

ROCKVILLE MEDICAL CARE

Janna Lachtchinina, MD
2401 Research Blvd., Suite 360 · Rockville, MD 20850 · p: 240.449.8900

New Patient Registration Form

Please bring your insurance card and a photo ID — we will make a copy at check-in, so you don't need to copy those details here.

Patient Information

First Name	Middle Name	Last Name (as on ID)	
Date of Birth	Sex / Gender	Preferred Language	
Street Address	City	State	Zip
Cell Phone	Home Phone	Email Address	
Occupation	Employer	Referred By	
Preferred Pharmacy	Pharmacy Phone	Previous / Referring Physician	
Preferred contact method: ☐ Cell ☐ Text ☐ Email ☐ Home		Interpreter needed? ☐ Yes ☐ No	
Race / Ethnicity (optional)		Preferred written language (optional)	

Race, ethnicity, and language are optional and self-reported. They help us provide equitable, well-coordinated care, and you may decline any item.

Emergency Contact

Name	Phone	Relationship to Patient
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Insurance

We will copy your insurance card at check-in. Please confirm the basics below; leave blank anything shown on your card.

Primary Insurance

Insurance Company	Member ID #	Group #
Subscriber Name (if not the patient)	Subscriber Date of Birth	Relationship to Patient

Secondary Insurance (if applicable)

Insurance Company	Member ID #	Group #
Subscriber Name (if not the patient)	Relationship to Patient	

Responsible Party (if not the patient)

Name	Relationship to Patient	Phone
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Signature of Patient or Authorized Guardian: _____ Date: _____

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Basic Health Summary

Patient Name: _____ Date of Birth: _____

Current Medications

☐ I take no regular medications.

List medications you take regularly, including over-the-counter and vitamins.

Medication Name	Dose	How often
Medication Name	Dose	How often
Medication Name	Dose	How often
Medication Name	Dose	How often
Medication Name	Dose	How often

Allergies

☐ No known drug allergies.

Allergy (medication, food, other)	Reaction
Allergy (medication, food, other)	Reaction
Allergy (medication, food, other)	Reaction

Past Medical History

Check any condition you have or have had:

- | | | |
|--|--|---|
| ☐ High blood pressure | ☐ High cholesterol | ☐ Diabetes |
| ☐ Thyroid disorder | ☐ Asthma / COPD | ☐ Heart disease |
| ☐ Stroke / TIA | ☐ Cancer | ☐ Depression / anxiety |
| ☐ Kidney disease | ☐ Liver disease | ☐ Seizures |
| ☐ Arthritis | ☐ Acid reflux / ulcer | ☐ Blood clots |

Other conditions: _____

Surgeries & Hospitalizations

Surgery or Hospitalization	Year
Surgery or Hospitalization	Year

Tobacco & Alcohol

Tobacco: ☐ Never ☐ Former Yes ☐

Current Alcohol: ☐ None ☐ Occasional ☐ Regular

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Consent to Treatment & Financial Agreement

Patient Name: _____ Date of Birth: _____

1. Consent to Treatment

I consent to evaluation, testing, and treatment as directed by my Rockville Medical Care, LLC physician or his or her designee.

2. Assignment of Insurance Benefits

I authorize direct payment of my insurance benefits to Rockville Medical Care, LLC, or to the treating physician, for services provided to me or my dependents. I understand it is my responsibility to know my insurance benefits and whether the services I receive are covered. I agree to be responsible for any copay, deductible, coinsurance, or balance that my insurer does not pay for any reason.

3. Medicare / Medicaid / TRICARE Certification

I certify that the information I provide in applying for payment under these programs is correct. I authorize the release of any records these programs may request, and I direct that payment of authorized benefits be made to Rockville Medical Care, LLC, or to the treating physician on my behalf.

4. Laboratory, Imaging & Diagnostic Services

I understand that I may receive a separate bill if my care includes laboratory, x-ray, or other diagnostic services performed by an outside provider, and that I am financially responsible for any copay or balance not reimbursed by my insurer for any reason.

5. Financial & Office Policies

- Copays, deductibles, and prior unpaid balances are due at the time of service.
- Statements may be mailed after a visit and are due upon receipt. Balances unpaid after 90 days may be referred to a collection agency.
- No-show / late cancellation: at least 24 hours' notice is required to cancel or reschedule. Failure to provide adequate notice may result in a \$35 fee.
- After-hours calls: a non-emergency after-hours call to the provider may incur a \$25 fee. For a true emergency (chest pain, shortness of breath, bleeding, etc.), if you have not heard back within 30 minutes, go to the nearest emergency room or call 911.
- Medical records: copies are \$0.76 per page plus actual postage. A \$22.88 retrieval and preparation fee applies only when records are sent to another provider — not when records are provided directly to you. No fee is charged for records used to file or appeal a Social Security disability (SSDI/SSI) claim.
- Forms or letters that require staff or provider completion require an office visit. STD results, disability or workers' compensation claims, and mental health matters are not handled by phone and require an appointment.

I have read and understand this Consent to Treatment & Financial Agreement, and I agree to its terms. I understand the practice may amend these terms from time to time.

Patient / Authorized Guardian Signature: _____ Date: _____

Printed Name: _____

Guarantor Signature (if different from patient): _____ Date: _____

Guarantor Printed Name: _____ Relation to Patient: _____

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Authorizations & Acknowledgments

Patient Name: _____ Date of Birth: _____

A. Communication Consent (mail & phone)

I authorize Rockville Medical Care, LLC to contact me by mail and phone regarding my healthcare — including appointment reminders, referral arrangements, and laboratory or test results — using the contact information I have provided. I understand that I may revoke this consent in writing at any time.

Consent to receive billing statements and other communications by email or text message (SMS) is addressed separately on the Electronic Communication Authorization included in this packet.

B. HIPAA Notice of Privacy Practices — Acknowledgment of Receipt

I acknowledge that I have been offered a copy of the Rockville Medical Care, LLC Notice of Privacy Practices, which describes how my protected health information may be used and disclosed and my rights regarding that information. I understand the current Notice is posted in the office and available on request. (My signature is an acknowledgment of receipt only and is not consent to any particular use or disclosure.)

C. CRISP Health Information Exchange

Rockville Medical Care participates in CRISP, the regional health information exchange serving Maryland and Washington, D.C. As permitted by law, my health information may be shared through CRISP to provide faster access to records and better coordination of my care. I understand I may opt out at any time by calling 1-877-952-7477 or visiting www.crisphealth.org. Even if I opt out, public health reporting and Prescription Drug Monitoring Program (PDMP) information will remain available to providers as required by law.

☐ I acknowledge the CRISP notice above.

By signing below, I acknowledge Sections A, B, and C on this page.

Patient / Authorized Guardian Signature: _____ Date: _____

Printed Name: _____

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Electronic Communication Authorization (Email / SMS)

Patient Name: _____ Date of Birth: _____

Understanding the risks of electronic communication by email and/or SMS (text message), I give consent for the following communication method.

Consent

I consent for Rockville Medical Care, LLC to communicate with me by email and/or SMS for billing and administrative purposes only:

☐ YES ☐ NO

Email address to be used: _____

Mobile number for SMS: _____

If this email address or mobile number belongs to a family member or someone other than the patient, please provide their name and relationship:

Name _____ Relationship _____

What electronic statements will contain

Statements sent electronically will contain the date of service, the amount due, and insurance information only. They will NOT include diagnosis or other medical information.

I recognize that electronic communications cannot be fully protected from unauthorized interception. This consent may be revoked in writing at any time.

Patient Signature: _____ Date: _____

Printed Name: _____

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Consent for Audio Recording & Augmented Intelligence Medical Scribe

Patient Name: _____

Date of Birth: _____

1. Purpose

To help your physician focus on you rather than note-taking, we use a secure, HIPAA-compliant augmented intelligence medical scribe service (Freed) that records the audio of your visit to help create your clinical note. The resulting notes are reviewed, edited if necessary, and personally approved by your physician before being placed in your Electronic Medical Record.

2. Maryland Two-Party (All-Party) Consent

Maryland law requires the consent of every person whose voice is recorded. By signing below, you give your express consent to the audio recording of conversations with your physician and clinical staff during your visit. If you do not consent, please notify our staff; your visit will be documented manually and your ability to receive care will not be affected.

3. Use & Disclosure of Your Health Information

The audio recording of your visit will be securely transmitted to our augmented intelligence scribe vendor, Freed, with whom we maintain a Business Associate Agreement requiring it to protect your health information under the HIPAA Privacy Rule, solely to create a written summary for your medical record. [Retention note — to be confirmed against the vendor's current policy: audio is retained only as long as needed to generate and verify the note, then deleted in accordance with the vendor's data-retention policy.] This authorization remains in effect while you are a patient of this practice unless you revoke it.

4. Your Rights

- You may refuse to sign this authorization; if you do, the augmented intelligence scribe will not be used for your visits, and this will not affect your ability to receive treatment, though it may change how your visit is documented.
- You may revoke this authorization at any time in writing, sent to the practice address above. Revocation will not apply to information already used or disclosed.
- You have the right to receive a copy of this signed form and to inspect and obtain a copy of the final, physician-approved notes.

5. Consent & Signatures

I have read and understand this consent. My questions have been answered. I voluntarily consent to the audio recording of my visit and authorize the use and disclosure described above.

Patient Name (printed): _____

Patient Signature: _____ Date: _____

Parent / Guardian (if patient is a minor) — Name & Relationship: _____

Parent / Guardian Signature: _____ Date: _____

Other adult(s) present during the visit whose voice may be recorded — consent to recording:

Name & Relationship: _____ Signature: _____

Name & Relationship: _____ Signature: _____

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Depression Scale — Short Form

Geriatric Depression Scale (GDS-15)

Patient Name: _____ Date: _____

Insurance Provider: ☐ Commercial ☐ Medicare

Instructions: Select (or circle) the answer that best describes how you have felt over the past week.

- | | | |
|---|---------------------------|--------------------------|
| 1. Are you basically satisfied with your life? | ☐ Yes | ☐ No |
| 2. Have you dropped many of your activities and interests? | ☐ Yes | ☐ No |
| 3. Do you feel that your life is empty? | ☐ Yes | ☐ No |
| 4. Do you often get bored? | ☐ Yes | ☐ No |
| 5. Are you in good spirits most of the time? | ☐ Yes | ☐ No |
| 6. Are you afraid that something bad is going to happen to you? | ☐ Yes | ☐ No |
| 7. Do you feel happy most of the time? | ☐ Yes | ☐ No |
| 8. Do you often feel helpless? | ☐ Yes | ☐ No |
| 9. Do you prefer to stay at home, rather than going out and doing things? | ☐ Yes | ☐ No |
| 10. Do you feel that you have more problems with memory than most? | ☐ Yes | ☐ No |
| 11. Do you think it is wonderful to be alive now? | ☐ Yes | ☐ No |
| 12. Do you feel worthless the way you are now? | ☐ Yes | ☐ No |
| 13. Do you feel full of energy? | ☐ Yes | ☐ No |
| 14. Do you feel that your situation is hopeless? | ☐ Yes | ☐ No |
| 15. Do you think that most people are better off than you are? | ☐ Yes | ☐ No |

Total Score: _____