

Jose F Alvarado and Associates

600 Glen Ave, Unit 103

Salisbury, MD 21804

Patient Information:

First Name: _____ Middle Name: _____

Last Name: _____ Nickname: _____

Date of birth: _____ Gender: _____ Social security number: _____

Ethnicity: _____ Race: _____ Preferred Language: _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Parents Information:

Guardian #1 Name: _____ Relationship: _____

Please circle one: Birth parent, Adopted, or Legal Guardian

Date of Birth: _____ Social Security number: _____

Employment: _____ Cell Phone Number: _____

Please circle one preferred appointment reminder: call, text or email

Email address: _____ Preferred Language: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Does Patient reside with you? _____

Guardian #2 Name: _____ Relationship: _____

Please circle one: Birth parent, Adopted, or Legal Guardian

Date of Birth: _____ Social Security number: _____

Employment: _____ Cell Phone Number: _____

Please circle one preferred appointment reminder: call, text or email

Email address: _____ Preferred Language: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Does Patient reside with you? _____

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Patient Name: _____ **DOB:** _____

Contact Preferences:

Please List Guardian responsible for Billing/Statements.

Guardian Name: _____

Address: _____ **City:** _____

State: _____ **Zip code:** _____

Guardian Phone number: _____

Insurance Information:

Primary Insurance Name: _____ **Policy Number:** _____

Group Number: _____ **Effective Date:** _____

Policy Holders Name: _____ **Relationship to policy holder:** _____

Secondary Insurance Name: _____ **Policy Number:** _____

Group Number: _____ **Effective Date:** _____

Policy Holders Name: _____ **Relationship to policy holder:** _____

Pharmacy Preferences:

Pharmacy Name: _____ **Pharmacy Phone Number:** _____

Pharmacy Address: _____ **City:** _____ **State:** _____

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Patient Name: _____ **DOB:** _____

Patients Past Medical History:

- ☐ Asthma
- ☐ Developmental Delay
- ☐ Speech Problems
- ☐ Breathing Difficulties
- ☐ Seizure Disorder
- ☐ Kidney Disease
- ☐ Heart Problem/Murmur
- ☐ Thyroid
- ☐ Vision Problems
- ☐ Bleeding Disorder
- ☐ Diabetes
- ☐ Eczema
- ☐ ADHD
- ☐ Anxiety
- ☐ Sickle Cell Disease
- ☐ Depression
- ☐ Cancer
- ☐ Other: _____

Current Medications:

Family Medical History

Patient Name: _____

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Alcoholism												
Anemia												
Autism												
Asthma												
Autoimmune Disorder												
Birth Defect/Congenital Anomaly												
Bleeding Disorder												
Cancer, Breast												
Cancer: (Specify)												
Cancer: (Specify)												
Depression												
Type I Diabetes												
Type II Diabetes												
Eczema (Atopic Dermatitis)												
Food Allergy												
Genetic Disorder												
Hay Fever (Allergic Rhinitis)												
Hearing Disorder												
Heart Attack/Coronary Artery Disease												
High Cholesterol												
High Blood Pressure												
Immune Disorder												
Inflammatory Bowel Disease (Crohn's/UC)												
Kidney Disease												
Intellectual or Learning Disability												
Migraine Headaches												
Psychiatric Disorder/ Mental Health Disorder												
Scoliosis												
Stroke												
Substance Abuse												
Thyroid Disorder												
Tobacco Use												
Tuberculosis												
Death before 56?												
Other?												

Informant: _____

Date: _____

Reviewed by: _____

Jose F Alvarado & Associates

Office Policies

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following office policies. If you have any questions about the policies, please discuss them with our office manager.

Appointments:

1. We value your time as parents and patients. Appointments are scheduled per patient. If you have more than one child to be seen, please make sure to make an appointment for each child.
2. If you are unable to keep a scheduled appointment, we require a 24-hour notice. **There is a charge of \$50.00 for missed appointments or ones canceled with less than 24-hour notice. After three missed appointments we will require that you find another practice.**
3. If you are late for your appointment (> 10 minutes), we will need to reschedule it unless we are able to accommodate you.
4. We strive to minimize any wait time, however, emergencies do occur. We appreciate your understanding.

Combined Visits:

1. If you are scheduled for a well child exam and other health concerns are discovered and or treated, your insurance company may consider these as two separate visits which could result in copays or deductibles due.

Financial Responsibility:

1. According to your insurance plan, you are responsible for copays, deductibles and co-insurance. **Copays are due at time of service.**
2. It is your responsibility to keep us updated with the correct insurance information. If you have not provided us with the correct information, you might be responsible for payment of that visit.
3. If your insurance requires a designated primary care physician, make sure our name appears on your card.
4. A \$25.00 fee will be charged for any checks returned for insufficient funds.

Vaccines:

1. Our providers firmly believe in the effectiveness of vaccines to prevent serious illnesses and save lives. We also believe in the safety of vaccines. We follow the schedule outlined by the American Academy of Pediatrics which has been scientifically tested for safety and efficacy. We will be happy to provide information to help you understand the science behind vaccines. We are committed to keep our patients safe and provide the best pediatric care which includes on time vaccinations. We do not believe in a safe "alternative" vaccine schedule. **If you don't agree to follow the AAP guidelines, we will request that you find another practice.**

Referrals and Prescription Refills:

1. We require a 48-hour notice for all non-emergency referrals or medication refills.

Forms:

We recognize that forms are required by schools, camps, daycares and other organizations regarding the health status of your child. **Completion of forms requires that your children be current with their well visits and immunizations.**

School and camp forms can be completed and signed at the time of the well visit if you bring the forms with you at no additional charge.

All other forms, and forms not presented at the time of well visit, are handled according to our new Form Policy.

School, camp and medication administration forms are completed within 5-7 business days for a fee of \$10 per packet of forms, unless you elect to pay the annual forms fee.

Urgent forms can be completed next business day for a fee of \$25.00

Complex forms (FMLA) and physician letters can be completed within 5-7 business days for a fee of \$30-\$50 depending on the complexity of such forms.

Families can elect to pay an annual fee of \$50 that covers all routine forms for the year.

Patient Name: _____

Date: _____

Signature: _____

Jose F. Alvarado & Associates

HIPAA Patient Consent Form

Patient Name: _____

- Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected health information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
 - The practice reserves the right to change the privacy policy as allowed by the law.
 - The patient has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
 - The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
 - The practice may condition receipt of treatment upon execution of this consent.
- We have chosen to participate in the Chesapeake regional Information System for our Patients ("CRISP"), a regional health information exchange ("HIEs") serving Maryland. CRISP is also affiliated with and shares data with other HIEs, including those in Alaska, Connecticut, D.C., Maryland, and West Virginia. 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 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 www.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.
- May we call, e-mail, or send text messages to you to confirm appointments? **Yes or No**
 - May we leave a message on your answering machine at home or on your cell phone. **Yes or No**
 - May we discuss your medical condition with any other member of your family? If **yes**, please name the members allowed to receive information.
- _____

Patient Name: _____

Date: _____

Signature: _____

Updated 12/2025

Jose F. Alvarado and Associates

Permission to Treat

This consent gives Jose F. Alvarado and Associates, permission to treat the patient for the items specified below.

I _____ (Parent/Legal Guardian) give permission for _____ (Patients Name), to be seen at Jose F. Alvarado and Associates, according to the guidelines listed below. This authorization will expire 1 year from the date signed.

I give permission for the following treatment:

_____ Well child checks or routine physical examinations

_____ Immunizations

_____ Sick visits and testing

_____ Other _____

Responsible adult allowed to bring patient to our office:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

If additional treatment is needed, verbal consent will be needed. I can be reached at (Phone Number) _____.

Parent/Legal Guardian Signature: _____

Date: _____

Jose F. Alvarado & Associates
600 Glen Ave, Unit 103
Salisbury, MD 21804
Phone (410) 742-7660 Fax (410) 742-5309

Authorization for Release of Medical Records

Patient Information:

Request Release From:

Name:

Date of Birth: _____

Social Security Number: _____

I hereby authorize you to release to _____, a copy of my medical records to be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Furthermore, I understand that this Protected Health Information may be redisclosed by the recipient and thus is no longer protected under privacy rules.

By signing this authorization, I understand that medical records released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drugs, and alcohol abuse, etc. I understand that release of psychotherapy notes requires an additional authorization.

Patient or Guardian Signature

Date

Patient or Guardian Printed Name

Please Include the following items:

☐ Admission Notes
☐ Discharge Summary
☐ Progress Notes
☐ Immunizations
☐ Laboratory Tests and X-Ray Reports

☐ Consultation Notes
☐ EKG's
☐ All Records

This authorization will expire on _____

If left blank will be good for one year from date signed.