J. Richard Lilly, M.D., A.B.F.P., & Associates, P.C.

PATIENT REGISTRATION - Please **PRINT** Clearly

Patient Name First	Middle	Last		**Date of Birth**	**Age**
Home Address	**Apt. No.**	**City**		**State**	**Zip code**
Occupation	**Social Security No.**	**Marital Status**	**Sex** M F	**Home Phone**	**Cell Phone**
Employer	**Address**			**Work Phone**	
Spouse (or Parent) Name	**Spouse (or Parent) Home Phone**			**Spouse (or Parent) Work Phone**	
Spouse (or Parent) Address					
Emergency Contact	**Relationship**	**Home Phone**		**Work Phone**	
Referred By:	**E-MAIL:**				

BILLING AND INSURANCE INFORMATION

Insurance Company Name (PRIMARY)	**Co-Pay $**	**ID or Policy Number**		**Group / Code**
Insurance Company Address		**Subscriber's Social Security**		**Date Effective**
Subscriber's Name	**Sex** M F	**Home Phone**	**Work Phone**	
Subscriber's Address		**Subscriber's Date of Birth**		**Relationship to Patient**
Insurance Company Name (SECONDARY)	**Co-Pay $**	**ID or Policy Number**		**Group / Code**
Insurance Company Address		**Subscriber's Social Security**		**Date Effective**
Subscriber's Name	**Sex** M F	**Home Phone**	**Work Phone**	
Subscriber's Address		**Subscriber's Date of Birth**		**Relationship to Patient**

POLICY CONCERNING PAYMENT OF MEDICAL BILLS / PATIENT AUTHORIZATION

I hereby authorize payment directly to J. Richard Lilly, M.D., A.B.F.P., & Associates, P.C., for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.
I have reviewed the practice's notice of privacy practice for information regarding the practice's use of protected healthcare information.
I authorize the above doctor and / or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature or copy on all insurance submissions.

Signature: X _____ Date: _____

Account #: **Entered By:** **Appt with Dr.:**

Patient Registration Form

Patient Information

Account #		**DOB**		**Home #**	
Last Name				**Work #**	
First Name		**SSN**		**Cell#**	
Middle		**Suffix**		**Email**	
Address 1		**City**		**Employer**	
		State		**Gender**	
Address 2		**Zip Code**		**Marital Status**	

Emergency Contact: _____ **Phone** _____ **Relationship to Patient:** _____

Meaningful Use Information:

Race: **Ethnicity:** **Language:**

Guarantor Information (Responsible for Bill) **Gender:** _____ **DOB:** _____ **SSN:** _____

Guarantor Name: _____ _____ _____ _____

First **Middle** **Last** **Home Phone** **Work Phone** **Cell Phone**

_____ _____ _____ _____

Mailing Address **City** **State** **Zip**

Insurance Information - Primary		**Insurance Information - Secondary**	
Subscriber Name:		**Subscriber Name:**	
Subscriber DOB:		**Subscriber DOB:**	
Insurance Carrier:		**Insurance Carrier:**	
Certification/ID #		**Certification/ID #**	
Group #:		**Group #:**	

Claims Mailing - Primary				**Claims Mailing - Secondary**			
		State:				**State:**	
Address		**Zip:**		**Address**		**Zip:**	
City:	**Phone:**			**City:**	**Phone:**		

Worker's Comp/Auto Liability Information **Case Number:** _____

Carrier Name: _____ **Contact Name:** _____

Fax Number: _____ **Contact Phone#:** _____

_____ _____ _____ _____

Mailing Address **City** **State** **Zip**

POLICY CONCERNING PAYMENT OF MEDICAL BILLS / PATIENT AUTHORIZATION

I hereby authorize payment to J. Richard Lilly, M.D., A.B.F.P., & Associates, P.C., for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. This authorization shall remain valid, until written notice is given by me revoking this authorization.

I have reviewed the practice's notice of privacy practice for information regarding the practice's use of protected healthcare information. I authorize the above doctor and / or any provider or supplier of services in this office to release any information that is needed during my care and information required to secure the payment of benefits. I authorize the use of this signature or copy on all insurance submissions. This shall remain valid until written notice is given by me to the office revoking this authorization.

Signature: X _____ **Date:** _____

Personal History

D.O.B.: **Date:**

Social History	**Daily Use**	**Interests**	**Family History**	**Yes**	**No**
Tobacco		Pets:	Diabetes		
Alcohol			TB		
Drugs		Hobbies:	Cancer		
Tea			Heart Disease		
Coffee		Religion:	Seizures		
Aspirin			Hypertension		

Children's Names	**D.O.B.**	**Education**	**Years Attended**
		High School	
		College	
		Graduate School	
		Other	

Deceased Family Members Name	**Relationship**	**Cause of Death**

Past History:	**Date**	**Where**
Operations (Surgery):		
Hospitalization (Other than Surgery):		
Accidents / Injuries:		
Emergency Room Visits (Other than Accidents):		
Past Illnesses:		

Do you wear your seatbelts?_____ Have you requested your Medical Records to be sent to us?

FINANCIAL POLICY

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

- Prompt payment allows us to control costs. Outstanding accounts cost both of us time and money; therefore, all patients will be required to establish financial arrangements for payment of their account either through an attorney, responsible insurance company, or payment directly from the patient at the time of service.

- All patient accounts are due and payable within 30 days of services rendered. As a courtesy our practice will establish a reasonable monthly payment plan to accommodate your needs or bill the insurance company you provide information on, as the responsible party for your injury. If payment from this company is not paid within 30 days, you, the patient, will be responsible and billed for such services. It is in your best interest to assist this office in getting payment directly from the insurance company or providers, so that out-of-pocket expenses are limited. If an attorney represents you, please give this office that information and an assignment agreement will be made with the attorney to have bills paid at the time of settlement.

- It should be mentioned that your insurance coverage is an agreement between you and your auto insurer, your employers WCC carrier, or the insurance carrier of the place where you were injured. It is your responsibility to remit payment for charges not covered by your claim. You will be required to pay for services at the time of visit or establish written financial agreements with our practice until your insurance problem is resolved.

- Each month you will receive a monthly statement for services which is due and payable within 30 days. If you are experiencing a set of circumstances out of your control, please call our practice and we will be happy to make special arrangements.

- All patients refusing to remit payment after 60 days of notice without pending insurance or a financial agreement will force us to limit their future credit until the previous balance is paid in full or written financial arrangements are accomplished. All patients will be required to sign a written legal agreement with our practice to alleviate any current delinquency.

- Please notify us immediately if a mistake appears on the statement.

- Our practice firmly believes that a good doctor / patient relationship is based upon understanding and open communications. I have instructed our staff to make every effort available to you to clarify any misunderstanding you may have concerning your balance. We hope to possibly avoid any disagreement over payment for professional services. If you have any questions concerning our policy or need assistance, please contact us immediately.

Thank you,
Administrative Staff

_____

Patient Signature: Date:

J. Richard Lilly, MD., A.B.F.P., & Associates, P.C.

Health and Medical History

Patient Name_____ Date of Birth_____ Today's Date _____

Chief Complaint (s)_____

Patient social history (please circle)

Marital Status	Single	Married	Separated	Divorced	Widowed		
Coffee or Caffeine use	Never	<1 per day	1 cup /day	2 cups/day	>2 cups /day		
Tobacco use	Never	Previously, but quit					
How many packs per day? _____	**How many years have/did you smoke? _____**						
Alcohol use	Never	Rarely	Moderate	Daily	Used to, but stopped		
Illicit Drug use	Never	Type / Frequency		_____			
Exercise	Never	Weekly	<5 day/wk	4 day /wk	3 day /wk	2 day /wk	daily
Excessive exposure at home or work to	None	Dust	Solvents	Airborne Particles		Noise	
Living arrangement	On your own		With family				
Sleep	Difficulty falling asleep		Continuity disturbances		Snoring	Early morning awakening	
	Daytime Drowsiness						

How many times a night do you wake up to use the bathroom? _____

Medication

Name Dose x Per Day

Allergies

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Past Medical History

Have **you** ever had the following? (Circle "no" or "yes;" leave blank if uncertain)

Measles	Yes	No	Anemia	Yes	No	Back trouble	Yes	No	Hepatitis	Yes	No
Mumps	Yes	No	Bladder Infections	Yes	No	High Blood Pressure	Yes	No	Ulcer	Yes	No
Chickenpox	Yes	No	Epilepsy	Yes	No	Low Blood Pressure	Yes	No	Kidney Disease	Yes	No
Whooping Cough	Yes	No	Migraine Headaches	Yes	No	Hemorrhoids	Yes	No	Thyroid Disease	Yes	No
Scarlet Fever	Yes	No	Tuberculosis	Yes	No	Date of last chest x-ray	_____		Bleeding Tendency	Yes	No
Diphtheria	Yes	No	Diabetes	Yes	No	Asthma	Yes	No	Any other disease	Yes	No
Smallpox	Yes	No	Cancer	Yes	No	Hives or Eczema	Yes	No	(please list)		
Pneumonia	Yes	No	Polio	Yes	No	AIDS or HIV+	Yes	No	_____		
Rheumatic Fever	Yes	No	Glaucoma	Yes	No	Infectious Mono	Yes	No			
Heart Disease	Yes	No	Hernia	Yes	No	Bronchitis	Yes	No	_____		
Arthritis	Yes	No	Blood or plasma			Mitral Valve Prolapse	Yes	No			
Venereal Disease	Yes	No	transfusions	Yes	No	Stroke	Yes	No	_____		

Females only

When was your last period? (start and finish)		
How often do you get your period?		
How long does your cycle last?		days
Do you get menstrual cramps?	Yes	No
How many pads do you go through per day?		
How many children have you had?		
How many pregnancies have you had?		

Males only

Do you have erectile dysfunction?	Yes	No
Do you have premature ejaculation?	Yes	No

BOTH Males and Females

Personal (**Optional**, and you may discuss this with doctor instead or not at all)

How often do you have sex per week?	_____	
Do you derive pleasure from episodes of romance?	Yes	No

Family Medical History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy /Convulsions						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						
Osteoperosis						
Other (specify)						

If deceased, cause of death

Father _____
Age of death _____

Mother _____
Age of death _____

Brother / Sister 1 _____
Age of death _____

Brother / Sister 2 _____
Age of death _____

Child 1 _____
Age of death _____

Child 2 _____
Age of death _____

Previous Hospitalizations / Surgeries / Serious Illness, and Allergies

Injuries (please list below)	Yes	No	**Hospitalizations**	Yes	No
Past Surgery (please list below)	Yes	No	**Blood Transfusion**	Yes	No

What	When	Hospital, City, State

Any other problems?

(please circle yes / no and explain)

Constitutional:	weight loss, chills, fever, etc	Yes	No	_____
Eyes:	pain, blurred vision, etc.	Yes	No	_____
Ears, nose, & throat:	hearing, dental problems, etc.	Yes	No	_____
Heart & Circulation:	chest pain, calf cramping, etc.	Yes	No	_____
Lungs:	short of breath, wheezing, etc.	Yes	No	_____
Stomach & Intestines:	abdominal pain, vomit blood, etc.	Yes	No	_____
Bladder & Kidneys:	blood in urine, burning, etc.	Yes	No	_____
Bone, Joints & Muscles:	spinal, arm or leg problems, etc.	Yes	No	_____
Skin & Breast:	rashes, lumps or bumps, etc.	Yes	No	_____
Neurological:	weakness, numb, balance, etc.	Yes	No	_____
Psychiatric:	nervousness, depression, etc.	Yes	No	_____
Endocrine:	diabetes, thyroid disease, etc.	Yes	No	_____
Blood Cells:	anemia, leukemia, etc.	Yes	No	_____
Allergic & Immunity:	lupus, polymyalgia, allergies, etc.	Yes	No	_____

Please be advised — In the event a staff member is accidentally exposed to a patient's body fluid by needle stick or other means, state law permits us to do necessary laboratory work to investigate exposure.

Patient's Signature_____ Date: _____
(Patient 18 years or older or legal guardian)

Physician's Signature _____ Date: _____

PATIENT SURVEY

Thank You for Choosing

J. Richard Lilly, M.D. A,B.F.P.
And Associates, P.C.

The Management of J. Richard Lilly, M.D. & Associates is committed to excellence and would like to hear from you. Please rate your visit and contact us by: mailing this card or leaving it with the Front Desk.

OFFICE ENVIRONMENT	Excellent	Acceptable	Poor
Parking Area	○	○	○
Lobby	○	○	○
Restrooms	○	○	○
Seating	○	○	○
Temperature	○	○	○
Cleanliness	○	○	○
QUALITY OF SERVICE			
Practitioner	○	○	○
Medical Assistant	○	○	○
Receptionist	○	○	○
Wait Time	○	○	○

EMPLOYEES OR PRACTIONER THAT DESERVES RECOGNITION: _____

_____

Comments/Suggestions: _____

_____

_____

_____

Please circle the practicioner you saw during your visit:

Dr. Lilly	Dr. Terry
Dr. Flores	Dr. Towns
Dr. Patel	N.P. Njoku
Dr. Sarwar	D. Okonofua, APRN, DNP
Dr. Sreekumar	N.P. Townsend
Dr. Tasneem	N.P. Wiggins

Name: (optional) _____

Telephone #/Return Call: _____

Date of Visit: _____

Office Location: _____

OFFICE HOURS and LOCATIONS
(301) 927- 7800
FAX: 301-209-9474
8:00AM - 8:00PM / Monday - Friday
9:00AM - 3:00PM / Saturday & Sunday
www.doctorlilly.com

Patients will be seen by appointment only.

- **HYATTSVILLE**
  5804 Baltimore Avenue
  Hyattsville, MD 20781
  9:00 AM - 8:00 PM/ Monday - Friday
  8:00 AM - 3:00 PM/ Saturday & Sunday

- **HYATTSVILLE**
  5806 Baltimore Avenue
  Hyattsville, MD 20781
  9:00 AM - 4:00 PM/ Monday – Friday
  8:00 AM –3:00 PM/ Saturday & Sunday

- **RIVERDALE**
  5711 Sarvis Avenue, Suite 302
  Riverdale, MD 20737
  9:00 AM - 4:00 PM/ Monday - Friday

- **BOWIE**
  14300 Gallant Fox Lane, Suite 126
  Bowie, MD 20715
  9:00 AM - 4:00 PM/ Tuesday & Thursday
  9:00 AM - 5:00 PM/ Wednesday & Friday

- **CROWNSVILLE**
  Mental Health Concerns
  1306 Eva Goude Drive
  Crownsville, MD 21032
  410-849-5631
  By Appointment / Monday – Friday

HANDICAP ACCESS AVAILABLE IN ALL OF OUR LOCATIONS

ADMINISTRATION - (301) 927-7800 (Option 4)
FAX: 301-927-0375
9:00 AM until 4:00 PM MONDAY - FRIDAY

Our patient's care is our first priority. If you have any comments, concerns, or questions about our staff, office procedures, or your visit, please call our administrative office.

**** Please let us know how we are doing.****
Please fill-out our patient survey with any comments or suggestions.

BILLING - (301) 927-7800 (Option 4)
9:00 AM until 4:00 PM MONDAY - FRIDAY
Any questions regarding your regular billing, worker's compensation, auto, or liability account should be addressed to the above number.

Check your statement carefully when you receive it. Let us know promptly if there is a problem so that we may assist you. Balances and Deductibles are due within 30 days of the receipt of your billing statement. Co-pays and past-due balances are required at the time of service.

We are contractually obligated to collect any co-pay, do-insurance and / or deductible and cannot "write-off" any portion of these debts. In addition, your contract may require that we report any willful non-payment of co-insurance, co-pays or deductibles to you insurance carrier.

No exceptions.
Any balance over 180 days old will be referred to a **Collection Agency** and will no longer be handled by this office.

Cell Phones

No cell phones beyond the waiting room due to sensitive medical equipment. Thank you.

J. Richard Lilly, M.D.
& Associates
301-927-7800
www.doctorlilly.com
Revised 1/6/17

J. RICHARD LILLY, MD ABFP
AND ASSOCIATES, PC

J. Richard Lilly, M.D. & Associates

Thank you for choosing us as your total family health care provider, specializing in pediatrics through geriatrics. We are committed to your treatment being successful. In this brochure, we have provided valuable information to help insure that we achieve this objective.

MISSION STATEMENT

At J. Richard Lilly M.D. and Associates, we are committed to providing excellent quality comprehensive health care as your Patient Centered Medical Home, and emphasize preventative medicine while reducing costs through disease prevention and coordination of care to the patients we serve. The Medical Home Model Practice provides enhanced patient experience of care, including increased quality, satisfaction and healthier patient populations. We are focused on being the best Medical Support System for each individual patient. We believe in cultivating a long lasting relationship of doctor and patient to promote a healthier you. We deliver this care in a warm and welcoming environment and incorporate modern technology in our practice at all levels. The dedicated clinician and non-clinician staff at J. Richard Lilly, M.D. and Associates work together as a team. We are focused on providing our patients with the highest quality medical care while paying close attention to, and nurturing each patient's individual needs.

OFFICE PHONE DIRECTORY

(301) 927-7800

www.doctorlilly.com

Press the following extensions:

1 DOCTOR / HOSPITALS / MEDICAL PERSONAL
2 APPOINTMENTS / REFERRALS / CANCELLATIONS
3 LAB RESULTS / PRACTITIONER / MA / MED REFILLS
4 BILLING
5 ALL OTHER MATTERS

Medical Emergencies after hours…….301-552-0800
Direct line to answering service at Doctors Hospital.
The answering service will relay the information concerning your need to the provider on call. A return call will be made to you. If your call has not been returned for any reason please call the answering service again.
***For medical emergencies call 911** or go to the nearest emergency room and notify your Insurance Company. Notify our office within 48 hours and be sure to make your follow up visit.

PROFESSIONAL MEDICAL STAFF

J. Richard Lilly, M.D., A.B.F.P., F.A.A.F.P.
Hyattsville/ Bowie Office
Family Practice (English)

Elizabeth A. Lilly, M.D., A.B.P.N.
Crownsville Office
Psychiatry (English)

Eduardo Flores, M.D.
Riverdale Office
Internal Medicine (English / Spanish)

Lisa Sindass, M.D.
Hyattsville Office
Pediatrics (English)

Shaaron Towns, M.D., A.B.P.
Hyattsville Office
Pediatrics (English / Spanish Assistant)

Agnes Floyd, CRNP
Hyattsville Office
Internal Medicine (English/Korean)

Chinma Njoku, DNP, CRNP
Hyattsville / Bowie Office
Family Practice (English / Igbo)

Rosalee Townsend, CRNP
Hyattsville Office
Family Practice (English)

Wennifer Wiggins, DNP,CRNP,FNP-BC
Hyattsville Office
Family Practice (English)

Prudence Mancho, CRNP, FNP
Hyattsville Office
Family Practice (English/French)

Elizabeth Vebangsi, CRNP, FNP
Hyattsville Office
Family Practice (English/Creo)

Lilieth Occenad, CRNP, FNP
Riverdale Office
Family Practice (English)

APPOINTMENTS and REFERRALS (Option 2)

For your convenience, all appointments and referrals for all locations are made from our appointment center.

We are available to make appointments and referrals from
8 AM - 8 PM Monday - Friday
Saturday & Sunday 9 AM - 3 PM.

- All office visits are by **appointment only**.
- All **form** completion: Bring your form to your visit and give to the MA prior to seeing the provider.
- Appointments are necessary for **non physician** visits. Example; blood work, EKG, blood pressure checks, and injections.

CANCELLATIONS & NO SHOWS

All cancellations or no shows without 24 hour notice will be charged $50 and $100 for a specialty test or your contracted co-pay and must be paid on or before the next scheduled visit.

LATE POLICY

We see patients by appointment. When our patients arrive on time, it helps the providers stay on schedule. If you arrive more than 10 minutes late for an appointment, you may be asked to reschedule. If you are a new patient and here for your initial visit, we can not extend a late arrival grace period. All new patients are asked to arrive 15 minutes prior to their appointment time to allow additional time for gathering all the needed information.

MEDICATIONS and REFILLS (Option 3)

Medication refills are issued **only** during the hours of 9am to 5pm, Monday-Friday. Please call your pharmacy for refills, do not call the office. If your insurance requires authorization for medications or referrals, please allow 72 hours.
Chronic medical conditions will require an office visit every 3 months unless stated otherwise by your practitioner.

LABORATORY AND DIAGNOSTIC TEST RESULT(Opt. 3)

Please take into consideration that some tests take up to two weeks for results. If you need to speak with someone concerning your results, please direct all inquiries to 301-927-7800 Opt. 3. All laboratory tests must be ordered by one of our practitioners.

MEDICAL RECORDS

New Patients: Please ask for a "Records Release Form" to request your records from your previous physician.
*If you are requesting a copy of your medical records from here to be sent to another facility, this will be done by Health Port. You will be billed separately by them.