the office & may request a copy at any time.)

Accessibility of Your Healthcare Information

Please select one of the following:

_____You may speak with family/friends with regards to the treatment or payment of my medical care.

_____You may NOT speak with family/friends with regards to the treatment or payment of my medical care, unless I give you specific written permission at a later time.

Please sign to acknowledge that the above indicates your requests concerning your medical information.

_____ _____

Patient Printed Name *Patient Date of Birth*

_____ _____

Patient/Guarantor Signature *Date*

_____

Relationship to patient (For minors/POA)

OFFICE USE ONLY: I attempted to obtain the patient's signature in acknowledgement, but the patient refused.
_____ Employee Initials

Robert F. Hoofnagle Jr., M.D., P.A./Baltimore Harford Surgical Center, L.L.C.
Financial Agreement

I, _____, have requested treatment from Robert F. Hoofnagle, Jr., M.D., P.A. and/or Baltimore Harford Surgical Center, L.L.C. and have read and understand the following:

1. I am responsible for all co-payments, deductibles and coinsurance for Robert F. Hoofnagle, Jr., M.D., P.A. and/or Baltimore Harford Surgical Center, L.L.C., as per the terms or contract with my insurance carrier.
2. If you are scheduled for a procedure, your insurance carrier(s) will be billed for both a surgical facility fee as well as a professional surgeon's fee. If you have a balance on your account you may possibly receive two bills: Robert F. Hoofnagle, Jr., M.D., P.A. and/or Baltimore Harford Surgical Center, L.L.C.
3. All co-payments for office visits and out of pocket expenses for surgery must be paid at the time of service.
4. I am responsible for obtaining any and all required referrals for service. I will be responsible for any balances, penalties, etc. that are assessed should I not obtain a referral for services rendered.
5. I am responsible for all non-covered services. The office will do its best to inform me of any services that will not or may not be covered. However, I understand that benefits are not determined by my insurance carrier until after the claim is submitted; therefore, there is no guarantee of payment by my insurance carrier.
6. I am responsible for updating my health insurance information with the office any time the information changes/terminates/new coverage begins. The office will submit my medical claims for me as per the terms of the contract with my insurance carrier.
7. The office is restricted to a "timely filing period." I understand that I must supply the office with my health insurance card in a timely fashion, so that the claim may be paid. Any claim unpaid because I did not supply the office with my health insurance information in a timely fashion is my responsibility and I agree to make payment.
8. The office does issue a fee for missed appointments. The current fees are $30 for office visits and $100 for scheduled surgery. I am responsible for payment of this fee if I fail to provide proper notification of cancellation for a scheduled appointment. To avoid this fee, I should call 24 hours prior to my scheduled appointment if I need to cancel or reschedule.
9. A check returned from my financial institution is subject to a returned check fee. This fee is based on the current rates set by the office's financial institution.
10. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt and all costs and expenses, including reasonable attorney's fees we incur in such collection efforts.

_____ _____

Patient Signature ***Date***

Robert F. Hoofnagle, J.R., M.D., P.A.
History and Intake Form

Patient Name:_____ **DOB:**_____
Pharmacy Name and location:_____
Primary Care Physician:_____

Past Medical History (Please circle all that apply)

Anxiety/Depression	Colon Cancer	Hypertension	Lung Cancer
Arthritis	Coronary Artery Disease	HIV/AIDS	Lymphoma
Asthma/COPD	Diabetes	Hypercholesterolemia	
Atrial Fibrillation	End Stage Renal Disease	Hyperthyroidism	Radiation Treatment
BPH	Hearing Loss	Hypothyroidism	Seizures
Breast Cancer	Hepatitis	Leukemia	Stroke

OTHER:_____

Past Surgical History (Please circle all that apply)

Appendix	Gallbladder	Kidney Stone	Pancreas
Bladder	Heart: Valve replacement	Kidney Transplant	Prostate Biopsy
Breast Biopsy	Coronary Artery Bypass	Nephrectomy	Prostatectomy
Breast: Lumpectomy	Mechanical Valve Repl.	Liver:Hepatectomy	Skin Biopsy
Breast: Mastectomy	Joint replacement: Hip	Liver Transplant	Spleen
Colon	Joint replacement: Knee	Ovaries	Testicle: Orchiectomy
Colostomy	Kidney Biopsy	Tubal Ligation	Uterus: Hysterectomy

Other:_____

Urological Disease History (Please circle all that apply)

Prostate Nodule	Hematuria	Sexual Dysfunction
Cancer (Bladder)	Hydronephrosis	Sexual Transmitted Disease
Cancer (Kidney)	Infertility	Undescended Testis
Cancer (Penile)	Priapism	Urethral Stricture
Cancer (Prostate)	Prostatitis	Urinary Incontinence
Cancer (Testicular)	Renal Insufficiancy	Urinary Retention
Elevated PSA	Renal Cyst	Urinary Tract Infection

Other:_____

Current Medications: Please include dosages and include all over the counter medications

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

Allergies: (List allergies and reactions or write NKDA for none)

DRUGS:_____
OTHER:_____

Smoking Status: Never Current: Packs per day_____ Former Cigar

Alcohol Use: None Less than 1 daily 1-2 drinks per day 3 or more drinks per day

Colonoscopy within last 9 years? Y/N

Family History: (Please list any family members, do not include yourself or spouse)

Prostate Cancer:_____
Bladder Cancer:_____
Kidney Cancer :_____
Kidney Stones :_____
Renal Disease :_____

Preferred Language: English Spanish Other:_____ Declined to Specify
Race: Asian Black or African American White Other:_____ Declined to Specify
Ethnic Group: Hispanic/Latino Non-Hispanic/Latino Declined to Specify

Review of Systems (Please circle all that apply)

Fever/chills	Constipation	HIV/AIDS	MRSA
Unintentional weight loss	Problems with bruising/bleeding		Premedication
Nausea/vomiting	Sleep Apnea	Hepatitis C	prior to procedure
Fatigue	Muscle Weakness	Artificial Heart Valve	
Chest Pain	Joint Pain	Defibrillator	
Abdominal Pain	Glaucoma	Pacemaker	

Advance Care Plan
For Patients 65 and Older

Please circle the answers that pertain to you. This is a new requirement that we need for your medical record. Thank you!

Today's Date_____

Patient Name:_____Date of Birth:_____

1. Do you have a healthcare proxy (Power of Attorney) in the event you are unable to make our own medical decisions? PLEASE CIRCLE ONE.

   YES NO

2. Do you have a living will? PLEASE CIRCLE ONE.

   YES NO

3. Which statement best reflects your wishes on advanced care recommendations? PLEASE CIRCLE ONE.

   - **DO NOT INTUBATE**: I do not wish to have a breathing tube, even if it is necessary to save my life

   - **DO NOT RESUSCITATE**: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life.

   - **FULL CARDIOPULMONARY RESUSCITATION**: I want full cardiopulmonary resuscitation efforts to be made