Rockville Concierge Doctors

Aimee Seidman, M.D., FACP

Patient Information (Please complete form in its entirety) Date_____

Name_____

Address_____

City_____ State_____ Zip_____

Phone_____ Cell_____ Work_____

Email_____

Birth Date_____ Age_____ Sex_____

Emergency Contact_____ Phone_____

Place of Employment_____

Pharmacy_____ Phone_____

Primary Insurance_____

ID#_____ Group#_____

Name of Holder_____

Birthdate of Holder_____ Relationship_____

Secondary Insurance_____

ID#_____ Group#_____

Name of Holder_____

Birthdate of Holder_____ Relationship_____

Signature_____ Date_____

Rockville Concierge Doctors

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Retainer Fee Schedule

Please indicate your preferred method of payment.

If you prefer your invoice to be mailed, please check this box ☐

Please note: You will receive an invoice by email automatically for yearly renewal unless we hear from you 30 days prior to your renewal date.

If your payments are late, you will need to pay retroactively in order to be seen by the doctors again. We will assess a $50 late fee after a two-week grace period unless other arrangements have been made.

☐ Personal check, made payable to: **AIMEE SEIDMAN M.D., P.C.** *Please note: There will be a $75 return check fee.*

☐ Credit Card (Mastercard, Visa, Discover, or AMEX). **By agreeing to pay with your credit card, you are obligated to the yearly contract whether paying annually or semi-annually. Credit card information is not saved and must be provided for each payment when due.**

Card # _____ Expiration _____ CCV _____

Please check your preferred schedule of payment. Semi-annual payments require a credit card.

If 18 to 39 years old, inclusive:

☐ Annually: 1 payment of $1,724.00 [Total $1,724.00].

☐ Semi-annually: 2 payments of $890.00 [Total $1,780.00].

If 40 to 67 years old, inclusive:

☐ Annually: 1 payment of $2,372.00 [Total $2,372.00]. *Deduct 10% [Total $2,135.00] if you are a family member of someone 40 years or older who belongs at full price (1 discount per family).*

☐ Semi-annually: 2 payments of $1,214.00 [Total $2,428.00]. *Deduct 10% [2 payments of $1096.00, Total $2192.00] if you are a family member of someone 40 years or older who belongs at full price (1 discount per family).*

If 68 to 89 years old, inclusive:

☐ Annually: 1 payment of $2,542.00 [Total $2,542.00]. *Deduct 10% [Total $2,288.00] if you are a family member of someone 40 years or older who belongs at full price (1 discount per family).*

☐ Semi-annually: 2 payments of $1,299.00 [Total $2,598.00]. *Deduct 10% [2 payments of $1172.00, Total $2344.00] if you are a family member of someone 40 years or older who belongs at full price (1 discount per family).*

If 90 years old or older:

☐ Annually: 1 payment of $3,144.00 [Total $3,144.00]. *Deduct 10% [Total $2,830.00] if you are a family member of someone 40 years old or older who belongs at full price (1 discount per family).*

Print Name _____ **Birth Date** _____

Address _____

City _____ **State** _____ **Zip** _____ **Phone** _____

Email _____

Signature _____ **Date** _____

9420 Key West Avenue • Suite 104 • Rockville • MD 20850
Telephone 301-545-1811 • Fax 301-545-1814
www.RockvilleConciergeDocs.com

Rockville Concierge Doctors

Aimee Seidman, M.D., FACP

Retainer Contract

I _____ (patient name) voluntarily agree to participate in the retainer practice model of Aimee Seidman, M.D., P.C. I understand that I will pay $_____ in _____ installments as a retainer fee (the "Retainer Fee").

The Retainer Fee includes a comprehensive annual history and physical examination, which will include certain basic blood work and, when indicated, an electrocardiogram, a vascular study of the lower extremities, and certain immunizations (hereinafter, the "Medical Services"). As used in this agreement, the term "Medical Services" also includes those medical services that the physician themselves are permitted to perform under the laws of the State of Maryland, and that are consistent with their training and experience as specialists in Internal Medicine.

The Retainer Fee also includes: 24-hours-a-day, 7-days-a-week access to my doctor; same- or next-day appointments for urgent needs and timely appointments for physicals. I will be able to contact my doctor by office phone, patient portal or email, fax, answering service or cell phone. Patient portal, email and fax should be reserved for non-urgent issues. In addition, my doctor will be in close contact with subspecialists with whom I am in treatment.

During office visits (other than certain labs with my annual history and physical), I understand that lab work will be billed to my insurance company, as will all radiological studies (X-rays, CT scans, MRIs, mammograms, sonograms, bone density studies, etc.). I understand that my doctor will be considered "out-of-network" by all insurance companies, and therefore the payment for these tests is subject to their reimbursement schedule. I understand that my doctor does not accept any insurance nor will he/she file claims on my behalf. It is my responsibility to file claims to my insurance companies for any reimbursement that may or may not be due to me.

I fully understand that I need to maintain my health insurance and I acknowledge that my doctor has advised me to obtain or keep in full force my health insurance policies in order to cover for healthcare costs not within the definition of Medical Services under this Agreement. I acknowledge that this Agreement is not a contract that provides health insurance, and this Agreement is not intended to replace any existing or future health insurance or health plan coverage that I may carry for myself and family.

The doctor or I may terminate this agreement at any time upon 30 days written notice. If the Agreement is terminated prior to the completion of one full year, I will be obligated to pay any unpaid annual Retainer Fee, and I will not be entitled to a refund of any part of the Retainer Fee.

The parties agree that any dispute or disagreement under this Agreement shall be resolved as we may amicably agree and, if we cannot agree, then in accordance with the rules and procedures of the American Arbitration Association then in effect in the state of Maryland. The decision of the arbitrator shall be binding on the parties and may be reduced to judgment in the state of Maryland.

Signature_____Date_____

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Authorized Contact Numbers and Patient Representatives

Patient Name_____ Date_____

I hereby authorize the office of Rockville Concierge Doctors to disclose any patient medical information for the above-named patient via any of the methods designated below.

Please indicate the authorized phone line(s) and phone number(s) where <u>we may leave a message</u> regarding your medical information/results:

- ☐ Home_____
- ☐ Work_____
- ☐ Cell_____

List any person(s) whom you authorize to receive or discuss your Protected Health Information as your patient representative:

Representative name_____

Phone or email_____

Relationship to patient_____

Representative name_____

Phone or email_____

Relationship to patient_____

Representative name_____

Phone or email_____

Relationship to patient_____

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Rockville Concierge Doctors **Aimee Seidman, M.D., FACP**

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Phone: 301-545-1811 Fax: 301-545-1814 www.rockvilleconciergedocs.com

Authorization To Release Healthcare Information

Patient's Full Name_____ Date of Birth_____

Previous Name_____

Patient's Address

Street_____City_____State_____ Zip_____

Phone_____

I request and authorize_____
(Name Of Physician Or Medical Facility)

Street_____City_____State_____ Zip_____

Phone_____ Fax_____

To release healthcare information of the patient named above to:

Rockville Concierge Doctors
Aimee Seidman, M.D., FACP
9420 Key West Avenue, Suite 104, Rockville, Maryland, 20850
Fax 301-545-1814 * For questions call 301-545-1811

- ☐ **All Medical Records (Immunizations, History and Physical, Consultations)**
- ☐ **Progress Notes**
- ☐ **Radiology Reports**
- ☐ **Labs**
- ☐ **Hospital Records/Discharge Notes**
- ☐ **Lab Reports**

- ☐ **Yes** I authorize the release of any records regarding drug, alcohol, or mental health treatment to Rockville Concierge Doctors
- ☐ **No**

- ☐ **Yes** I authorize the release of my STI results (including HIV/AIDS testing), whether negative or positive, to Rockville Concierge Doctors. I understand that I must give specific written permission before disclosure of these test results to anyone.
- ☐ **No**

Patient Signature_____ Date_____

Printed Name_____

Signature Of Authorized Representative_____
Representative's Authority to Act on Behalf of Patient_____

Rockville Concierge Doctors **Aimee Seidman, M.D., FACP**

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Patient's Full Name_____ Date of Birth_____

Previous Name_____

Patient's Address

Street_____City_____State_____ Zip_____

Phone_____

I request and authorize_____
(Name Of Physician Or Medical Facility)

Street_____City_____State_____ Zip_____

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Patient Signature_____ Date_____

Printed Name_____

Signature Of Authorized Representative_____
Representative's Authority to Act on Behalf of Patient_____

Rockville Concierge Doctors

Aimee Seidman, M.D., FACP

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND/OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. It describes how we may use and disclose your Protected Health Information to carry out treatment, payment, or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. "Protected Health Information" is information that identifies you individually, including demographic information that references your past, present, or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

We may use and disclose your Protected Health Information in the following situations:

- **Treatment:** We may use or disclose your Protected Health Information to provide medical treatment and/or services in order to manage and coordinate your medical care. For example, we may share your medical information with other physicians and health care providers, DME vendors, surgery centers, hospitals, rehabilitation therapists, home health providers, laboratories, nurse case managers, worker's compensation adjusters, etc., to ensure that the medical provider has the necessary medical information to diagnose and provide treatment to you.

- **Payment:** Your Protected Health Information will be used to obtain payment for your health care services. For example, we will provide your health care plan with the information it requires to reimburse you for the services we have provided to you, where appropriate. This use and disclosure may also include certain activities that your health plan requires prior to approving a service, such as determining benefits eligibility and prior authorization, etc.

- **Health Care Operations:** We may use and disclose your Protected Health Information to manage, operate, and support the business activities of our practice. These activities include, but are not limited to, quality assessment, employee review, licensing, and conducting or arranging for other business activities. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

- **Required By Law:** We will use or disclose your Protected Health Information when required to do so by local, state, federal, and international law. These situations include: public health department reporting (including of certain communicable diseases); concerns about abuse or neglect; Food and Drug Administration (FDA) requirements; legal proceedings; requests by law enforcement, coroners, funeral directors, and organ donation organizations; worker's compensation cases; and other uses and disclosers required under the law. We must make disclosures to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of Section 164.500.

USES AND DISCLOSURES IN WHICH YOU HAVE THE RIGHT TO OBJECT AND OPT OUT

- **Communication with family and/or individuals involved in your care or payment of your care:** Unless you object, disclosure of your Protected Health Information may be made to a family member, friend, or other individual involved in your care or payment of your care, whom you have identified.

- **Disaster:** In the event of a disaster, your Protected Health Information may be disclosed to disaster relief organizations to coordinate your care and/or to notify family members or friends of your location and condition. Whenever possible, we will provide you with an opportunity to agree or object.

PROTECTED HEALTH INFORMATION AND YOUR RIGHTS

The following are statements of your rights, subject to certain limitations, with respect to your Protected Health Information:

- **You have the right to inspect and copy your Protected Health Information:** Pursuant to your written request, you have the right to inspect and copy your Protected Health Information in paper or electronic format. Under federal law, you may not inspect or copy the following types of records: psychotherapy notes, information compiled as it relates to civil, criminal, or administrative action or proceeding; information restricted by law; information related to medical research in which you have agreed to participate; information obtained under a promise of confidentiality; and information whose disclosure may result in harm or injury to yourself or others. We have up to 30 days to provide the Protected Health Information and may charge a fee for the associated costs.

- **You have a right to a summary or explanation of your Protected Health Information:** You have the right to request only a summary of your Protected Health Information if you do not desire to obtain a copy of your entire record. You also have the option to request an explanation of the information when you request your entire record.

- **You have the right to obtain an electronic copy of your medical record:** You have the right to request an electronic copy of your medical record for yourself or to be sent to another individual or organization when your Protected Health Information is maintained in an electronic format. We will make every attempt to provide the records in the format you request; however, in the case that the information is not readily accessible or producible in the format you request, we will provide the record in a standard electronic format or a legible hardcopy form. Record requests may be subject to a reasonable, cost-based fee for the work required in transmitting the electronic medical record.

- **You have the right to receive a notice of breach:** In the event of a breach of your unsecured Protected Health Information, you have the right to be notified of such breach.

- **You have the right to request Amendments:** At any time if you believe the Protected Health Information we have on file for you is inaccurate or incomplete, you may request that we amend the information. Your request for an amendment must be submitted in writing and detail what information is inaccurate and why. Please note that a request for an amendment does not necessarily indicate the information will be amended.

- **You have a right to receive an accounting of certain disclosures:** You have the right to receive an accounting of disclosures of your Protected Health Information. An "accounting" being a list of the disclosures that we have made of your information. The request can be made for paper and/or electronic disclosures and will not include disclosures made for the purposes of: treatment; payment; healthcare operations; notification and communication with family and/or friends; and those required by law.

- **You have the right to request restrictions of your Protected Health Information:** You have a right to restrict and/or limit the information we disclose to others, such as family members, friends, and individuals involved in your care or payment for your care. You also have the right to limit or restrict the information we use or disclose for treatment, payment, and/or healthcare operations. Your request must be submitted in writing and include the specific restriction requested, to whom you want the restriction to apply, and why you would like to impose the restriction. Please note that our practice/your physician is not required to agree to your request for restriction with the

exception of a restriction requested to not disclose information to your health plan for care and services in which you have paid in full out-of-pocket.

- **You have a right to request to receive confidential communications:** You have a right to request confidential communications from us by alternative means or at an alternative location. For example, you may designate we send mail only to an address specified by you which may or may not be your home address. You may indicate which telephone numbers we should use to call and leave messages. You do not have to disclose the reason for your request; however, you must submit a request with specific instructions in writing.

- **You have a right to receive a paper copy of this notice:** Even if you have agreed to receive an electronic copy of this Privacy Notice, you have the right to request we provide it in paper form. You may make such a request at any time.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this notice and will notify you of such changes. We will also make copies available of our new notice if you wish to obtain one.

COMPLAINTS

If at any time you believe your privacy rights have been violated and you would like to register a complaint, you may do so with us or with the Secretary of the United States Department of Health and Human Services. If you wish to file a complaint with us, please submit it in writing to our Privacy/Compliance Officer to the address listed on the first page of this Notice. If you wish to file a complaint with the Secretary of the United States Department of Health and Human Services, please go to the website of the Office for Civil Rights (www.hhs.gov/ocr/hipaa/), toll free 877-696-6775, or mail to:

Secretary of the US – Department of Health and Human Services
200 Independence Ave S.W.
Washington, D.C. 20201

We will not retaliate against you for filing a complaint.

HIPAA Privacy Notice Acknowledgement

We are required by law to provide individuals with this notice of our legal responsibilities and privacy practices with respect to Protected Health Information. We are also required to maintain the privacy of, and abide by the terms of, the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at the main number listed on the first page of this notice.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices.

Print Name_____

Signature_____

Date_____