Frequently Asked Questions

Can I reach a healthcare provider after hours?

-Yes, when you call our main office number after business hours you will be transferred to an answering service. The provider on call will get back to you within 30 minutes of receiving your message. If it is an emergency you will contacted directly to the provider on call.

What if I need prescriptions refilled?

-We are capable of sending non-narcotic prescriptions electronically whenever you may need them. Simply call our office to request them and we will send them within 24 hours of your request. We do ask that all patients are seen at least once every 6 months to get refills.

Can I have labs drawn on site?

-Yes, Bioreference Lab has phlebotomy services on site. Bioreference is a separate company from ours, they do accept a large range of insurances but ultimately it is the patient's responsibility to make sure they are in your network.

Can I use my cell phone while waiting?

-No, we ask that you don't use your cell phone in the waiting room while waiting to see a provider.

What should I bring for my appointment?

-All patients should bring updated insurance cards, photo ID and co-payment

When do I arrive for my appointment?

-All new patients should arrive 15 minutes prior to their scheduled appointment with paperwork filled out.

What if I need a referral?

-We will need 48 hours' notice for any referral request. We also request when calling in for a referral that you have the doctors name, address, telephone number and fax number.

What about billing?

-It is your responsibility to find out from your insurance company what is covered to what extent. Our job is to offer the best care possible to you even if it involves provider that your insurance company doesn't otherwise prefer.

What if I have questions about a bill I've received?

-Kindly call (410) 719-0020. This is our billing contact phone number. If you don't get a good response call us at the main office number.

Can I drop off forms to be filled out?

-No, we ask all patients to please make an appointment to have ANY sort of paper work filled out. This is an important step to ensure the provider can work with you to fill out the forms accurately.

Does your office do suboxone or methadone treatment?

-No, we aren't licensed to do any substance abuse treatment.

REGISTRATION

(PLEASE PRINT)

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ (Last Name / First Name / Middle Initial) SS/HIC/Patient ID # _____

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____ (Last Name / First Name / Middle Initial)

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ Signature of Patient, Parent, Guardian or Personal Representative

_____ Date

_____ Please print name of Patient, Parent, Guardian or Personal Representative

_____ Relationship to Patient

The Primary Care Group of Maryland

Medication Update

Date ____/____/____

Name _____ Date of birth _____/_____/_____

Do you have any allergies? If so please list them _____

_____

Please list all current medication- please include any over the counter medications, vitamins and or supplements

Your Privacy Rights Regarding Your Health Information

Right to obtain a copy of this Notice of Privacy Practice

We will post a copy of our current Notice in our office. A copy of our current Notice will be available at our front desk or upon request. To request a copy of our current notice of Privacy Practice please call 410-553-6360.

Right to See and Copy Your Health Record

You have a right to look at and receive a copy of your health records and your billing record. You must submit a written request to The Primary Care Group of Maryland, Privacy Official, in order to inspect or copy your health record. If you request a copy of this information, we may charge a fee for the costs of copying, mailing and other associated supplies.

We may in certain circumstances, deny your request to inspect or copy your health information or billing information. If we do, we will tell you in writing our reason for the denial and explain your right to have the denial reviewed.

Right to update Your Health Record

If you believe that a piece of important information is missing from your health record, you have the right to request that we add an amendment to your record. Your request must be in writing and it must contain the reason for your request. To submit your request, contact the Privacy Official.

We may deny your request to amend your record if the information being amended was not created by us, if we believe the information is already accurate and complete, or if the information is not contained records that you would be permitted by law to see and/or copy. Even if we accept your amendment, we will not delete any information already in your records.

Right to Get a List of the Disclosures We Have Made

You have the right to request a list of the disclosures that we have made of your health information. The list will not contain disclosures that we have made for the purposes of treatment, payment and health operations. It will not contain disclosures that were authorized by you and certain disclosures excluded by law. The list will not contain disclosures that were made prior to April 28, 2003.

Your request must be in writing. To request a list of disclosures, please contact the Privacy Official. The first list you request in a twelve month period is free. For additional list, we may charge a fee, as permitted by law.

Right to Request a Restriction on Certain Uses or Disclosures

You have a right to request how we limit the use of your health information. We will consider your request; though we are not legally required to accept it, we will comply with your request. Unless you were to need emergency treatment. Your request must be in writing submitted to our Policy Official.

Right to Choose How to Receive Your Health Information

You have a right to request that we communicate with you in a certain way, such as by mail, or fax, or at a certain location. For example, you can ask that we only contact by mail.

Office Notice of Privacy Practices for The Primary Care Group of Maryland, LLC

Patient Responsibility:

1. To keep the office up to date with current demographic information, and to provide comprehensive health information including past and present illnesses, allergies and medications.
2. To inform the physician and the hospital of any advance directive or power of attorney.
3. To inform the staff immediately if there is any questions related to diagnosis, care and treatment.
4. To conduct oneself in a fair and courteous manner, considerate with staff and other patients.
5. To keep appointments or communicate with the office when appointments cannot be kept.
6. To promptly make arrangements for payments of bills and/or ask questions concerning that bill.
7. To inform the physician, or staff of any concerns or suggestions; either during or after you appointment.

Privacy Statement:

This office has always worked diligently to keep your health information secure and confidential. A new law requires us to continuing maintaining your privacy, to give you this notice and to follow the terms of this notice.

Lawful Use Of Medical Records:

The law permits us to use or disclose your health information to those involved in your care for example:

A. A portion of your file may be provided to a Specialty Physician who is involved in your care.
B. We may use or disclose your health information for payment of your services, such as sending a report of progress to your insurance company.
C. We may use or disclose your health information for our normal healthcare operations, such as staff entering your information into our electronic medical record system.
D. We may also use your information to contact you. For example, calling to remind you of appointments or test results. If you are not at home, only limited information will be left on a voicemail or whoever answers the phone.
E. In the case of an emergency, we may disclose your health information to a family member or another person responsible for your care.
F. We may release some of your information when required by law, but will make every attempt to contact you for authorization.
G. If this practice is sold; your information will become property of the new owner.

We have chosen to participate in the Chesapeake Regional Information System for our patients (CRISP), regional 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 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 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.

Except as described above, this practice will not use nor disclose your health information without your prior written authorization.

Your Right Regarding Your Personal Records:

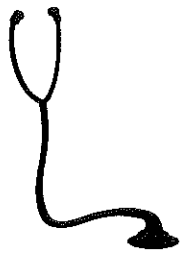
1. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill that request.
2. You have the right to know of any uses or disclosures we make with your health information beyond normal uses.
3. You have the right to transfer copies of your health information to another practice. You have the right to see and receive a copy of your health information, with few expectations. Give us written request regarding the information you would like copied and who it should be sent to. A reasonable processing fee will be applied.
4. You have the right to request an amendment or change to your health information. Your request must be submitted in writing. If we agree to an amendment or change, we will not remove nor alter earlier documents. But we will add any new information.
5. You have the right to receive a copy of this notice. If we change any details of this notice, we will notify you in writing. If you have a complaint or for more information/ assistance regarding your health information privacy, please contact our office, the physician or office manager and we will be more than happy to assist you.

By signing this I acknowledge I have received a copy of the privacy practices for this office.

Signed:_____ Date: _____

The Primary Care Group of Maryland

Internal Medicine



85 Kindred Way
Suite 101
Glen Burnie, MD 21061

Dear Patient,

We have recently had an increased volume of missed appointments. This often leads to missed opportunities to give patients same day appointments when they have urgent needs. We asked when at all possible you please give us 24 hours' notice to cancel an appointment. We have an automated system that provides you with a courtesy call to remind you of your appointments, when you get that call please call us to make us aware of a cancelation.

If you do not show up or do not give at least a 4 hour notice of a cancelation on two separate occasions you will then acquire a $30 missed appointment fee on the third offense. We know and understand emergencies do arise and will accommodate those as needed. But if you become a repeat offended the policy will have to be enforced.

By signing below you are acknowledging you know and understand the above policy.

Signed_____ Date_____

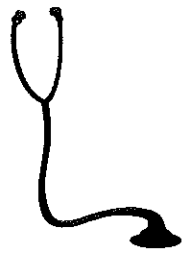
Nnaemeka Agajelu, MD
Nora N. Agajelu, CRNP
Eden Fernandez, PA-C

www.theprimarycaregroup.com

410.553.6360 (P)
410.553.6661 (F)

The Primary Care Group of Maryland

Internal Medicine



85 Kindred Way
Suite 101
Glen Burnie, MD 21061

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ SSN: _____

I request and authorize _____ to

release healthcare information of the patient named above to:

Name: The Primary Care Group of Maryland

Address: 85 Kindred Way Suite 101

City: Glen Burnie State: MD Zip Code: 21061

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

Witness Signature: _____ Date Signed: _____

Witness Name/Title: _____

THIS AUTHORIZATION EXPIRES **1 YEAR** AFTER IT IS SIGNED.

Nnaemeka Agajelu, MD
Nora N. Agajelu, CRNP
Eden Fernandez, PA-C
Anita Mbah, PA-C

www.theprimarycaregroup.com

410.553.6360 (P)
410.553.6661 (F)