BAY COMMUNITY HEALTH

Date:_____

Legal Name *Last*	*First*	*Middle Initial*	*Previous Last Name Used*
Legal Sex: Male Female	**Date of Birth** Month Day Year / /	**Social Security #**	

Please be aware that the name & sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence. Your answers to the following question will help us reach you quickly & discretely with important information.

Home Phone ( )	**Cell Phone** ( )	**Work Phone** ( )	**Best number to use:** ( ) Home ( ) Cell ( ) Work
Please indicate if BCH may leave a message for you on the following numbers: ( ) Home ( ) Cell			
Local Address	City	State	Zip
Billing Address (if different from above)	City	State	Zip
Email Address			Do not have email address Prefer not to share email address
Responsible Party Name	**Phone Number**	**Relationship to you**	
Responsible Party Address	City	State	Zip
Emergency Contact's Name	**Phone Number**	**Relationship to you**	

1) **Which category best describes your current annual income?**
< $15,000
$15,001-$25,000
$25,001-$35,000
$35,001-$50,000
>$50,001

2) **Family Size:** _____
Total # of family members residing in the same house

3) **Language(s)**
English
Spanish
Other: _____

4) **Require translation services**
Yes No

5) **Marital Status**
Single
Married
Divorced
Widowed
Separated
Partnered

6) **Have you ever served in the US military, armed forces, or uniformed services?**
Yes No

7) **Employment status:**
Full Time
Part Time
Not Employed
Self Employed
Retired

8) **Student status:**
Student Full Time
Student Part Time
Not a Student

9) **Racial Group(s)**
Black/African American
White/Caucasian
American Indian/ Alaska Native
Native Hawaiian/ Other Pacific Islander
Asian Indian
Chinese
Filipino
Japanese
Korean
Vietnamese
Other Asian
Guamanian or Chamorro
Samoan

10) **Ethnicity**
Hispanic/Latino/Latina
Mexican / Mexican American / Chicano/a
Puerto Rican
Cuban
Another Hispanic /Latino /Latina origin
Not Hispanic/Latino/Latina

11) **Do you think of yourself as:**
Heterosexual (or Straight)
Lesbian/Gay
Bisexual
Other (Queer, Asexual, Pansexual)
Don't Know
Choose not to disclose

12) **What gender do you identify with?**
Male
Female
Trans Male
Trans Female
Choose not to disclose
Other:_____

Please Turn Over

BAY COMMUNITY HEALTH

Date:_____

13) How did you learn about BCH: Friend/Family Other Doctor's Office Insurance Company Postcard/Mailing Hospital/ER Internet Advertising Capital Bay Weekly Other: _____	**14) Seasonal Agricultural Worker?** Yes No **15) Migrant Agricultural Worker?** Yes No	**16) Homeless since January this year?** Yes No **17) Public housing Resident?** Yes No	

Please indicate below if you have a **preferred pharmacy** for filling prescriptions:

Preferred Pharmacy:		**City**	

Payment/Insurance Information

PLEASE PROVIDE YOUR INSURANCE CARD AT THE TIME OF REGISTRATION.

METHOD OF PAYMENT

I understand and acknowledge that payment is due at the time service is rendered. This includes all co-payments and co-insurance responsibilities. Any variation to this policy must be pre-arranged through our Accounting Department, prior to being seen. We accept Cash, Checks, Money Orders, Visa, MasterCard, American Express, and Discover.

INSURANCE AUTHORIZATION, ASSIGNMENT AND PAYMENT OF SERVICES

I request that payment of authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to Bay Community Health (BCH) for any services furnished me by that party who accepts assignment/clinical provider. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to be released in order to process payment of such services. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for treatment. I also understand that it is my responsibility to be knowledgeable of my insurance benefits and requirements. I understand that based on my health insurance policy, there may be services that the Clinical Provider of BCH may deem necessary that may not be covered by my health insurance, and I shall be held responsible for the payment of such services. I understand and acknowledge that payment is due at the time service is rendered. This includes co-payments, patient responsibility percentage of office visit/procedural charge and any previous back charges. Any variation to this policy must be pre-arranged through our Accounting Department, prior to being seen.

AUTHORIZATION TO TREAT

Permission is hereby given to the Clinical Providers of BCH, to administer such diagnostic, operative, or treatment procedures to the above named patient that are deemed necessary. This includes accessing information from an Carequality/Commonwell Health Information exchange and online pharmacy database about medications that I may be taking for the purpose of continued treatment.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of this provider's *Notice of Privacy Policies*, detailing how my information may be used and disclosed as permitted under federal and state law.

ADVANCE DIRECTIVE

I acknowledge receipt of "Advance Directives" pamphlet/form. This information was given to me as part of my "New Patient" documents. I fully intend to read this pamphlet, and should I decide to choose the use of the advance directives, I will complete the form and will return the signed document back to OPC to maintain with my medical records.

The below signature acknowledges your agreement to the above disclosures:

X _____ **Date:** _____

Signature of Patient/Personal Representative

Relation to Patient

BAY COMMUNITY HEALTH

Patient Name _____ Date: _____

Name of Primary Care Physician	
Primary Care Physician Contact Number:	
Name of Psychiatrist (If applicable)	
Education:	
Current living situation:	
Work (employment, volunteer)	

What is the reason for this appointment today?

Smoking Status (or other forms of nicotine)

Do you smoke?	☐ Yes	☐ No
If Yes,		
When did you start smoking?		
How much do you smoke on a daily basis?		
Did you previously smoke cigarettes?	☐ Yes	☐ No
If Yes,		
How many years did you smoke?		
When did you quit smoking?		

Personal Substance Use/ Abuse

BAY COMMUNITY HEALTH

Alcohol	
Prescription Meds	
Marijuana	
Heroin	
Crack	
Cocaine	
Other	

Family History of Mental Health and Substance Abuse

Is there a biological family history (blood relatives of the patient: mom, dad, siblings, cousins, aunts, uncles, grandparents) of mental health issues or substance abuse issues?	☐ Yes	☐ No
If Yes,		
Please explain:		

Personal Mental Health

Have you ever had any mental health concerns (e.g. depression, anxiety, etc.)	☐ Yes	☐ No
If Yes,		
Please explain:		

Have you had suicidal thoughts?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever had homicidal thoughts?	☐ Yes	☐ No

BAY COMMUNITY HEALTH

Any history of incarceration? ☐ Yes ☐ No

Psychiatric History

Have you received any previous outpatient mental health treatment?	☐ Yes	☐ No
If Yes,		
Please explain:		

Explanation continued:

Have you received any previous inpatient mental health treatment?	☐ Yes	☐ No
If Yes,		
Please explain:		

Explanation continued:

Please list all current psychiatric medications that you are prescribed

Medication	Dosage	Frequency	Prescribed By

BAY COMMUNITY HEALTH

Dear Valued Client of Bay Community Health,

A large part of our mission is to provide quality access to care to our clients. This involves making sure all of our clients are treated with integrity and courtesy. With this in mind, we continually evaluate our policies and protocols to maintain a supportive and efficient standard of care.

As of January 1, 2020, all appointments for active behavioral health clients will be scheduled based on the following guidelines.

- Clients needing medication management must agree to and consistently see their respective therapists at least once a month. If a monthly therapy appointment is missed (cancelled, no show, etc.) any subsequent appointments for medication management will be cancelled until a monthly therapy session has been scheduled and completed.

- Clients with two ***consecutive*** missed appointments (either no-show or same day cancellation) will receive a letter and a phone call from our office. This letter will inform the client that all further appointments will be cancelled until the client contacts the office. Upon that contact, one appointment will be scheduled with the client's regular providers.

- If a client missed the new appointment after receiving a missed appointment letter, the client will be placed on inactive status from the behavioral health department. If the client does want to continue care with our department, they will be scheduled for a new client appointment to reestablish with the behavioral health providers.

These changes will be put into place to better serve clients who are in need of behavioral health services and are committed and actively involved in their behavioral health care.

Should you have any questions regarding these changes, please feel free to contact our office at (443) 607-1432.

Thank you for your consideration.

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

BAY COMMUNITY HEALTH

BAY COMMUNITY HEALTH
Notice of Privacy Practices
Effective Date: January 1, 2013

This notice describes how health information about you may be used and disclosed and how you can get this information. PLEASE READ IT CAREFULLY.

Our Pledge to You about Protecting Your Health Information We at Bay Community Health (BCH) understand that health information about you and your health care is personal. We are committed to protecting this most private information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by this health care practice, whether made by your personal doctor or health care practitioner or others working in this office. This notice will tell you about the ways we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and certain obligations we have to use or disclose it. LAW REQUIRES US TO:

- Make sure that health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy with respect to your health information; and
- Follow the terms of this notice currently in effect

How We May Use and Disclose Health Information About You ***For Treatment*** We may use health information about you to provide you with health care treatment or services. We may disclose information about you to doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our office, at the hospital if you are hospitalized under our supervision, or at another doctor's office, lab, pharmacy, or other health care provider to whom we may refer you for consultation, to take x-rays, to perform lab tests, to have prescriptions filled, or other reasons. The information is needed by these professionals in order to know what treatments you will need. They will record actions taken in the course of your treatment and note how you respond. In the event of a disaster, we may also disclose health information about you to another organization assisting in disaster relief so that your family can be notified about your condition, status and location. ***Communications with Family*** Using our best judgment, we may disclose to a family member, personal representative, or any other person you identify, health information about you related to that person's involvement in you care if you do not object, or in the event of an emergency. ***Appointments*** We may use your information to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may be of interest to you. ***For Payment*** We may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payer, such as an insurance company or health plan. The bill may contain information that identified you, your diagnosis, and treatment or supplies you received in the course of care. ***For Health Care Operations*** We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of medical staff, risk or quality improvement personnel, and others to:

- Evaluate the performance of our staff;
- Assess the quality of care and outcomes in your case and similar cases;
- Learn how to improve our facilities and services; and
- Determine how to continually improve the quality and effectiveness of the health care we provide.

Health Information Exchanges We may participate in various health information exchanges to facilitate the secure exchange of your electronic health information between and among several health care providers or other health care entities for your treatment, payment, or other healthcare operations purposes. We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide health information exchange. As permitted by law, your 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 more informed decisions. You may "opt-out" and prevent searching of 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.

Health Care Oversight Activities We may disclose health information to a health oversight agency for activities authorized by law. These activities include, for example, audits, investigations, inspections, and licensure. They are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. ***As Required by Law*** We may use and disclose information about you as required by law. For example, we may disclose information for the following purposes:

- For judicial and administrative proceedings;
- To assist law enforcement officials in their duties, and
- To report information related to victims of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

To Avert a Serious Threat to Health and Safety We may use or disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of another person or the public. Any disclosure, however, would only be made to someone able to help prevent the threat. ***For Public Health*** We may use or disclose your health information for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report reactions to medications or problems with products;
- To notify people of recalls for products they may be using, and
- To notify a person who may have been exposed to disease or may be at risk for contracting the disease or condition.

Military or Veterans If you are a member of the armed forces or separated/discharged from military service, we may release health information about you as required by military command authorities or the Department of Veteran Affairs. We may also release health information about foreign military personnel to the appropriate foreign military authorities. ***Workers Compensation*** We may disclose health information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness. ***Coroners, Health Examiners and Funeral Directors*** We may release health information to a coroner or health examiner. For example, this may be necessary to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties. ***Inmates*** If you are an inmate of a correctional institution or under custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release may be necessary for the institution to provide you with the health care, to protect your health and safety or that of

others, or for the safety and security of the correctional institution. ***Government Functions*** We may release health information to specialized government functions such as protection of public officials (President of the United States and others), or reporting to various branches of the armed services, authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. ***Lawsuits and Disputes*** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Your Health Information Rights The health and billing records we maintain are the physical property of Bay Community Health. The information in them, however, belongs to you. You have a right to: ***Inspect and Copy*** You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records. This does not include psychotherapy notes. To inspect and/or copy health information you must request this in writing using the form that we will provide to you upon request. Medical Record copies may be processed by an independent company, and a fee by this company or by Bay Community Health is billed to the patient. The fee varies based on the individual's medical records and specifics of the request, and the request will be processed within 2 to 3 weeks of date of the request. We may deny your request to inspect and copy your health information in very limited circumstances. If you are denied access to your health information, you may request a review of the denial. The person conducting the review will
not be the same one that denied your request. We will comply with the outcome of this review. ***Right to Amend*** If you feel that health information we have about you is incorrect or incomplete; you may ask us to amend the information. To request an amendment you need to submit your request in writing, on one page of paper, legibly handwritten or typed to Bay Community Health, HIPAA Officer, 134 Owensville Road, West River, MD 20778. In addition, you must provide the reason for wanting to amend the information. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information that you would be permitted to inspect and copy; or
- Is accurate and complete.

Any amendment we make to your health information will be disclosed to those with whom we share information as previously described. ***Right to an Accounting of Disclosures*** You have the right to request a list of accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, or health care operations, as previously described. To request a list of disclosures, you must submit your request in writing to Bay Community Health, HIPAA Officer, 134 Owensville Road, West River, MD 20778. Your request must state a time frame that may be no longer than six (6) years and may not include dates prior to April 13, 2003. The first list you request within a twelve-month period will be free. For additional lists, we will charge you the cost of providing the list. We will notify you of the cost involved and you may choose to modify or withdraw your request at that time and before the costs are incurred. We will mail you a list of disclosures in paper form within 30 days of your request, or notify you if we are unable to supply the list within that time period and the date by which we can supply the list, but this date will not exceed a total of 60 days from the date you made the request. ***Right to Request Restrictions.*** You have the right to request a restriction of limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment of your care, such as a family member or friend. ***We are not required to agree to your request for restrictions if we are not able to ensure our compliance or if we believe it will negatively impact the care we may provide you.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request in writing to Bay Community Health, HIPAA Officer, 134 Owensville Road, West River, MD 20778. In your request, you must tell us what information you want to limit and to whom you want the limits to apply. ***Right to Request Confidential Communications*** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example; you can ask that we only contact you at work or by mail to a post office box. To request confidential communications, you must make your request in writing to Bay Community Health, HIPAA Officer, 134 Owensville Road, West River, MD 20778. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must tell us how or where you wish to be contacted. ***Right to a Paper Copy of this Notice.*** You have the right to obtain a paper copy of this notice at any time. To obtain a copy, please request it from Bay Community Health, HIPAA Officer, 134 Owensville Road, West River, MD 20778.

Changes to this Notice We reserve the right to change this notice. We reserve the right to make revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain the effective date on the first page.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Bay Community Health, HIPAA Officer, 134 Owensville Road, West River, MD 20778. All complaints must be submitted in writing. ***You will not be penalized for filing a complaint.***

Acknowledgement of Receipt of this Notice
We will request that you sign a separate form or notice acknowledging that you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name and date the acknowledgement form. This acknowledgement will be filed with your records.

Bay Community Health sincerely respects your privacy rights, and will make every reasonable attempt to protect your health information. It is important that you read this notice carefully, and if you have questions or concerns regarding this notice, please contact:

Bay Community Health
Attention: HIPAA Officer
134 Owensville Road
West River MD 20778
410-867-4700

BAY COMMUNITY
HEALTH

Bay Community Health

Notice of Privacy Practices Acknowledgement

Effective Date: January 1, 2013

I have been provided a paper copy of the Notice of Privacy Practices effective as of the date above.

_____
Patient's Name

_____
Patient's Signature

_____
Date

TO BE RECORDED IN PMS/SCANNED IN EPR

BAY COMMUNITY HEALTH

Bay Community Health
134 Owensville Road
West River MD 20778
Phone: 410 867-4700 / Fax: 410 867-4934

Patient Name _____ **DOB:** _____

Patient preferred telephone number to be contacted: _____

Please indicate additional persons with whom we may contact on your behalf and indicate their relationship to you:

Name	Relation to Patient	Telephone #	Phone Type
			H W C
			H W C
			H W C
			H W C
			H W C

Patient additional comments: _____

Signature: _____ **Date:** _____

Print Name: _____

BCH Employee Initials: _____

Authorization for Release of Medical Records

Bay Community Health
134 Owensville Road
West River, Md. 20778
(T) 410-867-4700 (F) 855-772-1468

I authorize the following protected health information to be released from the medical record of:

Last Name _____ First Name _____ Today's Date _____

Birthdate _____ Email Address _____ Phone Number _____

Release Records
✓ **To**
□ **From**

Bay Community Health
134 Owensville Road
West River, Md. 20778
(T) 410-867-4700
(F) 855-772-1468

Release Records
□ **To**
✓ **From**

Name/Organization _____
Address _____
City / State / Zip _____
Phone _____ Fax _____

Please mail my records **Please call when my records are ready for pick up** **Please fax my records**
Other: _____ **Note: Send PAPER RECORDS only**

I understand that to the extent that any recipient of this information, as identified above, is not a "covered entity" under Federal or Maryland privacy law, the information may no longer be protected by Federal and Maryland privacy laws once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.

TO BE RELEASED	**Date of Service**	**TO BE RELEASED**	**Date of Service**
✓ Chart Summary		✓ Immunizations	
✓ Office visit	Last Visit & Full PE	✓ Radiology reports	Past 5 years
□ GYN visit		Consultation Reports	
Urgent Care visits		Full Psychiatric Hx	
✓ Lab work	Past 1 Year	Other	

➔ Note: If specific dates to be released or a specific provider are not indicated, all records in the category marked will be released.

Indicate the PURPOSE for this disclosure:_____
I understand the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
I understand I have the right to revoke this authorization I must do so in writing and in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition_____.
If I fail to specify and expiration date, event or condition, this authorization will expire in six months of dated signature. I understand that authorizing the disclosure of this phi is voluntary. I need not sign this for in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact BCH Privacy Officer.
I understand that I may incur a charge for the copying or inspection of patient records. A minimum clerical fee of $_____and per page fee of $_____.

Signature of Patient or Patient Representative _____ Printed Name/Relationship of Patient Representative _____ Date _____

If documents are being picked up at BCH, from someone other than the patient. This authorization form must indicate this accordingly

Signature of person picking up documents _____ Printed Name/Relationship _____ Date _____

BAY COMMUNITY HEALTH

BAY COMMUNITY HEALTH
Patients' Bill of Rights & Responsibilities

Bay Community Health is committed to providing quality health care. A well-informed patient that participates in treatment decisions and communicates openly with their healthcare professionals is a patient that will ultimately benefit greatly in their continued healthcare.

You have the Right …

- To considerate and respectful treatment from your first phone call throughout your office visit and follow-up care.
- To know the names and professional status of the people serving you.
- To privacy/confidentiality concerning your own health care program and medical records.
- To participate in choosing a form of treatment.
- To consent to or refuse any care or treatment.
- To examine and receive an explanation of all charges.
- To receive full information and counseling or the availability of known financial resources for your health care.
- Timely resolution of any questions, complaint, or problem regarding BCH services and/or procedures.

You have the Responsibility …

- To be honest about your medical history.
- To follow health advice and instructions.
- Report any significant changes in symptoms or failure to improve.
- Maintain and have available an updated detailed medication list.
- Provide sufficient time in making "Follow-Up" and "Annual" appointments to ensure appointment availability.
- To keep appointments or provide 48 hours advance notice for cancellation.
- To insure you obtain prescriptions at the time of your office visit. If a prescription refill must be called in, allow a minimum of 48 hours notice.
- Allow 3-5 working days for specialty referrals.
- Allow 5-7 working days for completions of forms. Forms must be completed/signed by patient; some forms will require an appointment and some forms may incur a patient fee.
- Be knowledgeable and well-informed about your health insurance coverage, especially in regard to:
    1. Prescription/Medication formularies
    2. Preferred Lab Providers
    3. Specialty-Care providers, policies, and procedures
    4. Non-Covered medical services
- To be respectful of all other patients, visitors, and staff.

BAY COMMUNITY HEALTH

Bay Community Health
Patient Information Sheet

Bay Community Health welcomes you and your family, and we appreciate the opportunity to provide your health care services. We provide Primary Care and Behavioral Health services at all Bay Community Health Locations.

Office Hours

Visit our website (www.baycommunityhealth.org) to view our office hours by location.

Appointment Scheduling/Cancellations/Late Arrivals

- Established patients should arrive 15 minutes prior to appointment time
- New patients should arrive 30 minutes prior
- Sick visits are typically scheduled for the same day or within 48 hours of appointment request
- Same-day appointments are granted based on availability
- Follow-up office visits are scheduled at check-out
- Physical exams/well exams are usually scheduled within 2 to 6 weeks of appointment request
- Our providers may occasionally be running late, and your visit may be delayed. Our staff will try to inform you if this occurs.
- **Cancellations:** 48-hour advance notice on all cancellations is requested
- **Late arrivals**: If you arrive more than ½ way after the start of your scheduled appointment time, please know we will have to reschedule your appointment.

Insurance

While filing of insurance claims is a courtesy we extend to our patients, it is your responsibility to bring your valid and up to date proof of insurance coverage and a photo ID to each appointment. Please be familiar with your co-pay, which is to be paid at each visit.

If you do not have insurance, we can connect you with a BCH team member to discuss health insurance enrollment and/or our sliding fee scale program.

Prescriptions

Our providers believe that patients should be evaluated prior to being prescribed new medications. Prescription refills should be made through the pharmacy, which requires patients to inform their pharmacy with 48 hours advanced notice. "Controlled substance" medications will not be prescribed on Fridays or on the day before a Federal holiday and in most cases will require an appointment with the primary provider. To avoid delays with medication refills, please review medication needs at each office visit.

Patient Portal Access

Our patient portal can be utilized by our patients to request appointments, request medication refills, update patient demographics and correspond with our providers. IF you are interested in establishing a portal account, please provider your email to our front desk staff. You will receive an email with your account information to help set up your account.

Care of Minors

No children under the age of 18 will be seen with the written consent of a parent or legal guardian. Please speak with a front desk team member to obtain the consent form.

Return Telephone Messages

Our providers and/or medical support staff attempt to return all messages in a timely fashion. Return calls are often made during the lunch or late afternoon hours and sometimes on the following day.

BAY COMMUNITY HEALTH

Medical Referrals

You may require a medical referral for specialty and/or urgent care. Bay Community Health requests 5 working days to process these referrals. In many cases an office evaluation will be requested to determine the referral's necessity. Please remember there are many health insurance companies many more individual policies. It is the patient's responsibility to know and abide by the regulations of his or her insurance coverage.

Medical Records/Medical Forms

To obtain a copy of Bay Community Health medical records patients must complete a "Request for Medical Records" form and allow a minimum of 5 working days for processing. The processing fee varies depending on the size of the medical chart, but the basic fee is typically $25.00. There is no charge to obtain copies of immunization records or records pertaining to State of Maryland Workman's Compensation. Depending on the form, there may be a charge applied to the patient bill for this processing. It may also be necessary for the patient to be evaluated in the office prior to form completion.

CRISP

Bay Community Health has chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a statewide health information exchange. As permitted by law, your 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 more informed decisions, you may "Opt-Out" and prevent searching of your health information available through CRISP by calling 1-877-951-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website www.crisphealth.org.

Inclement Weather

In the event that the office closes for inclement weather, we will make every attempt to notify our patients via our website, a direct text/email blast message and/or a message on our office voicemail.

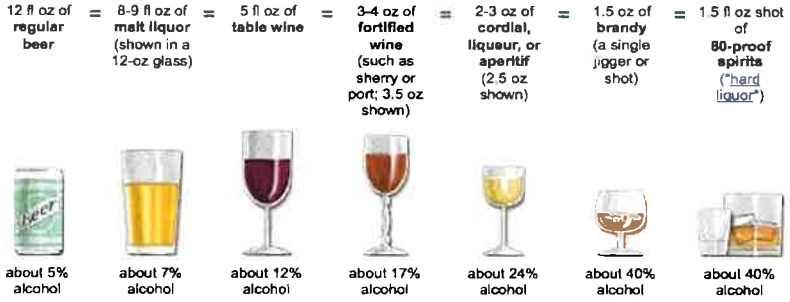
SBIRT Screening

Name: _____ Date of Birth: _____

Please circle the response that applies

PHQ-2: Over the last 2 weeks, how often have you been bothered by the following problems?		Not at all	Several Days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed or hopeless	0	1	2	3

Before answering questions 3-5, please refer to the standard drink chart to the right



Alcohol Use:		0	1	2	3	4
3	How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times per week	4 or more times a week
If you answered Never to question 3, please skip to question 6						
4	How many drinks containing alcohol do you have on a typical day?	1 or 2	3 or 4	5 or 6	7 or 9	10 or more
5	How often do you have six or more drinks on one occasion	Never	Less than monthly	Monthly	2-3 times per week	4 or more times a week
Alcohol Use Score: _____						

PHQ-2:				
1	In the past 3 months, have you used marijuana or any other street drugs such as crack, cocaine, heroin or prescription drugs for nonmedical reasons?	Yes	No	If yes, please list the drugs used in the last 3 months 1. _____ 2. _____ 3. _____

2	In the past 3 months, have you used prescription drugs such as painkillers, sleeping pills, uppers or medications for bad nerves that were not prescribed by your doctor?	Yes	No	If yes, please list the prescription drugs used in the last 3 months 1. _____ 2. _____ 3. _____

PHQ-9		Not at all	Several days	More than half the days	Nearly every day
Over the **last 2 weeks**, how often have you been bothered by any of the following problems? (Circle your response)					
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have notices? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3
	Add Columns				
				Total	

Please circle the appropriate response				
If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

In the past month, have you felt depressed or sad most days, even if you felt okay sometimes?	Ye	\lo
In the past 2 years, have you felt depressed or sad most days, even if you felt okay sometimes	Ye	\lo

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	**YES**	**NO**
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

This instrument is designed for screening purposes only and not to be used as a diagnostic tool.
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