Doctors Community Practices - Digestive Disease Center
REGISTRATION FORM

(Please Print)

Today's date:	

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Social Security number:	Home Phone number:	Cell number:	Birth date: / /	Age:	Sex: ❑ M ❑ F
Email address:					
Street Address:					
P.O box:	City:	State:	Zip Code:		
Occupation:	Employer:	Work Phone Number ( )			
Referring Provider Name:	Referring Provider Phone and Fax Numbers:				
Primary Physician Name:	Primary Physician Phone and Fax Numbers:				
Preferred Pharmacy Name and Address:	Preferred Pharmacy Phone and Fax Numbers:				

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )	
Name of Insurance	Subscribers Name:	Subscribers Social Security No:		
Policy Number:	Group number:	Subscriber DOB: / /	Co Pay Amount: $	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:	
Subscribers Address:				
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone # ( )	Work phone # ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Doctors Community Practices or my insurance company to release any information required to process my claims.

Patient/Guardian signature: Date:

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.

Doctors Community Health System and Affiliates

When this Notice states Practice, "we" or "us", it refers to its employees, volunteers and physicians who provide services.

Health Records
A record is kept for every visit you make to a hospital, physician's office, clinic or other healthcare provider. This information, referred to as your health record, includes data concerning your diagnosis, symptoms, procedures, lab results, examinations, treatment and many other details of your healthcare. This record is used by many healthcare professionals who participate in your care and treatment. Understanding your healthcare record, and how it is used by these individuals, will allow you to ensure the accuracy of documentation as well as make informed decisions.

Your original health record is the legal property of the Practice; however, you have the right to obtain a copy.

This Notice provides ways in which we may use and disclose the medical information in your health record. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

Patient Rights Related to Health Information
As a patient a Doctors Community Health System and Affiliates you are entitled to complete confidentiality regarding your personal health information. You have the right to:

- Request restrictions on certain uses of your health information. However, the Practice is not required to agree with your request and will notify you if we are unable to agree. Your request must be in writing and it must describe what information you want to limit – whether you want to limit our use, disclose or both – and to whom you want the limits to apply. To request such restrictions, you must make your request in writing prior to the treatment or service. In your request, you must tell us what information you want to restrict and to what health plan the restriction applies.
- Request access to your healthcare information with certain limitations imposed by federal and/or state law.
- Receive confidential communications from us.
- Inspect and obtain a copy of your health record. (A fee may be charged.)
- Request that your health record be amended; however the Practice may deny your request in certain circumstances.
- Know, with certain limitations, to whom and why your health information has been given from or after April 14, 2003.
- As us to correct your health information that you think is incorrect or incomplete. You must make that request in writing to the Practice Administrator stating the correction and why you feel it should be changed. We may deny your request, but we'll tell you why in writing within 60 days.
- You have the right to choose someone to act for you. If you have given someone the medical power of attorney or he/she is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure that person has the authority and can act for you before we take any action.

Notification of a Breach
You have the right under HIPAA, or as required by law, to be notified if there is a breach of your protected health information.

Report a Problem
If you feel that your privacy has been violated in any way, you have the right to file a complaint by contacting the privacy officers at Doctors Community Hospital (address and phone number below). You can also contact the U.S. Department of Health and Human Services, Office for Civil Rights, by mail (200 Independence Avenue, SW, Washington, DC 20201), telephone (877.696.6775) or website www.hhs.gov/ocr/privacy/hipaa/complaints. Doctors Community Health System and Affiliates will not retaliate in any way if you file a report.

NOTE: An inmate does not have the right to this notice.

How to Exercise These Rights
Submit your request in writing to the privacy officer at Doctors Community Hospital at the address below. We will respond to your request within the time limits as required by federal or state law.

Responsibilities of the Practice
The Practice is required to maintain the confidentiality of medical information. We must provide you with this Notice of Privacy Practices detailing responsibilities regarding any documentation we maintain. If you would like more information regarding the privacy of your health record, please contact the privacy officer at Doctors Community Hospital (address and phone number below). We will not disclose your medical information or use it in for any purpose other than those contained in this Notice.

We will abide by the terms of this Notice. We may change the terms of this Notice at any time. The new Notice will apply to all health records we maintain at that time. The Notice of Privacy Practices in effect will be posted in our office and will be provided at the time of registration.

Use of Medical Information
Your healthcare information will be used or disclosed for the following purposes. For each category of uses or disclosures, we will provide some examples. Not every use or disclosure in a category will be listed.

- Treatment
  We will use your medical information to provide you with medical treatments or services. For example, information obtained by your health practitioner in this hospital will be recorded in your health record and used to determine the course of treatment that should work best for you. This consists of your physicians and others involved in providing you with care. Your health information may be shared with others involved in your care, such as specialty physicians or lab technicians.

- Payment
  Your healthcare information will be used to receive payment for services rendered by us. For example, a bill may be sent to either you or a third party payer with accompanying documentation that identifies you, your diagnosis, procedures performed and supplies used. If you pay for your healthcare in full and out-of-pocket, you may request that we not share your information with your insurance company.

- Healthcare Operations
  We will use and disclose your health information as part of hospital operations. These operational uses and disclosures are necessary to make sure that all of our patients receive appropriate care. For example, we may use your medical information to review our treatment and services to evaluate the performance of our staff in caring for you. We may combine information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also combine the medical information we have with medical information from other hospitals to compare how we are doing and identify potential improvements.

- Individuals Involved in Your Care or Payment
  We may release medical information about you to a friend or family member who is involved in your medical care or helps pay for your care.

- Business Associates
  We contract with business associates to provide some services. An example is the reference lab. To protect your health information, we require business associates to appropriately safeguard your information and notify us if a breach of such information has occurred.

- Research
  Under certain circumstances, the information in your health record may be disclosed to healthcare professionals and government agencies for the purpose of research and review. If your information is used for research purposes, your identifying information will be removed.

- Marketing
  We may use your medical information to forward promotional gifts of nominal value, to communicate with you about products, services and educational programs, to communicate with you about care coordination and to communicate with you about treatment alternatives. We do not sell your health information to third parties for their marketing activities unless you provide authorization in writing.

- Special Situations
  We will use and disclose medical information about you:
  - To facilitate organ and tissue donations.
  - For specialized government functions, including the military, national security, criminal corrections and public benefit.
  - For Workers Compensation.
  - For public health activities.
  - To prevent and avoid a serious threat to the health or safety of the public or another person.
  - For health oversight activities including, for example, audits, investigations, actions, inspections and licensure.
  - To notify government authorities of suspected abuse, neglect or domestic violence.
  - For law enforcement, judicial or administrative proceedings.
  - For lawsuits and disputes in response to a valid court or administrative order or in the course of defending ourselves.
  - To medical examiners, coroners or funeral directors.
  - In response to investigations by the Department of Health and Human Services.

- Future Appointments
  Your personal information may be used to contact you regarding future appointments.

- ❖ Individuals that Have Been Deceased for More Than 50 Years
  Health information is not protected for persons that have been deceased for more than 50 years and may be used or disclosed without regard to the Privacy Rule.

Except as described above, we will only disclose your health information with your written authorization, which you may revoke in writing at any time.

Health Information Exchange
We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and the District of Columbia. 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 disable access to 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. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers. Even if you opt-out, your ordering or referring physician(s) may access your diagnostic information and refer you to other providers.

This Notice also describes the privacy practices of an Organized Health Care Arrangement "OHCA" between us and certain eligible healthcare providers and organizations. We may participate in the ePrescribing (DrFirst, eRX), Immunet and Southern MD Regional Transformation Coalition (TLC-MD/eQHEALTH). These OHCAs allow legally separate covered entities to use and disclose PHI for the joint operations of the arrangement. We participate in such an arrangement of healthcare organizations who have agreed to work with each other to facilitate access to health information relevant to your care. For instance, if you go to a hospital for emergency care and are unable to provide information about your health, the OHCA will allow us to use your PHI from our OHCA participants to treat you. When it is needed, ready access to your PHI means better care for you. DCH and any members of the OHCA must be able to share your health information freely for treatment, payment and healthcare operations. OHCA members may choose to have their own NPP. For information about organizations participating in the OHCA, please contact the Privacy Officer listed below.

Availability of Notice
You will find this Notice of Privacy Practices posted in the Practice, particularly in areas where healthcare services are provided. You have the legal right to a paper copy of this Notice.

You will be provided with a copy of this Notice, at the least, on your first visit to the Practice for healthcare services or as soon as possible after services are provided (for example, emergency situations). Upon request, this Notice will be mailed to you.

You will be requested to provide written acknowledgement that you have received this Notice.

Contact for additional information:
Privacy Officer
Doctors Community Hospital
8118 Good Luck Road
Lanham, Maryland 20706
301.552.8118

Doctors Community Practices
Digestive Disease Center
8116 Good Luck Road, Suite 010
Lanham, MD 20706
Office: 240-965-4413
Fax: 240-542-2997

Meaningful Use Information Form

Last Name: _____ First Name: _____

Date: _____/_____/_____ Date of Birth: _____/_____/_____

Primary Care Physician: _____

We are now required to collect preferred language, race and ethnicity. You may choose to decline if you prefer not to report this information. Thank you for your corporation.

Preferred Language	Race	Ethnicity
☐ English	☐ Asian	☐ Hispanic/Latino
☐ Spanish	☐ Black or African American	☐ Not Hispanic or Latino
☐ Other: _____	☐ American Indian/Alaskan Native	☐ Decline to Report
☐ Decline to Report	☐ Pacific Islander/Native Hawaiian	
	☐ White	
	☐ Other	
	☐ Unknown	
	☐ Decline to Report	

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HIPAA PRIVACY AND PROTECTED HEALTH INFORMATION (PHI)

The "Notice of Privacy Practices" provides information about how Doctors Health Services and the Affiliates may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our Notice of Privacy Practices states that we reserve the right to change the terms of the notice. Should this happen, we will display the new and effective date in our office. Our Notice of Privacy Practices is displayed in our waiting room for your review, and by signing below you acknowledge that you have received a copy of the Practice's Privacy Notice.

By completing the following you authorize the Practice disclose your "PHI" to only the following individuals and/or facilities, unless additional written consent is given:

Spouse:_____ Child(ren):_____

Parent(s):_____ _____

Sibling(s):_____

Legal Partner:_____ Other:_____

Consent for Treatment

I, the undersigned, voluntarily consent to treatment by the medical provider(s) and staff of Doctors Community Practices, LLC (The Practice). I understand that I have the right to revoke this consent, except where The Practice has already made disclosures under prior consent. I understand that treatment will not be provided to me in the event I alter the policies of this document.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Printed Name