NEW PATIENTS
WELCOME
TO OUR PRACTICE

EDIXON@HEALTHTOHOMEMEDICAL.COM
PHONE: 443.987.2272
FAX: 636.242.5084

DEAR NEW PATIENT,

We would like to take this opportunity to WELCOME you to our practice. and to thank you for choosing Health to Home Medical Services to participate in your healthcare. We look forward to providing you with personalized, comprehensive health care focusing on your wellness and prevention. Health to Home Medical Services is a medical practice that comes to you and was started with your healthcare needs in mind. We aim to provide COMPREHENSIVE medical care to focus on all your health care needs, offering a varied range of services. We strive to show you that we care about your health goals by helping you to improve your physical, emotional, and social well-being through the COMPASSIONATE care we provide. Our services are CONVENIENT and allow you to receive care where you feel most comfortable and in a way that meets your scheduling needs. From routine checkups to long-term chronic care, Health to Home Medical Services provides everything you need to manage your overall wellness when it's convenient for you.

HEALTH TO HOME Medical Services

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Our expertise: Your provider will be a board-certified Nurse Practitioner who is trained in treating ages 13 and above for primary care and basic urgent care needs, as well as the needs of the elderly and medically complex home-bound patients. Our providers' clinical skills are matched by their genuine compassion and concern for your care.

Our care: We provide high-quality, personalized, and confidential medical care in the convenience and comfort of your own home. You will take part in the decisions that affect your health and will be cared for with respect and dignity every step of the way. We also provide important care coordination to help you access community resources and other services available in your home. We believe that our specialty services and care coordination demonstrate our commitment to providing you with the highest quality care possible.

Our services: Health to Home Medical services can diagnose and treat you in the convenience of your home where we know you'll feel most comfortable. Our services include:

- Individual and customized In-Home Primary Care
- In home lab and diagnostic testing
- Managing chronic health conditions
- Coordination of all home care services
- Telehealth Services
- Medical Marijuana certification
- Weight loss management

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HEALTH TO HOME MEDICAL SERVICES
FREQUENTLY ASKED QUESTIONS/GUIDELINES

What are your hours? Office staff will be available to answer calls and address concerns Monday-Friday 9am-5pm. Please try to handle all issues during office hours. You can call (443) 987-2272 to contact an office staff member. If you do not receive an answer. Please leave a DETAILED message and someone will return your call as soon as possible. If it is a medical emergency, please call 911 immediately.

When can I schedule a visit? For patients receiving home based primary care, chronic care management services, your nurse practitioner will be scheduling you visit every 6-8 weeks and scheduling a visit is not necessary. For urgent care telehealth visits or visits for other needs you can schedule through our online portal or by calling (443) 987-2272

When can I speak to my provider? Call (443) 987-2272 for any issues requiring you to speak to your provider. Please keep in mind that your provider may be very busy seeing medically complex patients throughout the day and may not return your call until the end of the day.

How are my services paid for? We accept private pay patients, as well as medical insurance. It is very important that we have the correct and most up-to-date insurance information on file. If you change insurance, either primary or secondary, please notify us immediately so we can reflect those changes. Please REMEMBER that Medicare deductibles are required to be paid at the start of every year before Medicare begins paying for services. In 2021, Medicare's annual deductible is $203.00. Outstanding balances will prevent you from being seen by your provider. However, we understand that each patient's financial situation differs from patient to patient.

Therefore, we can schedule a payment plan for you. We will try our best to make the payment plan fit within your means. If you have set up a payment plan, you'll still be able to continue care with us. Please keep in mind that you are responsible for all deductibles, co-pays, and other charges that may not be covered by your insurance. If receiving Primary care services, please keep in mind insurance will reimburse for only one primary care provider.

How can I get medications refilled? Medication refills can be handled over the phone by contacting the office Monday through Friday 9 am-5 pm. Please allow 5-7 days for medication refills. You can also use your patient portal to request medication refills.

How can I get medical forms completed? All forms and letters can take up to two weeks to complete. If you need forms filled out, please send them to the office fax (636) 242-5084 or leave them with a nurse practitioner.

How should I prepare for my visits? Before each visit, please gather all your medication bottles for the nurse practitioner to review. If you are being seen by nurses or other home health care providers, seen any specialist, or have recently been to the ER or hospitalized please gather any papers for your Nurse Practitioner to review.

How to I obtain certification for medical cannabis? A patient needs an in-person visit with a registered provider with whom the patient has a "bona-fide provider-patient relationship". If the patient meets the provider's criteria for treatment with medical cannabis, the provider will issue a certification.

What conditions may qualify for medical cannabis? If the patient has a chronic or debilitating disease or medical condition that causes cachexia, anorexia, waiting syndrome, severe or chronic pain, severe nausea, seizures, severe or persistent muscle spasms, glaucoma, post-traumatic stress disorder (PTSD), or another chronic medical condition which is severe and for which other treatments have been ineffective.

How do I get started with my medical cannabis certification? Please visit https://mmcc.maryland.gov/Pages/patients_regisadult.aspx to register with the Maryland Cannabis Administration.

What kind of weight loss management is available? Your Nurse Practitioner will provide you with a 1:1 health assessment to understand your food, exercise, sleep and emotional health habits to determine your needs along with a health history assessment. If appropriate your provider may prescribe GLP-1 medications (glucagon-like peptide 1s) which are the most effective medication for long-term, sustained weight loss. The GLP-1 medications, Saxenda and Wegovy®, are FDA-approved for weight loss. GLP-1 medications stimulate the secretion of insulin and slow the release of glucagon in your body, influencing blood sugar control. GLP-1s also help with weight loss by reducing appetite and increasing satiety. GLP-1 medication is most effective when combined with intensive lifestyle intervention for habit change across food, exercise, sleep, and emotional health.

I, ______________________________________, agree that I've read Health to Home Medical Services, "Patient Frequently Asked Questions and Guidelines" and agree to follow each- as mentioned above.

____

Signature of Patient: Date:

If signing on behalf of a patient, I acknowledge and agree that I have read this Notice of Privacy Practices in its entirety. I've also been authorized to be the patients' Power of Attorney.

____

Signature of Power of Attorney & Relationship Date:

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HEALTH TO HOME MEDICAL SERVICES
CONSENT TO TREAT

Consent to Health to Home Medical Services for treatment and services:

I, ____, request and Health to Home Medical Services to provide me with medical treatment and agree to follow what the Nurse Practitioner may deem necessary or is advisable for the greater good of my overall health. This care may include but is not limited to routine diagnostics, radiology and laboratory procedures, medication management, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel may render care and services to me (the patient) according to my primary care provider's instructions. I have been informed that I may be discharged from Health to Home Medical Services if I am noncompliant with medical advice/treatment that my provider may recommend.

I agree to pay for any charges that are not covered by insurance including any deductibles and coinsurances.

____

Signature of Patient: Date:

____

Signature of Power of Attorney & Relationship Date:

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HEALTH TO HOME MEDICAL SERVICES
HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND SIGN WHERE INDICATED.

The terms of this Notice of Privacy Practices ("Notice") apply to Health to Home Medical Services, its affiliates, and its employees. Health to Home Medical Services will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law. We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by Health to Home Medical Services. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act ("HIPAA"). A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer at the address below.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

We participate in the CRISP health information exchange (HIE) to share your medical records with your other health care providers and for other limited reasons. You have the right to limit how your medical information is shared. We encourage you to read our Notice of Privacy Practices and find more information about CRISP medical record sharing policies at www.crisphealth.org.

Authorization and Consent: Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such

revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, another law provides the insurer with the right to contest a claim under the policy or the policy itself.

Uses and Disclosures for Treatment: We will make uses and disclosures of your protected health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

Uses and Disclosures for Payment: We will make uses and disclosures of your protected health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your payments.

Uses and Disclosures for Health Care Operations: We will make uses and disclosures of your protected health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation, and licensing, etc. For instance, we may use and disclose your protected health information for purposes of improving the clinical treatment and patient care.

Individuals Involved In Your Care: We may from time to time disclose your protected health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

HEALTH TO HOME MEDICAL SERVICES
HIPPA NOTICE OF PRIVACY PRACTICES

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request, and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. With such a request, you must provide an appropriate alternative address or method of contact. You also have the right to request that we do not send you any future marketing materials and we will use our best efforts to honor such request. You must make such requests in writing, including your name and address, and send such writing to the Privacy Officer at the address below.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

- Any purpose required by law
- Public health activities such as required reporting of immunizations, disease, injury, birth and If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect, or domestic violence.
- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls.
- To a government oversight agency conducting audits, investigations, civil or criminal proceedings.

- Court or administrative ordered subpoena or discovery request; To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- Functions (such as identification) concerning deceased persons.
- Cadaveric organ, eye, or tissue donation.
- Research, under certain conditions.
- To prevent or lessen a serious threat to health or safety.
- Essential government functions
- Workers 'compensation for benefit determination.

DISCLOSURES REQUIRING AUTHORIZATION

Psychotherapy Notes: We must obtain your specific written authorization prior to disclosing any psychotherapy notes unless otherwise permitted by law. However, there are certain purposes for which we may disclose psychotherapy notes, without obtaining your written authorization, including the following: (1) to carry out certain treatment, payment, or healthcare operations (e.g., use for the purposes of your treatment, for our own training, and to defend ourselves in a legal action or other proceeding brought by you), (2) to the Secretary of the Department of Health and Human Services to determine our compliance with the law, (3) as required by law, (4) for health oversight activities authorized by law, (5) to medical examiners or coroners as permitted by state law, or (6) for the purposes of preventing or lessening a serious or imminent threat to the health or safety of a person or the public.

Genetic Information: We must obtain your specific written authorization prior to using or disclosing your genetic information for treatment, payment, or health care operations purposes.

Sale of Protected Information: We must obtain your authorization prior to receiving direct or indirect remuneration in exchange for your health information; however, such authorization is not required where the purpose of the exchange is for: Public health activities; Research purposes, provided that we receive only a reasonable, cost-based fee to cover the cost to prepare and transmit the information for

research purposes; Treatment and payment purposes; Health care operations involving the sale, transfer, merger or consolidation of all or part of our business and for related due diligence; Payment we provide to a business associate for activities involving the exchange of protected health information that the business associate undertakes on our behalf (or the subcontractor undertakes on behalf of a business associate) and the only remuneration provided is for the performance of such activities; Providing you with a copy of your health information or an accounting of disclosures; Disclosures required by law; Disclosures of your health information for any other purpose permitted by and in accordance with the Privacy Rule of HIPAA, as long as the only remuneration we receive is a reasonable, cost-based fee to cover the cost to prepare and transmit your health information for such purpose or is a fee otherwise expressly permitted by other law; or Any other exceptions allowed by the Department of Health and Human Services.

RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION:

Access to Your Protected Health Information: You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable electronic format, if readily producible. Requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person. You will be charged a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies, you will be charged a fee for copying and postage.

Amendments to Your Protected Health Information: You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make requested amendments, but we will give each request careful consideration. All amendment requests must be in writing, signed by you or a legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we

may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.

Accounting for Disclosures of Your Protected Health Information: You have the right to receive an accounting of certain disclosures made by us of your protected health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12- month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Protected Health Information: You have the right to request restrictions on uses and disclosures of your protected health information for treatment, payment, or health care operations. We are not required to agree to most restriction requests but will attempt to accommodate reasonable requests when appropriate. You do, however, have the right to restrict disclosure of your protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the protected health information pertains solely to a health care item or service for which you, or someone other than the health plan on your behalf, has paid Health to Home Medical Services in full. If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as appropriate. We will notify you if we remove a restriction imposed in accordance with this paragraph. You also have the right to withdraw, in writing or orally, any restriction by communicating your desire to do so to the individual responsible for medical records.

Right to Notice of Breach: We take very seriously the confidentiality of our patient's information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially

involving your unsecured health information and inform you of what steps you may need to take to protect yourself.

Paper Copy of this Notice: You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice. To do so, please submit a request to the Privacy Officer at the address below.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf . There will be no retaliation for filing a complaint.

By signing below, I agree that I have read this Notice of Privacy Practices.

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Signature of Patient: Date:

____

Signature of Power of Attorney & Relationship Date:

HEALTH TO HOME MEDICAL SERVICES
CHRONIC CARE MANAGEMENT CONSENT

As a patient with two or more chronic conditions with Medicare, you may benefit from chronic care management. Our goal is to make sure you get the best care possible from everyone that is involved with your care. We can help coordinate your visits with other doctors, facilities, lab, radiology, or another testing; we can talk to you on the phone about your symptoms; we can help you with the management of your medications, and we will provide you with a comprehensive care plan.

Medicare will allow us to bill for services such as care coordination, correspondence with patients and family, and discussion with nurses or specialists during any month that we have provided at least 20 minutes of non-face-to-face care of you and your conditions. However, you must provide your consent to participate in this program. Failure to consent to CCM may mean that certain services done outside the scope of an office visit may no longer be able to be performed unless they are deemed to be medical emergencies. This allows patients and caregivers to call our office in-between appointments and have services done without an appointment. For example, medication refills, ordering of labs, referrals, asking providers questions about their care. If you choose not to be a part of our CCM program, such services will require an appointment and/or additional fees.

You agree and consent to the following:

- As needed, we will share your health information electronically with others involved in your care. Please rest assured that we continue to comply with all laws related to the privacy and security of your health information.

- We will bill Medicare for chronic care management for you when the services are provided. Our office will have a record of our time spent managing your care if you ever have a question about what we did each month.
- Only one practitioner can bill for CCM services for you. Therefore, if another one of your practitioners has offered to provide you with this service, you will have to choose which practitioner is best able to treat you and all your conditions. Please let our staff know if you have entered into a similar agreement with another practitioner/practice.

You have the right to: A comprehensive care plan from our practice to help you understand how to care for your conditions so that you can be as healthy as possible. This will be provided to you upon request. Discontinue this service at any time for any reason. Because your signature is required to end your chronic care management services, please ask any of our staff members for the Chronic Care Management termination form. Our goal is to provide you with the best care possible, to keep you out of the hospital, and to minimize costs and inconvenience to you due to unnecessary visits to doctors, emergency rooms, labs, or hospitals. We know your time and your health is valuable and we hope that you will consider participating in the program with our practice.

By signing below, I consent to and authorize Health to Home Medical Services to provide Chronic Care Management services as described.

____

Signature of Patient: Date:

____

Signature of Power of Attorney & Relationship Date:

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RELEASE OF MEDICAL INFORMATION

Permission to get records

I, ________________________________, with a date of birth,________________, give my permission
(patient name) (patient's DOB)
for ______________________________to give my medical records (as described on p. 2) to
(doctors or hospital name who has records)
_________________________________so that he/she can better understand my condition and help me. (my doctors name)

Permission to get sensitive information

By putting my initials by each item below, I understand that I allow records to be sent that may have information about:

_____________ my mental health,
_____________a disease I may have that others could get from me, like HIV/AIDS,
_____________genetic records, and/or
_____________drug and alcohol records.

I understand that:

- I do not have to share these records.
- If I want to take away the permission for my doctor to get these records, I need to talk to my doctor or a staff person and sign a paper.
- This form is only good for 1 year from the date I sign it.

____
Signature of Patient: Date:

____
Signature of Power of Attorney & Relationship Date:

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Date: ______________________________

Page 2

Requesting records from:

Name of Practice: ____

Name of Physician: ____

Fax number: ____

Address: ____

Types of records we are requesting:

☐Any and all types of records you have for this patient

☐Doctor visit notes	☐Doctors orders
☐Emergency room notes	☐Nurses notes
☐Urgent care notes	☐Discharge summary
☐History and physical	☐Lab reports
☐Hospital progress notes	☐Radiology reports
☐Operation or procedure notes	☐Consultations
☐Clinic notes	☐Other ____________________________
☐Pathology reports	

Records within the following dates:

☐All records for this patient

☐Records dated between _______________________ and _____________________

Please send records to:

Attention: ____

At fax number: ____

Or mail to: ____

____

____

For any questions please call (phone number): ____________________________________

and ask for: ____