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?

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 transfusions	Yes	No	Mitral Valve Prolapse	Yes	No			
Venereal Disease	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

J. Richard Lilly M.D., ABFP and Associates, PC

CONSENT TO LEAVE MEDICAL INFORMATION
(On voicemail)

Patient Name: ________________________________ Date of birth: ____________ Account # ____________
(Print)

I wish to be called using the below number(s) regarding my test results, treatments plans, referrals and/or billing and payment information. The best telephone number(s) to reach me are:

Home ___________________________ Cell _______________________ Other ______________________

☐ I do give permission to leave relevant medical information on my answering machine or voicemail.

☐ I do not give permission to leave relevant medical information on my answering machine or voicemail.

____________________________________ __________________________________ __________________
Signature of Patient/Guardian | Relationship to Patient | Date

Thank you for scheduling your physical/well woman exam today. A "physical/well woman exam" is considered a preventative or wellness visit. This visit will address preventative health only and is not meant to diagnose or treat problems.

If your provider addresses and/or treats other health issues at this visit that are new or chronic in nature instead of scheduling you for a follow up or sick visit, your health insurance company may assess an additional patient liability (copay, coinsurance, deductible) for those services. Although most insurance plans include benefits for one preventative health visit each year, some do not. If you have any doubts, please check with your insurance plan.

If you need further explanation about incurring additional fees for services provided during your visit today, please discuss your concerns with your provider.

I acknowledge that I have read this notice prior to my physical or well women and I understand that depending on the issues addressed or treated, additional charges may apply.

Patient Name: ___________________________________ **Date of Birth:**________________________

Patient Signature: ________________________________ **Date:**_________________________________

(Office Use Only) Patient's Account#_______________

Revised 08/29/17 MB

J. RICHARD LILLY, MD ABFP
AND ASSOCIATES, PC
5804 Baltimore Avenue
Hyattsville MD, 20781
(301) 927-7800
Fax: (301) 927-0375

Authorization and Release of Medical Information Form
For Family Members/Friends

Patient Name ______________________________ Date of Birth _____/______/_____

I, ____, give permission to all my health care and medical providers and payers to disclose and release my protected health information described below to:

		Type of Information Allowed to Disclose (Check one or both)		**Method of Disclosure** (Check one or both)	
Name	**Relationship**	**Medical**	**Billing**	**By Phone**	**In Person**

Health Information to be disclosed (Check all that apply):

□ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment and billing, for all conditions) OR

□ My complete health record, as above, with the exception of the following information:
(Check as appropriate):

□ Mental health records
□ Communicable disease (including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Other (Please specify ____________________________

____

This health information may be used to enable the person(s) I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (Check one):

□ All past, present, and future periods, OR
□ Date or event: ____
unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers.

____
Name of the individual Giving this Authorization

____ ____________
Signature of the Individual Giving this Authorization Date

Account#:________

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that you cancel your appointment within 24-48 hours. Please keep in mind that when you do not cancel an appointment, you may be preventing another patient from getting much needed treatment just as you would expect for yourself and your family. This will enable another person who is waiting for an appointment to be scheduled. When cancellations are not done within 24-48 hours notice, we are unable to offer that appointment to another patient. Appointments which are not cancelled within 24 hours may be subject to a **$50.00** non cancellation fee. Procedure cancellations require 5-7 business day notice, and are subject to a **$100.00** non cancellation fee.

Patients who do not show up for their appointment without a call to cancel an appointment or procedure appointment will be considered as a **NO SHOW**. Patients who No-Show four (4) or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments, and your insurance company will be notified.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that Special unavoidable circumstances may cause you to cancel within 24-48 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department (301) 927-7800, Monday-Friday 9-4.

I acknowledge that I have read and have been advised of the above policy.

__________________________________ **Date of birth** ___________

Patient Name (Please Print)

____ ______________

Signature of Patient or Patient Representative **Date**

Updated 01/23/19 MB

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
8:00 AM - 8:00 PM • MONDAY - FRIDAY
9:00 AM - 3:00 PM SATURDAY & SUNDAY
www.doctorlilly.com

Patients will be seen by appointment only.

❑ **HYATTSVILLE**
5804 Baltimore Avenue
Hyattsville, MD 20781
7:30 AM - 8:00 PM / Monday - Friday
9:00 AM - 3:00 PM / Saturday & Sunday

❑ **HYATTSVILLE**
5806 Baltimore Avenue
Hyattsville, MD 20781
7:30 AM - 4:00 PM / Monday - Friday
9:00 AM - 3:00 PM / Saturday & Sunday

❑ **RIVERDALE**
5711 Sarvis Avenue, Suite 302
Riverdale, MD 20737
9:00 AM - 5:00 PM / Monday - Friday

❑ **BOWIE**
14300 Gallant Fox Lane, Suite 126
Bowie, MD 20715
9:00 AM - 5:00 PM / Monday - Friday

HANDICAP ACCESS AVAILABLE IN ALL OF OUR LOCATIONS

PROFESSIONAL MEDICAL STAFF

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

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

Jay Stern, M.D.
Hyattsville Office
Internal Medicine (English)

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

Ashley Willis, M.D.
Hyattsville Office
Family Practice (English)

Agnes Floyd CRNP
Riverdale Office
Internal Medicine (English / Korean)

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

Rosalee Townsend, CRNP
Hyattsville Office
Family Practice (English)

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

Leah Nelson, CRNP
Hyattsville Office
Family Practice (English)

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

Anita David, CRNP
Hyattsville Office
Family Practice (English Tamil, Malayalan)

Brigid Prosser, CRNP, FNP
Hyattsville Office
Family Practice (English/Spanish)

Audrey Harris, CRNP
Hyattsville Office
Family Practice (English)

J. RICHARD LILLY, MD ABFP
AND ASSOCIATES, PC

Family Practice
Internal Medicine
Pediatrics

Primary Care for the whole family
Dedicated to providing quality care

J. Richard Lilly, MD & 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 out 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 out patients with the highest quality medical care while paying close attention to, and nuturing each patient's individual needs.

OFFICE PHONE DIRECTORY
(301) 927-7800
www.doctorlilly.com

Press the following extensions:

1 DOCTORS/HOSPITALS/MEDICAL PERSONNEL
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 doctor 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.

ADMINISTRATION: (301) 927-7800 (Option 4)
FAX: 301-927-0375
9:00 AM UNTIL 5:00 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 5:00 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, co-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 your 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, MD & Associates
301-927-7800
www.doctorlilly.com
Revised 11/11/19

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 7:30 AM - 8 PM Monday - Friday
Saturday 9 AM - 3 PM & Sunday 9 AM - 2 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 check, and injections.

CANCELLATIONS & NO SHOWS
All cancellations or no shows without 48 hour notice will be charged $50 and $100 for a specialty test or 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 to 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 cannot 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 of the needed information.

MEDICATIONS & REFILLS (Option 3)
Medication refills are reviewed during the hours of 9am to 5pm, Monday-Friday. Requests are filled within 24-48 hours.
Chronic medical conditions will require an office visit every 3 months unless stated otherwise by your practitioner.

FORMS
A visit is required for form completion. Forms may take up to 2-4 days to be completed after your visit if lab work is required. You may be referred out if needed for additional clearance.

LABORATORY & DIAGNOSTIC TEST RESULTS (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, 9am to 5pm Monday - Friday. 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 CIOX. You will be billed separately by them.