

Potomac Physician Associates, PC

Name: _____ () Male () Female Date: _____
 Birthdate: _____ Work # _____ Home# _____ Cell# _____
 Occupation: _____ Marital Status: S M D W (please circle)
 Emergency Contact: _____
 Relationship: _____
 Phone number: _____ Other #: _____
 Reason for today's visit: _____

PAST MEDICAL HISTORY

Check which condition(s) you are currently being treated for or have been in the past :

Arthritis Depression/ Anxiety High cholesterol Stroke
 Asthma Diabetes
 Headaches Hypertension Thyroid Problems
 Birth defects Heart Attack IBS/ Digestive problems Other _____
 Bleeding disorder/
 Anemia Heart Disease Seasonal allergies
 Cancer Heartburn/ Ulcer Seizure Disorder
 Type _____
 What is the year of your last colonoscopy? _____

CURRENT MEDICATIONS

MEDICATION ALLERGIES

Medication Name	Dosage	# Times daily	Please list any drug allergies with reactions:
List any medications you are currently taking, please include any over the counter medications, vitamins, supplements etc...			
1.			1.
2.			2.
3.			3.
4.			4.
5.			5.

SOCIAL HISTORY (please circle Yes or No)

Do you use tobacco? YES NO Formerly (year quit _____)
 If yes what kind and how much per day? _____ # years _____

Do you drink alcohol? YES NO Formerly (year quit _____)
 How many drinks per week? _____

Do you use drugs? YES NO Formerly (year quit _____)
 If yes what types? _____ How many times per week? _____

Do you drink caffeinated beverages? YES NO
 If yes how many per day? _____

Do you Exercise? YES NO
 If yes how many times per week? _____

Do you wear a seatbelt? YES NO

Who else lives at home? _____
 Do you feel safe at home? YES NO



POTOMAC PHYSICIAN ASSOCIATES

Meena Andrew, D.O.
 Dave Chen, M.D.
 Brent K. Cole, M.D.
 David W. Hirshfield, M.D.
 Andrea C. Karp, M.D.
 Thomas J. McNamara, M.D.
 Geeta Raja, M.D.
 Lakshmi S. Sastry, M.D.
 Jessica Hoch, P.A.-C
 Richard Martin, P.A.-C
 Kellie Powers, P.A.-C.
 Paul Thom, P.A.-C

10215 Fernwood Road
 Suite 100
 Bethesda, MD 20817
 301.493.4440
 301.493.9778 Fax
 www.ppa.md

Patient Responsibilities

Patient Name: _____ DOB: _____

The doctors of PPA want to keep healthcare accessible and affordable to our patients. You can help by taking responsibility for the following:

1. Notify us of any changes in your address or insurance information at the time of the change.
2. Know your insurance policy. Every policy has its own rules and regulations. It is in your best interest to know what your policies are, and if referrals are required. If you are seeing a specialist and arrive without getting proper referrals you understand that this means you become responsible for this service.
3. We order tests that are medically necessary. It is your responsibility to know what tests your insurance policy covers and does not cover. (This includes all lab and radiology tests.)
4. All appointments must be scheduled in advance. A \$50.00 No Show or Late Cancellation fee will apply if you do not cancel your annual appointments 24 hours in advance or do not show for your annual appointment.
5. Co-payments must be made at the time services are rendered. (This is a health insurance requirement.)
6. Pay your bill promptly. If there is financial hardship, please contact the billing department at (301)917- 6513 in advance of appointment.
7. If your check is dishonored or returned for any reason, we may electronically debit your account for the amount of the check plus a processing fee of \$35.00.
8. When needing a prescription refill or referral request of any kind, we will require 48 hours from the time of your call to process your request.

I _____ have read and understand the above policies.

Patient's Signature: _____ Date: _____

PPA Witness: _____ Date: _____



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PATIENT ACKNOWLEDGEMENT & CONSENT FORM

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Acknowledgement of Notification

The educational pamphlet entitled "Notice of Privacy Practices" provides information about how Potomac Physician Associates may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our **Notice of Privacy Practices** states that we reserve the right to change the terms described. Should this happen, we will post the changes in all of the offices.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions; but if we do, we are bound by our agreement with you.

By signing below, you acknowledge receipt of our **Notice of Privacy Practices**.

Patient Signature

Date

Consent for Use and Disclosure of Information

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to **Potomac Physician Associates** for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its' agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

Patient Signature

Date

Print Full Name



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PERSONAL REPRESENTATIVE, FAMILY OR OTHER ENTITIES AUTHORIZED ACCESS TO PROTECTED INFORMATION TO BE USED AND/OR DISCLOSE (OPTIONAL)

Name or specifically identify these persons and/or entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment and other healthcare operations.

Name of Authorized Person or Entity Relationship Phone #

Name of Authorized Person or Entity Relationship Phone #

AUTHORIZATION FOR USE OF ANSWERING MACHINE AND/OR VOICE MAIL

Potomac Physician Associates physicians and healthcare staff routinely are unable to contact patients directly during normal business hours. On these occasions our offices leave messages on communication devices provided by our patients. Due to the new federally mandated HIPAA Privacy Rule we must obtain your authorization to continue this mode of communication. Protected Healthcare Information that we may possibly disclose on your home, work, or cell phone would include, but is not limited to: test/lab results, prescription/pharmacy information, appointment instructions for visits and procedures, and surgical posting/scheduling information.

_____(Initial) I agree to allow Potomac Physician Associates physicians and healthcare staff to leave messages that include Protected Healthcare Information of the following: Please initial next to the applicable communication devices:

_____ home number, _____ work number or _____ cell number

_____(Initial) No, I do not agree to allow Potomac Physician Associates physicians and healthcare staff to leave messages that include Protected Healthcare Information on my home, work and cell phone.

Patient's Signature

Date

For PPA Internal Use Only

UNABLE TO OBTAIN NOTICE RECEIPT ACKNOWLEDGEMENT

Option 1: I could not obtain a signed Notice Receipt Acknowledgement from the patient for the following reason:

Option 2: I attempted to obtain a signed Notice Receipt Acknowledgement from the patient on ____/____/____, but was unable for the following reason:

PPA Employee Signature

Date

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We believe that your health information is private to you. We make every effort to protect your information from unnecessary disclosure. Some of the characteristics of our practice include the following procedures:

We may use a sign-in sheet to facilitate patient visits.

When legally appropriate, we shred information that may contain protected healthcare information.

We employ firewalls and passwords to protect your information from unauthorized individuals.

We educate our staff as to the importance of protecting health care information.

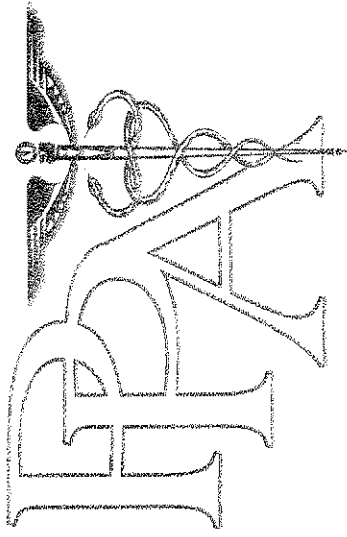
We require your written authorization prior to disclosing information to sources not defined in this document.

You may revoke your written authorization at any time by sending us a written request.

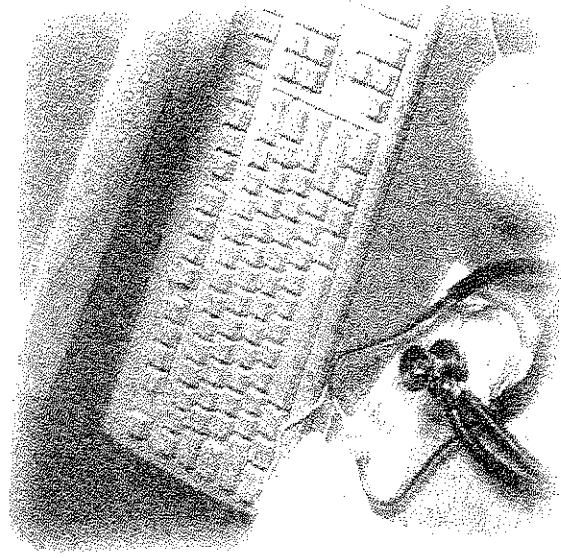
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Printed in the USA



Notice of Our Privacy Practices



FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have questions or would like additional information, please contact the HIPAA Policy Officer for this practice. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Maryland Health Information Exchange/CRISP: We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide internet-based 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

Potomac Physician Associates

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Privacy Practices

UNDERSTANDING YOUR HEALTH RECORD & INFORMATION: Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS: Unless otherwise required by law your health record is the physical property of the healthcare practitioner or facility that compiled it; the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information, and request amendments to your health record. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect, and obtain a copy of your health record. You may obtain an accounting of disclosures of your health information, request communications of your health information by alternative means or at alternative locations, revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES: This organization is required to maintain the privacy of your health information, and in addition, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. This organization must abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have provided. If we maintain a Web site that provides information about our customer services or benefits we will post our new notice on that Web site. We will not use or disclose your health information without your authorization, except as described in this notice.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS

We will use your health information for treatment. For example: Information obtained by a healthcare practitioner will be recorded in your record and used to determine the course of treatment that should work best for you. By way of example, your physician will document in your record their expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations (example varies by practitioner type). We will also provide your other practitioners with copies of various reports that should assist them in treating you.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations. For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we've asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Directory (inpatient settings): Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relatives, close personal friends or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research (inpatient): We may disclose information to researchers when an institutional review board, that has reviewed the research proposal and established protocols to ensure the privacy of your health information, has approved their research.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fundraising effort.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with tracking births and deaths, as well as with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals. An inmate does not have the right to the Notice of Privacy Practices.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Notice of Privacy Practices availability: This notice will be prominently posted in the office where registration occurs and patients will be provided with a hard copy.

Effective Date: This notice will be effective from April 14, 2003.

Modification & Amendment: This notice may be modified or amended by other documents, upon notification from your healthcare provider.