20528 Boland Farm Road, Suite 104
Germantown, MD 20876
301-972-0400
301-916-1453 Fax

9420 Key West Avenue, Suite 410
Rockville, MD 20850
301-947-6816
301-217-0358 Fax

18111 Prince Philip Drive, Suite 121
Olney, MD 20832
301-570-1545
301-570-3061 Fax

PLEASE FILL OUT AND PUT IN BASKET

PATIENT NAME (*print*) ______________________________

DATE OF BIRTH ______________________________

TIME OF APPOINTMENT ______________________________

TIME OF SIGN IN ______________________________

NEW PATIENT? ______YES ______NO

HAS YOUR INSURANCE CHANGED? ______YES ______NO

HAS YOUR ADDRESS CHANGED? ______YES ______NO

HAS YOUR PHONE NUMBER CHANGED? ______YES ______NO

ANY OTHER CHANGES? ______YES ______NO

IS THIS WORKMAN'S COMP OR MVA RELATED? ______YES ______NO

PATIENT INFORMATION

PATIENT NAME: ______________________ **TODAY'S DATE:** __________

HOME ADDRESS: ______________________

CITY, STATE, ZIP: ______________________

HOME: __________ WORK: __________ CELL: __________

PREFERRED REMINDER METHOD: HOME • WORK • CELL *(Please circle)*

RACE: __________ ETHNICITY, IF OF HISPANIC ORIGIN: __________

EMAIL ADDRESS: ______________________

DATE OF BIRTH: __________ SOCIAL SECURITY NUMBER: __________

SEX: ____ MALE ____ FEMALE

MARITAL STATUS: ____ SINGLE ____ MARRIED ____ PARTNER ____ OTHER

PATIENT'S OCCUPATION: ______________________

NAME OF EMPLOYER: ______________________

SPOUSE'S NAME: ______________________

NAME OF RESPONSIBLE PARTY IF UNDER 18: ______________________

EMERGENCY CONTACT NAME: ______________________

EMERGENCY CONTACT PHONE NUMBER: ______________________

PLEASE CHECK YOUR PREFERENCE:

IS IT OK TO LEAVE A MESSAGE (MESSAGE MAY INCLUDE TEST RESULTS) ON YOUR:

____ Home Phone ____ Cell Phone ____ Office Phone

____ Never leave a message, only speak with me

IS IT OK TO LEAVE A MESSAGE (MESSAGE MAY INCLUDE TEST RESULTS) WITH YOUR:

____ Spouse ____ Parent ____ Significant Other

____ Other, please specify __________

INSURANCE INFORMATION

INSURANCE COMPANY: ____________________

INSURANCE ID NUMBER: ____________________

INSURANCE GROUP NUMBER: ____________________

THIS IS THE ONLY INSURANCE I HAVE: ______YES ______NO

THIS POLICY IS THROUGH MY EMPLOYER: ______YES ______NO

*** ***If you answered yes to both questions do not complete any more questions but sign on line at the bottom***

*** ***If you answered no to either question above complete the remainder of the form and sign at the bottom***

NAME OF POLICY HOLDER: ____________________
First *Initial* *Last*

POLICY HOLDER'S SEX: ______MALE ______FEMALE

POLICY HOLDER'S DATE OF BIRTH: ____________________

POLICY HOLDER'S ADDRESS: ____________________
Street

____
City *State* *Zip Code*

POLICY HOLDER'S SOCIAL SECURITY NUMBER: ____________________

POLICY HOLDER'S PHONE NUMBER: ____________________

POLICY HOLDER'S EMPLOYER: ____________________

PATIENT'S RELATIONSHIP TO POLICY HOLDER: ______WIFE ______HUSBAND ______CHILD

DO YOU HAVE ANOTHER HEALTH INSURANCE COMPANY: ______YES ______NO

IF YES, NAME OF INSURANCE COMPANY: ____________________

INSURANCE ID NUMBER: ____________________

INSURANCE GROUP NUMBER: ____________________

NAME OF POLICY HOLDER: ____________________

Family HealthCare has my permission to bill the insurance companies listed above for services rendered to me or my dependent. I am certifying that the insurance information is accurate.

____________________ ____________________
Date *Signature*
Patient or Parent/Guardian

Notice of Privacy Practices for

FAMILY HEALTHCARE

20528 Boland Farm Road, Suite 104
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Olney, MD 20832
301-570-1545
Fax: 301-570-3061

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW CAREFULLY.

OUR PRIVACY PROMISE TO YOU, OUR PATIENTS

YOUR INFORMATION IS IMPORTANT AND CONFIDENTIAL. OUR ETHICS AND POLICIES REQUIRE THAT YOUR INFORMATION IS HELD IN STRICT CONFIDENCE.

Effective April 1, 2003

PRIVACY NOTICE

____
Signature

____
Date

Notice of Privacy Practices for

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Effective April 1, 2003

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any of your records that we may have created or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT: Rebecca Woodward, Office Manager 20528 Boland Farm Road #104, Germantown, MD 208726 301-972-0400

C. WE MAY USE AND DISCLOSE YOUR PHI IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice - including, but limited to, our doctors and nurses - may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your PHI to a friend or family member that is involved in your case, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.

8. Disclosures Required by Law. Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES:

1. Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing and controlling disease, injury, or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your PHI to health oversight agency for activities authorized by law. Oversight

activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning the death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena, or similar legal process,
- To identify/locate a suspect, material witness, fugitive, or missing person,
- In an emergency to report a crime (including the location of victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Deceased Patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions: (a) the use or disclosure involves no more that a minimal risk to your privacy based on the following: (i) an adequate plan to the identifiers for improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (b) the research could not be practicably be conducted within the waiver; (c) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health and Safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We may also disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions of law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution and/or (c) to protect your health and safety of other individuals.

12. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR PHI:

You have the following rights regarding the PHI we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we may contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Rebecca Woodward, Office Manager, 301-972-0400** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **Rebecca Woodward, Office Manager, 301-972-0400.** Your request must describe in clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. Since your chart is a legal document which we are required to maintain, if you wish to review it, we would be glad to copy it for you. The charges for copying charts will be according to the state's mandated guidelines.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Rebecca Woodward, Office Manager, 301-972-0400.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; and (d) not created by our practice, unless this individual or entity created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment, or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented-for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Rebecca Woodward, Office Manager, 301-972-0400.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six(6) years from the date of the disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Rebecca Woodward, Office Manager, 301-972-0400.**

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Rebecca Woodward, Office Manager, 301-972-0400.** All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by the applicable law. Any authorization you provide us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note:* We are required to retain records of your care.

HEALTH QUESTIONNAIRE

PATIENT NAME: ______________________________ **DATE OF BIRTH:** ______________

Do you have an Advance Directive? ______________ If so, does this office have a copy? ______________

Please list your medication allergies: ______________________________

____

Please list your current medications, including over the counter meds. Please include dose and directions for each med:

1. ______________ 6. ______________
2. ______________ 7. ______________
3. ______________ 8. ______________
4. ______________ 9. ______________
5. ______________ 10. ______________

Are you a smoker? ______________ Cigarettes or Cigars? ______________ How many per day? ______________

Do you consume alcoholic beverages? ______________ How often? ______________

Do you use illegal drugs? ______________

Please list any chronic medical conditions/past illnesses (e.g. asthma, high blood pressure, diabetes):

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Please list any past surgeries:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Please list any family health history (heart problems, breathing issues, cancers, chronic diabetes, etc.):

Mother ______________________________

Father ______________________________

Siblings ______________________________

Maternal Grandmother ______________________________

Maternal Grandfather ______________________________

Paternal Grandmother ______________________________

Paternal Grandfather ______________________________

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In step with becoming a patient centered home medical office, Family HealthCare will be utilizing a patient portal. This patient portal will allow patients to communicate with the office via e-mail. Patients will be able to request appointments, request medication refills and correspond with Family HealthCare personnel.

In order for you to have access to the portal, Family HealthCare will need a current e-mail address, as well as a signed consent. This consent will be valid for one year. It will need to be resigned on a yearly basis in order for the portal to continue to be accessed.

By signing this release you, the patient, agree to abide by the guidelines put forth by Family HealthCare regarding this portal. Additionally you agree to the disclaimers listed on the patient portal website regarding emergency conditions.

If you are interested in having access to the Family HealthCare portal, please include your e-mail address, signature and today's date at the bottom of this release.

Print Name and Date of Birth:

____

Current E-Mail Address (Please Print):

____

Signature:

____

Date:

____

MONICA HOWARD, M.D. ▪ MARTHA SKURLA, D.O. ▪ JESSE SADIKMAN, M.D. ▪ MEGAN WOLLMAN-ROSENWALD, M.D. ▪ JIMMY SHEIKH, M.D.
RITA SHARMA, M.D. ▪ RACHEL SCHREIBER, M.D., FAAAAI ▪ LEON KAO, M.D. ▪ MICHAEL GEE, M.D. ▪ AUDREY WEITZMAN, P.A.
LISA SCHREIBER, P.A. ▪ MEREDITH HARDING-BREMNER, P.A. ▪ NILS BROWNWORTH, P.A. ▪ JEREMY WETTER, P.A. ▪ BRENDA STEPHENS, C.R.N.P.

POLICIES AND PRACTICES

PREVENTIVE VS PROBLEM-ORIENTED EXAMS

Insurance companies distinguish office visits as either preventive or problem-oriented. If a patient is seen for a preventive exam (ie, a complete physical, a well-child exam) and also has new or established problems and/or significant new complaints, **this visit may be billed as both a preventive exam and a problem-oriented exam**. Some insurance companies now cover a "free" yearly preventive exam for each patient. Please know that this includes only your preventive care. It does not cover any new concerns or chronic conditions. New problems and chronic conditions will be billed to the insurance company as a problem-oriented visit.

PRESCRIPTION REFILLS

Please allow **48 hours** for prescription refills (Monday–Thursday). If a prescription refill is requested on a Friday, it may not be refilled until Monday. Please understand, however, that each refill takes our personal attention and we may rarely require extra time.

COPAYMENTS

Please know that all copayments are due at the time of your appointment.

COMPLETION OF FORMS

All forms to be completed by medical staff members will be subject to a **$10 charge** that will be paid at the time in which the form is completed and received. There is no charge for a form that is completed during an office visit.

______________________________ NAME

______________________________ DATE

To Our Family HealthCare Patients:

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.

Please sign below to verify that you have read and understand the above.

________________________ ________________________

Printed Name Date of Birth