LAUREL MEDICAL ASSOCIATES

DARRYL A. HILL, MD.

South Lakes Office Park

13635 Baltimore Avenue
Laurel, Maryland 20707
Tel: 301-497-0401
Fax: 301-497-0402
www.laurelmedicine.com

Home Care Checklist

Regarding: ______________________________________ Date: ______________

Thank you for your interest in the home care program.

In order for our office to better serve your health care needs; please provide the requested information below.

- Complete health insurance information ASAP (copy both sides).
- Photo Identification
- Medical history and Medication List
- Provide hospital records from your most recent hospitalization
- Updated phone number
- Family Contact in case of an Emergency (phone number and name)
- Contact office to discuss your account
- Please send payment for your travel fee/home care fee
- Contact the office so that we may schedule your next visit

Sincerely,

The Home Care Team

Diplomat American Board of Internal Medicine

Updated 01/14/2020

Darryl A. Hill, M.D.FACP
Laurel Medical Associates
13635 Baltimore Avenue
Laurel, Maryland 20707
homecaredoctor@laurelmedicine.com
(301)497-0401

Home Care Program

Dear Prospective Home Patient,

Thank you for your interest in our home care program. We hope you value this service. Many believe that the best place for a person to receive valuable health care services is in the comfort of their home with their family. We appreciate the opportunity to provide medical services in your home.

To help cover the cost of this service, please be aware that there is an annual fee that depends upon your location. This fee helps cover our travel and other non-covered expenses that are not covered by your insurance. Please feel free to contact the office to obtain the amount you are required to pay. We can accept your payment via credit card over the phone or you can mail your check or money order to the address shown above.

Sincerely,

Home Care Team

Laurel Medical Associates

Updated 01/14/2020

Laurel Medical Associates, LLC
13635 Baltimore Avenue
Laurel, Maryland 20707
301-497-0401
(301) 497-0402- fax
www.laurelmedicine.com

HOME PATIENT INFORMATION

PATIENT'S NAME (First, Middle, Last)	MARTIAL STATUS SEX S M W D SEP M F	DOB	ETHINICITY	RACE
STREET ADDRESS	CITY AND STATE	ZIP CODE	TELEPHONE #1 (HOME)	
		LANGUAGE SPOKEN	CELL #	
DRUGS ALLERGIESS, IF ANY		E-MAIL ADDRESS		
DO YOU HAVE A LIVING WILL ?				
HOW DID YOU HEAR ABOUT US? (I.E. NEWSPAPER, POST CARD, REFERRAL OR INSURANCE CARRIER WEBSITE)				
PREFERRED PHARMACY NAME/PHONE/CITY/ZIP				
NO PREFERRED PHARMACY ☐				
NO INFORMATION AVAILABLE ☐				
PLEASE SEND A COPY OF PRIMARY /SECONDARY INSURANCE CARDS				

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please check the following and sign)

___I authorize use of this form on all my insurance submissions.

___I authorize disclosure of protected health information for treatment, payment and health operation.

___I authorize release of information to all my insurance Companies.

___I understand that I am responsible for non-covered services, missed appointments, remaining deductibles, co-pay's and co-insurances.

___I authorize my doctor to act as my agent in helping me obtain payment from the insurance Companies.

___I authorize payment directly to my doctor.

___I permit a copy of this authorization to be used in place of the original.

___I acknowledge that I have received Notice of Privacy Practices information.

Sign Name:____ Date:__________________

CALL BACK WITH THE PHARMACY INFORMATION OR EMAIL TO

homecaredoctor@laurelmedicine.com

Tear along perforated line for contact number and email address

- -

Phone Number	Email Address
301-497-0401	**homecaredoctor@laurelmedicine.com**

updated 01/14/2020

New Patient Medical Information (circle/list all that apply)

Patient Name: DOB: Date:

Past Medical History

1. Diabetes
2. High blood pressure
3. Heart Attack
4. Kidney Disease or Failure
5. Asthma
6. Gastroesophageal Disease (GERD)
7. Kidney Failure
8. Dementia
9. Stroke
10. Decubitis Ulcer
10. Cancer
11. Other

Family History

1. Diabetes
2. Hypertension
3. Heart Attack
4. Other

____

____

Past Surgical History

1. Gall Bladder
2. Appendix
3. Tonsils

ALLERGIES

1. Penicillin
2. Sulfa
3. Other

____

____

Social History:

1. Smoking: packs per day____________ How many years?____________
2. Alcohol: Y/N. If yes explain:______________________________

Thank you for you time.

MEDICATION LIST

Name: ______________________/______________________________

Last First

DOB: ________________________

MM/DD/YYYY

Medication	Dosage	Date Started	Recent Refill

Updated 01/14/2020

LAUREL MEDICAL ASSOCIATES
PATIENT ACKNOWLEDGEMENT/CONSENT FORM

Laurel Medical Associates "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. Please acknowledge reading this office's "Notice of Privacy Practices" by initialing below.

____
Initials

Our "Notice of Privacy Practices" states that we reserve the right to change the terms described. Should this happen, you will receive a copy by mail.

____
Initials

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.

____
Initials

By signing this form, 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.

____
Initials

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Laurel Medical 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, and 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. ______________

Initials

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information.

______________________________	______________________________
Patient's Printed Name	Patient's Date of Birth
______________________________	______________________________
Patient/Legal Representative	Signature Date
______________________________	______________________________
Relationship to Patient	Witness Date

The following names listed below are the names of people that I would like to be involved in or have access to my protected health information on a routine basis. I give permission for and its affiliated companies to share my protected health information with:

______________________________	______________________________
Name	Relationship
______________________________	______________________________
Name	Relationship
______________________________	______________________________
Name	Relationship

Laurel Medical Associates Agreement/Advance Beneficiary Notice

Laurel Medical Associates (LMA) offers home medical care in the comfort of your home. LMA believes that these are very unique medical services that benefit patients and help to improve their quality of life. There are unique challenges to providing these services in the home which our office attempts to control as we provide these services. They include: inclement weather, traffic, missed appointments and this notice attempts to help us manage these challenges.

More importantly, your health (or your loved one) is what is most important. We will provide the best care possible in your home that is customized to what you prefer. We will refer you to other home care providers if they can help improve your health. These providers include: home physical therapist, nurses, dentists, podiatrist, and phlebotomist to check your lab studies. We are aware that at times you will need a higher level of care and will be referred to a specialist or emergency room when this happens. Home care services are not always covered by insurance companies and you or your designated representative will be responsible for all services not covered by your insurance company. Patients are usually scheduled as soon as possible. If you can not be seen in a timely manner you will be referred to the emergency room or another appropriate setting.

1. If a patient is not able to sign this document, their representative will be required to sign this document and be responsible for services provided.

2. We have a "no refund policy" for the Homecare Program.

3. Upon completion of your registration which includes payment, appointments are usually scheduled in 4-8 weeks. If not seen within 8 weeks and will not start the Homecare Program and the office has already began to process the paperwork, the "no refund policy" will be applied.

4. If a new patient requires an urgent appointment sooner than 4 weeks a fee of fifty dollars may apply.

5. Inclement weather policy. For safety reasons, home visits are usually not completed when there is inclement weather.

6. Traffic policy. Because of congestion and traffic delays, we may be required to cancel or postpone appointments.

7. Narcotics and Controlled Substances. These require a written prescription which is completed at the time of your visit.

8. Communicating with the office is important. Each patient is encouraged to have an account with our patient portal. This allows us to communicate with you securely by e-mail for appropriate concerns. This is not appropriate for urgent medical concerns. For new patient problems or medical concerns, a phone appointment is encouraged to likely discuss those issues. Call the office and the staff will schedule a time for your phone appointment. This phone appointment will allow the doctor to discuss your concern with minimal interruption. This is sometimes not covered by the insurance and you will be billed at forty-five dollars per seven minutes if it is considered non billable to your insurance. Discounted phone appointments can be purchased at time of registration.

9. When contacting the office for non-urgent matters please listen closely to the voice messages and leave messages in the appropriate mailbox, or you can use the portal. This includes refill requests.

Laurel Medical Associates Agreement/Advance Beneficiary Notice

10. If there are any special circumstances that are needed when visiting you such as: dogs, pets, gates, parking, or security passes, you will need to obtain these for the doctor. If the doctor is delayed or required to take additional time, you will be billed for the time required. This fee will usually be twenty five to fifty dollars.

11. Please be aware that there are fees for: any late, after hours, evenings, weekends, holidays and urgent appointments. Please check with the office for an updated price list if needed.

12. A $75.00 fee will be charged for sessions missed without providing the office with 24 hour notice. This includes traveling to your home and no one answers the door. Payment will be required before any future visits are scheduled.

13. Certain documents will be completed without any additional fees. Some forms will require a fee and you will be informed of this before completion of specific paperwork.

14. To help cover administrative and postage overhead, a $75 fee will apply annually and is optional if you believe you will require a significant amount of these services. Alternatively, a $15 fee will be applied to all first class mailings for shipping and handling.

15. A fee will be applied for all returned checks and stop payment returned checks.

16. You or your designee is responsible for all late fees and attorney fees related to your account.

17. There is an annual travel fee depending on your location. Please call the office to obtain the fee for your surrounding area. This fee helps to cover fees not covered by your insurance company. This includes but is not limited to travel. This fee is nonrefundable and will be billable annually.

18. Please note that this mobile service does not give specific appointment times because of traffic patterns which we can not control. At times, because of traffic and weather we will need to modify appointments. If there is urgency, appointments can always be scheduled in the office or patients can go to the emergency room.

19. There will be times when the office will need to email you or send a text message; therefore you give us permission to do so.

Under no circumstances does LMA want you to be waiting at home for medical care or services that require a more urgent medical evaluation. If so, we advise immediate care by a physician.

By signing below you acknowledge agreement and your understanding to the statements above. If at any time this agreement is broken we reserve the right to discontinue homecare services and provide in office care. If we are unable to care for you we will provide names of other care providers or resources if available.

Patient Name	**Signature**	**Date**
Authorized Representative/Relationship	**Signature**	**Date**

South Lakes Office Park
13635 Baltimore Avenue
Laurel, Maryland 20707
(301) 497-0401
www.laurelmedicine.com

LAUREL MEDICAL ASSOCIATES
Patient Waiver

CREDIT AND PAYMENT POLICIES

Our goal is to provide you with the highest quality care at a reasonable/reduced cost compared with other practices. Your travel fee is due upon registering for the program and is not billable to any insurance companies. **We will bill your primary insurance carrier for services rendered but any copayments, deductibles, coinsurance or uninsured amounts will be billed to you after your insurance payment has been posted to your account unless you have a secondary carrier.**

Signature ____ **Date** ____________________

PATIENT MISSED APPOINTMENT POLICY

(Home Care Program appointments only)

We are committed to fully assist you with your Health Care needs and thus, you are expected to make necessary arrangements once your appointment is scheduled. We are reserving this time specifically for You. If you need to cancel or reschedule an appointment, please do so 24-hours prior to your appointment time. A $75 fee will be charged for sessions missed without such prior notification. This fee will be due prior to your next treatment (insurance is not responsible for this fee). All cancellations and no shows are documented in our system as part of your record. We understand there are occasional emergency situations and we appreciate your consideration of our time. In instances of repeated non-compliance with scheduled visits, we reserve the right to discontinue care. By signing below, you agree to this policy.

Signature ____ **Date**____________________

Laurel Medical Associates (LMA)
Notice of Privacy Practices

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. DO NOT HESITATE TO ASK QUESTIONS.

Understanding your health record

A record is made each time you visit a hospital, physician, or other healthcare provider. Your symptoms, examination and test results, diagnoses, treatment, and a plan for future care recorded. This information is most often referred to as your "health or medical record," and serves as a basis for planning care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will help you to ensure its accuracy, and enable you to relate to who, what, when, where, and why others may be allowed access to your health information. This effort is being made to assist you in making informed decisions before authorizing the disclosure of your medical information to others. Use or disclosure of your health information will follow the more stringent of State or Federal Laws.

Understanding your health information rights

Your health record is the physical property of the health care practitioner or facility that created it, but the content is about you, and therefore belongs to you. You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. Your rights include being able to review or obtain a paper copy of your health information, and to be given an account of all disclosures. You may also request communications of your health information be made by alternative means to alternative locations. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.

Our responsibilities

This office is required to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. This office is required to abide by the terms of this notice and to notify you if we are unable to grant your requesed restrictions or reasonable desires to communicate your health information by alternative means or to alternative locations.

This office reserves the right to change its practices and effect new provisions that enhance the privacy standards of all patient medical information. In the event that changes are made, this office will notify you at the current address provided on your medical file. If applicable, this office will post changes on our website that provides information about our customer service and/or benefits.

Other than for reasons described in this notice, this office agrees not to use or disclose your health information without your authorization.

To receive additional information or report a problem

If you believe your privacy rights have been violated, you have the right to file a complaint with the office by contacting the individual on page 5 or by contacting the Secretary of Health and Human Services, with no fear of retaliation of this office.

Your health information will be used for treatment, payment, and healthcare operations only.

Treatment-information obtained by your health practitioner in this office will be recorded in your medical record and used to determine the course of treatment that should work best for you. This consists of your physician recording his/her own expectations and those of others involved in providing you care. The sharing of your health information may progress to others involved in your care, such as specialty physicians or lab technicians.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or a third party payer with accompanying documentation that identifies you, your diagnoses, procedures performed and supplies. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Laurel Medical Associates. For example, information on the services you received may be used by the staff in this office to assess the care you received and the outcome of your case compared to others like you. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectivess of the care and services we provide.

Understanding our office policy for specific disclosures

- Business Associates - Some or all of your health information may be subject to disclosure through contracts for services to assist this office in providing health care. For example, it may be necessary to obtain specialized assistance to process certain laboratory tests or radiology images. To protect your health information, we require these Business Associates to follow the same standards held by this office through terms detailed in a written agreement.
- Notification - Your health record may be used to notify or assist family members, personal representatives, or other persons responsible for your care to enhance your well-being or your whereabouts.
- Communication with Family - Using best judgement, a family member, or close personal friend, identified by you, may be given information relevant to your care and/or recovery.
- Funeral Directors - Your health information may be disclosed consistent with the laws governing mortician services.
- Organ Procurement Organizations - Your health information may be disclosed consistent with laws governing entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation or transplant.
- Marketing - This office reserves the right to contact you with appointment reminders that apply to you.
- Fund Raising - this office reserves the right to contact you as part of fund raising efforts.
- Patient Directory (typically applicable only to inpatient settings) - Unless you object, this facility will use your name, room number, general condition, and religious affiliation for directory purposes. This information will be made available to clergy, and others who ask for you by name.
- Research (typically applicable only to inpatient settings) - Your information will be disclosed to researchers upon Institutional Review Board approval, and upon the assurance that established protocol to ensure the privacy of your health information has been obtained.
- Food and Drug Administration (FDA) - This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.
- Worker's Compensation - This office will release medical information to the extent authorized by law in matters of worker's compensation.
- Public Health Reporting - This office is required by law to disclose health information to public health and/or legal authorities charged with tracking reports of birth and morbidity. This office is further required by law to report communicable disease, injury, or disability.
- Correctional Facilities - This office will release medical information on incarcerated individuals to correctional agents or institutions for necessary welfare of the

individual or for the health and safety of other individuals. The rights outlined in this Notice of Privacy Practices will not be extended to incarcerated individuals.

- Law Enforcement - Your health information may be disclosed for law enforcement purposes as required under state law or in response to a valid subpoena. Provisions of federal law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys in the event that a staff member or business associate of this office believes in good faith that there has been unlawful conduct or violations of professional or clinical standards that may endanger one or more patients, workers, or the general public.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Fund raising. Unless you request us not to, we will use your name and address to support our fund-raising efforts. If you do not want to participate in fund-raising efforts, please let us know.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

[LMA)] Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting LMA. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

> **Dr. Darryl A. Hill**
> Laurel Medical Associates
> 13635 Baltimore Avenue
> Laurel, Maryland 20707

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is:

> **[Debra Grimes]**

Effective Date
This notice is effective on or after January 2020.