Mid Maryland Neurology PA

172 Thomas Johnson Dr, Suite 202
Frederick, MD 21702

Office Policies

Welcome to our office. We're committed to providing you with the best possible care. To achieve that goal, your understanding of our office policy is essential. Please read and sign at the bottom. Your signature indicates you have read and understand our office policies.

*** PAPERWORK MUST BE COMPLETED PRIOR TO YOUR APPOINTMENT, ***
ARRIVE 15 MINUTES EARLY, OTHERWISE YOU MAY BE RESCHEDULED.

1. ***Copayment and Balances.*** *All Copayments are due the day of your visit. If you cannot pay your copayment at the time of your visit, a fee of $10.00 will be charged in addition to your copayment. Balances that are 30 days or more past due will be collected at your next visit, NO EXCEPTIONS! Please get in touch with our biller to make payment arrangements.*
2. **Referrals.** If your insurance requires a referral and you do not bring one, *you may be responsible for the full amount of the visit.*
3. **Returned "Bounced" Checks.** You will be responsible for the original amount of your check, plus an additional charge of $50.
4. **Missed Appointments/Cancellation Policy for in-office and telemed: We use an automated system to confirm your appointment. Calls go out three days before your scheduled appointment. We do require 48 hours' notice to cancel or change an appointment. You are responsible for keeping us updated on all changes in your demographic information. If you cannot keep your appointment, notify us as soon as possible. If you call after business hours, please leave a message on the NON-urgent line.** *If we are not notified at least **48 hours before** your appointment, you might be charged the following:*
    a. ***Follow-up appointments $50.00 for No Show or same-day cancellation***
    b. ***Botox/Myobloc appointments $100.00 for No Show or same-day cancellation***
    c. ***EMG and EEG appointments $150 for No Show or same-day cancellation***
    d. *If you are a new patient, we might NOT offer you another appointment.*
5. **Coverage.** Your insurance is a contract between you and your insurance company. You must know the details of your coverage as we cannot research your plan at each visit. Your policy may be subject to deductibles, co-pays, referrals, and authorizations. If you have Medicare and another policy, *make sure your carrier knows who is primary and who is secondary. Please inform us if you purchase a Medicare Advantage Plan.*
6. **Lateness.** Our physicians usually on time except for an occasional emergency. We ask the same of our patients. If you are **more than 10 minutes late** you may be asked to reschedule your appointment.
7. **Opiate/Narcotic Prescriptions and Prescription Refills. Due to CDC, Federal and State rules and restrictions we will not prescribe chronic opiate/narcotics after January 1 2020.**

- Patients requiring chronic opiod/narcotics with be referred to a pain management practice.
- Scheduled prescriptions are never refilled on weekends, holidays or after office hours.
- Abuse of scheduled medication will result in discharge from the practice.
- Receiving a duplicate scheduled Rx from other physicians is not allowed and may result in discharge from the practice.
- Under no circumstances will we refill a scheduled Rx early, if a Rx is lost, stolen, thrown out, etc
- We require 24-hour notice for ALL prescription refills.
- **You are not to stop by the office at your leisure and ask for refills.**

I have read and understand all Mid Maryland Neurology's office policies. I agree to follow these policies.

Signature_____ Date: _____

Boyd A. Dwyer, MD **Richard T. Leschek, DO**

Mid Maryland Neurology, PA

Phone: 301-698-8300 ~ Fax: 301-698-8389
172 Thomas Johnson Dr, Suite 202
Frederick, Maryland 21702

Forms Completion Policy

(Date 7/10/2015)

Patients may require forms to be completed by one of the providers (disability, FMLA, life insurance, MVA, etc.). Completion of forms requires administrative time to gather data, physician time to review, and time to complete the form. Some forms are lengthy, complex, and require a physical exam by a licensed health care provider. To expedite processing these forms in a timely manner, we have developed the following Forms Completion Policy.

1. You must be an established patient. A provider of *Mid Maryland Neurology PA* will not complete any type of form until you have been seen in our office *at least 2 times*.
2. ***Forms cannot be completed on the day presented*** to the office *UNLESS you have scheduled an office visit specifically for forms completion*. When you schedule your appointment, inform the receptionist that you have forms to be completed. All office visits will also include a normal history and physical examination
3. If you have seen the doctor within the past 90 days, then you may choose to leave the forms and the doctor will complete them within 7 business days.
4. Charges:

    a. Disability, FMLA, Durable Medical Equipment, Insurance policy, (including, but not limited to): ***$25 charge to the patient (cash or credit card), payable upon submission of the forms.*** *(Forms in excess of 3 pages will be charged an additional $5 per page.)*
    b. Letters on *Mid Maryland Neurology PA* letterhead for medical needs (including, but not limited to): ***There will be a $10 fee charged to the patient (cash or credit card), payable upon patient receipt of the requested letter.***
        a. Excuse for Jury Duty for a medical condition
        b. Special consideration for needs
        c. Other letters requested
        d. Letters on *Mid Maryland Neurology PA* letterhead requested by a lawyer or legal representative will be done at the physician's discretion. Final charge will be determined by length and complexity of the letter.
        e. Handicapped Tags/Parking Permits. ***There is a $10 charge.***

We are not obligated to complete these forms. We reserve the right to refuse to complete any form. If records are requested in addition to a completed form, then the form will be sent from our office once payment has been received from the company requesting this information. No forms or records will be sent to a third party without a signed release from the patient.

Mid Maryland Neurology, PA

Patient Information

Name	Date of Birth	Age	Social Security Number

Home Address	City	State	Zip

Mailing Address (if different from above)	City	State	Zip

Home Phone ❑ Check if preferred for appointment reminders	Work Phone

Sex: ❑ Male ❑ Female	Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced	Spouse's Name

E-mail	Cell Phone ❑ Check if preferred for appointment reminders ❑Text reminders

Primary/Referring Physician's Name (*Required*)	Address	City	State	Zip

Employment Information

Employed ❑ Yes ❑ No	Employer (Parent's employer if minor)	Position

Employers Address	City	State	Zip	Phone

Spouse's Employer	Spouse's Social Security Number

Spouse's Employer's Address	City	State	Zip	Phone

Responsible Party Information

Person Responsible for Medical Expenses	Relationship to Patient	Phone

Address	City	State	Zip

Primary Insurance Information

Insurance Company	Policy Number	Medicare Number

Address of Insurance Company	City	State	Zip	

Subscriber's Name	Subscriber' Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other:

Policy Holder's Social Security Number:	Policy Holder's Date of Birth

Secondary Insurance Information

Insurance Company	Policy Number	Medicare Number

Address of Insurance Company	City	State	Zip

Subscriber's Name	Subscriber' Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other:

Policy Holder's Social Security Number:	Policy Holder's Date of Birth

Emergency Contact Information

Person to Contact in Case of Emergency (Other than Spouse)	Relationship to the Patient	Phone

Authorization For the Release Of Information and for Payment to Mid-Maryland Neurology

I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administrating claims for insurance benefits. I also authorize payment of insurance benefits directly to *Mid-Maryland Neurology* . I am responsible for payment if my insurance does not pay for services. I acknowledge the receipt of Mid Maryland Neurology's privacy practices.

X

Signature of Patient, or Parent if a minor ***Date***

We reserve the right to charge $50.00 for missed appointments if not given 48 hours notice of the cancellation.

Mid Maryland Neurology

NEW PATIENT HISTORY FORM

FILL THIS FORM OUT COMPLETELY **BEFORE** YOUR VISIT

Name: _____ **Today's Date:**_____

Age: _____ **Birth Date:** _____

Present Illness: Please *briefly* describe your current symptoms:

Past Medical History: Please check all that apply:

- ❑ Arthritis
- ❑ Asthma ❑ COPD
- ❑ Anemia
- ❑ Cancer: type_____
- ❑ Concussion/Head Injury
- ❑ High Cholesterol
- ❑ Diabetes ❑ Prediabetes
- ❑ Dementia/Alzheimer's
- ❑ Depression
- ❑ Epilepsy/Seizures
- ❑ HIV
- ❑ High Blood Pressure
- ❑ Headaches
- ❑ Heart Disease/ ❑Heart Attack
- ❑ Kidney Disease ❑ Kidney stones
- ❑ Liver Disease
- ❑ Lung Disease
- ❑ Migraines
- ❑ Myasthenia Gravis
- ❑ Multiple Sclerosis
- ❑ Parkinson's
- ❑ Sleep apnea ❑CPAP
- ❑ Stroke
- ❑ Thyroid problems
- ❑ Ulcers
- ❑ "Reflux"
- ❑ Other

Any Serious Injuries or Surgeries?

Medications:

Name	*Dose*	*How taken (frequency)*

Allergies:

❑ Aspirin ❑ Sulfa ❑ Codeine/morphine ❑ Penicillin

❑ Other Drugs:

Family History:

	Father	Mother	Brothers(1,2…)	Sisters(1,2…)
Number (of Bro/Sisters)	XXX	XXX		
Age (or age at death)				
Cause of Death				
Health (good/bad)	❑ Good ❑ Bad	❑ Good ❑ Bad		
Conditions (check if yes)				
Epilepsy	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑
Heart Disease/MI	❑	❑	❑	❑
Memory problems	❑	❑	❑	❑
Migraine/headaches	❑	❑	❑	❑
Multiple Sclerosis	❑	❑	❑	❑
Muscular Dystrophy	❑	❑	❑	❑
Parkinsons	❑	❑	❑	❑
Stroke	❑	❑	❑	❑
Tremor/shakes	❑	❑	❑	❑
Other:				

Social History:		*type*		
Tobacco/Vape:	❑ Yes ❑ No		____per day	X ___ years
Alcohol:	❑ Yes ❑ No		____per day/week	X ___ years
Caffeine:	❑ Yes ❑ No		____per day	
Cannabis:	❑ Yes ❑ No			X ___ years

Have you ever been treated for alcoholism? ❑ Yes ❑ No When? _____

Have you ever been treated for Drug addiction? ❑ Yes ❑ No When? _____

Occupation: _____

Symptoms Review: Check if *positive.*

General
- ❑ Weight Loss >5lb
- ❑ Weight Gain >5lb
- ❑ Fatigue
- ❑ Fever/chills

Eyes
- ❑ Loss of vision
- ❑ Double vision
- ❑ Blurred vision

Ears/Nose/Throat
- ❑ Vertigo
- ❑ Hearing loss
- ❑ Ringing in ears
- ❑ Difficulty swallowing
- ❑ Loss of taste
- ❑ Loss of Smell

Muscles/Joints
- ❑ Joint pain
- ❑ Muscle pain

Heart and Lungs
- ❑ Chest pain
- ❑ Palpitations
- ❑ Irregular Heart beat
- ❑ Shortness of breath

Mood
- ❑ Anxiety
- ❑ Depression
- ❑ Mood swings
- ❑ Irritability
- ❑ Unexplained/uncontrolled crying
- ❑ Unexplained/uncontrolled laughing

Kidney/Urine/Bladder
- ❑ Incontinence
- ❑ Painful urination
- ❑ Frequency
- ❑ Urgency
- ❑ Blood in urine

Skin
- ❑ Rash
- ❑ Sun sensitivity
- ❑ Hair loss

Sleep
- ❑ Insomnia
- ❑ Snoring
- ❑ Daytime sleepiness
- ❑ Nightmares
- ❑ Difficulty breathing

Gastrointestinal
- ❑ Nausea
- ❑ Vomiting
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Constipation
- ❑ Diarrhea
- ❑ Blood in stools

Neurologic
- ❑ Blackouts
- ❑ Cramps/ muscle spasms
- ❑ Dizziness
- ❑ Falls
- ❑ Headaches
- ❑ Imbalance
- ❑ Memory loss
- ❑ Mental confusion
- ❑ Numbness/tingling
- ❑ Speech difficulty
- ❑ Tremor/shaking
- ❑ Weakness

PRIME-MD PHQ-2

Over the past 2 weeks have you been bothered by any of the following problems?			Yes	No
1. Little interest in doing things			❑	❑
2. Feeling down depressed or hopeless			❑	❑

What tests have you had for this problem or over the past year? What are the results?

Test	*Date*	*facility*	*Results*
CT Scan			
EEG (brain wave)			
EMG			
MRI			
Blood Work			
Other			

Mid Maryland Neurology

Initial Visit Headache Questionnaire

Name: _____ **Date:** _____

Onset:

At what age did you start having headaches? _____

Frequency:

How many total days a month do you have some form of headache? (all headaches) _____

How many days in the past month did you take pain medicine? _____(***including*** OTCs Excedrin, Tylenol, etc.)

How often do your headaches occur?

_____ X /Day _____ X /Week _____ X /Month _____ X /Year ❑ Constant

How long ago did the *current* headache start? (if constant) _____

Has your headache pattern changed in the last three to six months? How?

_____

Duration:

How long does a typical headache last?

_____ Seconds _____ Minutes _____ Hours _____ Days ❑ Constant

Quality of Pain

How would you best describe the quality of the pain? *Check all that apply*

Throbbing/pulsating ❑	Pressing/squeezing ❑	Stabbing ❑	Dull/nagging ❑	Other ❑

Does the headache ever waken you from sleep? ❑ Yes ❑ No

Location:

On what part of your head does the headache start?

❑ Left	❑ Right	❑ Both sides	❑ Around eye	❑ All over
❑ Front	❑ Back			

Severity:

Mark down the number of headaches each month that are:

Mild _____ Moderate _____ Severe _____

How would you grade the severity of your *average* headache?

❑ 1(least) ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑10(worst)

Associated Symptoms:

- ❑ Nausea
- ❑ Vomiting
- ❑ Light sensitivity
- ❑ Noise sensitivity
- ❑ Loss of vision
- ❑ Flashing lights
- ❑ Visual blurring
- ❑ Double vision
- ❑ Tearing
- ❑ Nasal congestion
- ❑ Drooping eyelid
- ❑ Strange visual patterns (zigzags, sparkling, shimmering or colored lights)
- ❑ Difficulty speaking
- ❑ Difficulty understanding
- ❑ Numbness
- ❑ Weakness
- ❑ Dizziness/vertigo

❑ Do you ever have ***warning symptoms*** 20 to 30 minutes prior to a headache? ❑ Yes ❑ No

❑ Other?

Initial Visit Headache Questionnaire

Triggers:

Check any of the following that seem to bring on your headaches.

❑ Menstrual cycle	❑ Missed meals	❑ Other:
❑ Insufficient sleep	❑ Odors	
❑ Change in weather	❑ Stress	
❑ Loud noises	❑ Bright lights	
❑ Exertion	❑ Alcohol	
❑ Sex	❑ Motion Sickness	
❑ Foods: (list)		

Treatment:

Have you tried the following ***abortive*** headache medications. *Check **if used***

Medication	*Effective?*	*Side effects (if any)*
❑ Sumatriptan (Imitrex)	❑ Yes ❑ No	
❑ Sumatriptan and Naproxyn (Treximet)	❑ Yes ❑ No	
❑ Rizatriptan (Maxalt)	❑ Yes ❑ No	
❑ Almotriptan (Axert)	❑ Yes ❑ No	
❑ Eletriptan (Relpax)	❑ Yes ❑ No	
❑ Zolmatriptan (Zomig)	❑ Yes ❑ No	
❑ Naratriptan (Amerge)	❑ Yes ❑ No	
❑ Frovatriptan (Frova)	❑ Yes ❑ No	
❑ Dihydroergotamine (Migranal or DHE)	❑ Yes ❑ No	
❑ Prednisone	❑ Yes ❑ No	
❑ Isometheptene/dichloralphenazone (Midrin)	❑ Yes ❑ No	
❑ Ketorolac: Toradol, Sprix	❑ Yes ❑ No	
❑ NSAIDs: ibupofen/naproxyn/diclofenac	❑ Yes ❑ No	
❑ Others:		

Have you tried the following ***preventative*** headache medications. *Check **if used***

Medication	*Effective?*	*Side effects (if any)*
❑ Amitriptyline, nortriptyline(Elavil,Pamelor)	❑ Yes ❑ No	
❑ Propranolol, metoprolol, atenolol	❑ Yes ❑ No	
❑ Depakote	❑ Yes ❑ No	
❑ Topiramate(Topamax,Trokendi, Qudexy)	❑ Yes ❑ No	
❑ Verapamil	❑ Yes ❑ No	
❑ Zonisamide	❑ Yes ❑ No	
❑ Botox	❑ Yes ❑ No	
❑ CGRP mAb's:Aimovig, Ajovy Emgality	❑ Yes ❑ No	

Tests:

Check all tests you have had for your headaches

Test	*Date*	*Results*
❑ MRI head		
❑ MRI C-spine		
❑ CT head		
❑ EEG		
❑ Spinal tap		
❑ Blood work		

The Migraine Disability Assessment Test

The **MIDAS** (Migraine Disability Assessment) questionnaire was put together to help you measure the impact your headaches have on your life. The information on this questionnaire is also helpful for your primary care provider to determine the level of pain and disability caused by your headaches and to find the best treatment for you.

INSTRUCTIONS

Please answer the following questions about ALL of the headaches you have had over the last 3 months. Select your answer in the box next to each question. Select zero if you did not have the activity in the last 3 months. Please take the completed form to your healthcare professional.

_____ 1. On how many days in the last 3 months did you miss work or school because of your headaches?

_____ 2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.)

_____ 3. On how many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?

_____ 4. How many days in the last 3 months was your productivity in household work reduced by half of more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.)

_____ 5. On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches?

_____ Total (Questions 1-5)

What your Physician will need to know about your headache:

_____ A. On how many days in the last 3 months did you have a headache? (If a headache lasted more than 1 day, count each day.)

_____ B. On a scale of 0 - 10, on average how painful were these headaches? (where 0=no pain at all, and 10= pain as bad as it can be.)

Scoring: After you have filled out this questionnaire, add the total number of days from questions 1-5 (ignore A and B).

MIDAS Grade	Definition	MIDAS Score
I	Little or No Disability	0-5
II	Mild Disability	6-10
III	Moderate Disability	11-20
IV	Severe Disability	21+

If Your MIDAS Score is 6 or more, please discuss this with your doctor.

Mid Maryland Neurology, PA

172 Thomas Johnson Dr, Suite 202, Frederick, MD 21702
Phone: 301-698-8300 ~ Fax: 301-698-8389

HIPAA AUTHORIZATION ACKNOWLEDGENENT AND CONSENT FORM

Date: _____

Patient Name: _____

____ (Patient initials**) Notice of Privacy Practices**. I acknowledge that I have received the Mid Maryland Neurology PA's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my Protected Healthcare Information(PHI) for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a questions or complaints. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

____ (Patient initials) **Release of Information**. I hereby permit Mid Maryland Neurology PA and the physicians or other health professionals involved in my care to release PHI for purposes of treatment, payment, or healthcare operations.

- Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment.
- This authorization permits Mid Maryland Neurology to use and/or disclose individually identifiable health information to any person or entity liable for payment on the Patient's behalf, in order to verify coverage or payment questions, or for any other purpose related to benefit payment.
- Individually identifiable health information may include DOB, address, phone numbers, insurance information, dates of services, type of service, treatment history, medical history, family history, physical examination, medication history, emergency records, laboratory and radiology reports, operative reports, physician notes, consultations, neuropscychiatric evaluation and drug and alcohol history (i.e. as explained in the HIPAA brochure). I understand that these medical records may contain references to mental health, substance abuse, and/or HIV/AIDS related information along with routine medical dictation and lab work.
- If I am covered by Medicare. I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of Medicare claims.

Disclosures to Family Members and/or Friends

I give permission for Mid Maryland Neurology, Drs. Boyd Dwyer and Richard Leschek to discuss and disclose PHI for purposes of communicating results findings and care decisions to the persons listed below. You have the right to revoke this authorization in writing. *This permission must be updated yearly.*

Name (First Last)	Relationship	Phone(if known)

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Date

Boyd A. Dwyer, MD **Richard T. Leschek, DO**

Mid Maryland Neurology, PA

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172 Thomas Johnson Dr, Suite 202
Frederick, Maryland 21702

IMPORTANT INFORMATION ABOUT PATIENT E-MAIL

As a patient of *Mid Maryland Neurology PA,* you may request we communicate with you by electronic mail (e-mail). This Fact Sheet will inform you about the risks of communicating with your health care provider or program via e-mail and how *Mid Maryland Neurology, PA* will use and disclose provider/patient e-mail.

E-mail communications are a two-way communications. However, responses and replies to e-mails sent to or received by either you or your health care provider may be hours or days apart. This means that there could be a delay in receiving treatment for an acute condition.

E-mail messages on your computer, laptop, or other device have inherent privacy risks especially when your e-mail access is provided through your employer or when access to your e-mail messages is not password protected. *You should be aware of and understand that if you use e-mail provided by your employer, any e-mail sent on your employer's system may be viewed by your employer.*

Unencrypted e-mail provides as much privacy as a postcard. You should not communicate any information with your health care provider that you would not want to be included on a postcard that is sent through the Post Office.

E-mail is sent at the touch of a button. Once sent, an e-mail message cannot be recalled or cancelled. Errors in transmission, regardless of the sender's caution, can occur. You can also help minimize this risk by using only the e-mail address that you provide to our practice/ program/ provider.

In order to forward or process and respond to your e-mail, individuals at *Mid Maryland Neurology, PA* other than your health care provider may read your e-mail message. Your e-mail message is not a private communication between you and your treating provider.

Neither you nor the person reading your e-mail can see the facial expressions or gestures or hear the voice of the sender. E-mail can be misinterpreted.

At your health care provider's discretion, your e-mail message and any and all responses to them may become part of your medical record.

Appropriate uses for E-mail

E-mail may be used to request information and ask non-urgent questions. It is not an appropriate place to have long discussions regarding health issues and sensitive medicolegal matters. *It should not be used in emergencies*. If you are experiencing a sudden or severe change in your health or need an immediate response, contact your healthcare provider's office by telephone, call 911, or go to an emergency room. E-mail may be used for:

- General medical advice after an initial face-to-face visit
- Lab or radiology test results
- Patient educational material
- Other non-urgent communication

Communication with your doctor by e-mail is consider a privilege and should not be abused!

Boyd A. Dwyer, MD Richard T. Leschek, DO

Mid Maryland Neurology, PA

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172 Thomas Johnson Dr, Suite 202
Frederick, Maryland 21702

Patient Request for E-mail Communications

Patient Name: _____ Date of Birth: _____

Email Address: _____ Phone Number: _____

Communications over the Internet and/or using the e-mail system may not be encrypted and may not be secure. There is no assurance of confidentiality when communicating via e-mail. To request that your provider or *Mid Maryland Neurology, PA* communicate with you via email you must complete this form and return it to this office.

Please be advised that:

- This request applies only to the healthcare providers of *Mid Maryland Neurology, PA* including Dr. Dwyer and Dr. Leschek.
- If you would like to request to communicate via e-mail with another health care provider or program, you must complete a separate request for that office.
- *Mid Maryland Neurology, PA* will not communicate health information that is specially protected under state and federal law (e.g., HIV/AIDS, substance abuse, mental health information) via e-mail.
- You must provide your email address when registering for your visit with your provider

I understand and agree to the following:

- I certify the e-mail address provided on this request is accurate, and that I accept full responsibility for messages sent to or from this address.
- I have received a copy of the **IMPORTANT INFORMATION ABOUT PATIENT E-MAIL** form, and I have read and understand it.
- I understand and acknowledge that communications over the Internet and/or using the email system may not be encrypted and may not be secure; that there is no assurance of confidentiality of information when communicated via e-mail. *If this is of concern to you, you should not communicate with your healthcare provider through e-mail.*
- I understand that all e-mail communications may be forwarded to other physicians for purposes of providing treatment to me.
- I agree to hold *Mid Maryland Neurology, PA* and individuals associated with it harmless from any and all claims and liabilities arising from or related to this request to communicate via e-mail.

_____ _____

Signature of Patient **Date**

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues:
We can share health information about you for certain situations such as:
Preventing disease
Helping with product recalls
Reporting adverse reactions to medications
Reporting suspected abuse, neglect, or domestic violence
Preventing or reducing a serious threat to anyone's health or safety

Do research: We can use or share your information for health research.

Comply with the law:
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests:
We can share health information about you with organ procurement organizations

Work with a medical examiner or funeral director:
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests:
For workers' compensation claims
For law enforcement purposes or with a law enforcement official
With health oversight agencies for activities authorized by law
For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions:
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities:
We are required by law to maintain the privacy and security of your protected health information.
We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
We must follow the duties and privacy practices described in this notice and give you a copy of it.
We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice:
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Boyd A. Dwyer, MD

Richard T. Leschek, DO

Mid Maryland Neurology, PA

172 Thomas Johnson Drive

Suite 202

Frederick, Maryland 21702

Phone: 301-698-8300

Fax: 301-698-8389

When it comes to your health information, you have certain rights.

YOUR RIGHTS

This section explains your rights and some of our responsibilities to help you.

Get paper copy of your medical record:

We will provide a copy or a summary of your health information, usually ***within 30 days of your written request. We may charge a reasonable, cost-based fee.*** You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

Ask us to correct your medical record:
You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications:
We will say "yes" to all reasonable requests. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

Ask us to limit what we use or share:
You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information:
You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice:
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you:
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated:
You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share:
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
Share information with your family, close friends, or others involved in your care
Share information in a disaster relief situation
Include your information in a hospital directory
If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:
Marketing purposes Sale of your information
Most sharing of psychotherapy notes

In the case of fundraising:
We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES & DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you
We can use your health information and share it with other professionals who are treating you.
Example: *A doctor treating you for an injury asks another doctor about your overall health condition.*

How we run our organization:
We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: *We use health information about you to manage your treatment and services.*

Bill for your services:
We can use and share your health information to bill and get payment from health plans or other entities.
Example: *We give information about you to your health insurance plan so it will pay for your services.*

Mid Maryland Neurology, PA

Dr. Boyd Dwyer
&
Dr. Richard Leschek

DIRECTIONS TO:
172 ***Thomas Johnson Dr.***
Suite 202
Frederick, MD 21702

From: 270 North:

Route 270 north to Route 15 north. Follow to Exit for Motter Ave. Make right onto Opossumtown Pike, go 2 lights and make a Right on Thomas Johnson Drive. Go about 0.25 miles on the right you will see the "Ambers Professional Buildings" across from The Fulton Bank
We are building 172, Suite 202.

From: Route 15 South:

Route 15 South exit onto Christophers Crossing in Frederick.
Take left onto Thomas Johnson Drive south about 1.8 miles. You will see "Ambers Professional Buildings" on the Left. We are the brown group of buildings across from The Fulton Bank. We are building 172, Suite 202

Any problems please call 301-698-8300 and stay on the line for the operator