Welcome to
Rockville Concierge Doctors

An Internal Medicine Practice Serving Rockville and the Montgomery County Community since 2006

Health insurance does not guarantee good health care! We provide patient-centered health care, the way it used to be, while using the latest advancements in medicine and technology.

The benefits of joining our practice are numerous:

ACCESS – Same day or next day appointments. No waiting. Contact your personal physician via their cell phone, email, or answering service anytime, day or night. A phone consultation will often prevent an office visit.

QUALITY OF CARE – Your personal physician spends the time necessary to invest in your health and address any questions you or your designated loved ones have. The average office visit for our patients is 30 minutes or longer, versus the national average of six minutes. Our physicals last 90 minutes.

CARE COORDINATION – Your personal physician is your medical advocate and will coordinate all of your healthcare needs, including specialist care as medically necessary.

LIMITED PRACTICE SIZE – We limit the number of patients each doctor sees to less than 20% of a traditional practice. The average traditional medical practice has over 2,300 patients. Aimee Seidman, M.D. limits her practice to 400 patients.

ANNUAL PHYSICAL – A comprehensive health and wellness assessment.

WELLNESS PROGRAMS – Such as heart disease prevention, smoking cessation, and osteoporosis prevention, to name a few.

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

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.

☐ 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 $1,800.00 [Total $1,800.00].
☐ Semi-annually: 2 payments of $927.00 [Total $1,854.00].

If 40 to 67 years old, inclusive:
☐ Annually: 1 payment of $2,400.00 [Total $2,400.00]. Deduct 10% [Total $2,160.00] 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 $1,236.00 [Total $2,472.00]. *Deduct 10% [2 payments of $1,112.50, Total $2,225.00] 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 $2,580.00 [Total $2,580.00]. Deduct 10% [Total $2,322.00] 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 $1,328.50 [Total $2,657.00]. *Deduct 10% [2 payments of $1,196.00, Total $2392.00] 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 $3,180.00 [Total $3,180.00]. *Deduct 10% [Total $2,862.00] 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** _____

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 physical.
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 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 thirty (30) days' written notice. If the Agreement is terminated prior to the completion of one full year, I will remain obligated to pay any unpaid annual Retainer Fee, and I will not be entitled to a refund of any portion of the Retainer Fee.

In the event the practice terminates this Agreement, the practice will continue to provide medically necessary primary care services during the thirty (30) day notice period to allow reasonable time for the patient to establish care with another primary care provider. Upon written request, the practice will also provide copies of medical records in accordance with applicable law.

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 _____

Rockville Concierge Doctors

Aimee Seidman, M.D., FACP

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 we may leave a message 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 _____

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** _____

Place of Employment _____

Emergency Contact _____ **Phone** _____

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** _____

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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 explains how we may use and disclose your Protected Health Information (PHI) for purposes related to treatment, payment, healthcare operations, and other uses permitted or required by law. It also outlines your rights regarding access to and control of your Protected Health Information. "Protected Health Information" refers to information that identifies you individually, including demographic information and details related to your past, present, or future physical or mental health condition and related healthcare 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 and to coordinate your medical care. For example, we may share your medical information with other physicians, healthcare providers, hospitals, laboratories, pharmacies, rehabilitation therapists, home health providers, or other medical personnel as necessary to diagnose and provide treatment.

- Payment: Your Protected Health Information may be used to obtain payment for healthcare services provided to you. For example, we may provide your health insurance company with information needed to process claims, determine eligibility, obtain prior authorizations, or reimburse services rendered.

- Healthcare Operations: We may use and disclose your Protected Health Information to support the daily operations of our practice. These activities may include quality assessment, employee review, licensing, training, scheduling, and other administrative functions. We may also contact you regarding appointment reminders, treatment alternatives, or other health-related benefits and services that may be of interest to you.

- Required by Law: We may use or disclose your Protected Health Information when required to do so by federal, state, or local law. Examples include reporting communicable diseases, responding to court orders or legal proceedings, complying with government regulations, workers' compensation claims, law enforcement requests, and disclosures required by the Department of Health and Human Services for compliance investigations.

Uses and Disclosures in Which You Have the Right to Object and Opt Out

- Communication with Family and Individuals Involved in Your Care: Unless you object, we may disclose your Protected Health Information to a family member, friend, or other individual involved in your care or payment for your care, when you have identified that person as involved in your healthcare.

- Disaster Relief: In the event of a disaster, your Protected Health Information may be disclosed to disaster relief organizations to assist in coordinating your care or notifying family members or friends of your location and condition. Whenever possible, we will provide you with an opportunity to agree to or object to such disclosures.

Protected Health Information and Your Rights

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

- **You have the right to inspect and copy your Protected Health Information:** Upon written request, you may inspect and obtain a copy of your Protected Health Information in paper or electronic format. Certain records may be restricted under federal or state law, including psychotherapy notes, information related to legal proceedings, research information under confidentiality agreements, or information that could result in harm to yourself or others if disclosed. We may charge a reasonable fee associated with copying or providing records.

- **You have the right to request a summary or explanation of your Protected Health Information:** You may request a summary of your medical information instead of receiving a complete copy of your medical record. You may also request an explanation of the information contained in your record.

- **You have the right to obtain an electronic copy of your medical record:** You may request an electronic copy of your medical record for yourself or direct that it be sent to another individual or organization if the information is maintained electronically. We will attempt to provide records in your requested format whenever reasonably possible. Requests may be subject to a reasonable, cost-based fee for preparation or transmission.

- **You have the right to receive notice of a breach:** In the event of a breach involving your unsecured Protected Health Information, you have the right to be notified in accordance with applicable law.

- **You have the right to request amendments:** If you believe the Protected Health Information, we maintain about you is inaccurate or incomplete, you may submit a written request asking that the information be amended. Your request should explain the reason for the requested amendment. Please note that submitting a request does not guarantee the amendment will be made.

- **You have the right to receive an accounting of disclosures:** You may request a list of certain disclosures we have made from your Protected Health Information. This accounting will not include disclosures made for treatment, payment, healthcare operations, communications with individuals involved in your care, or disclosures otherwise permitted by law.

- **You have the right to request restrictions on your Protected Health Information:** You may request restrictions on the way we use or disclose your Protected Health Information for treatment, payment, or healthcare operations, or to individuals involved in your care. Requests must be submitted in writing and include the specific restriction requested and the reason for the request. While we will consider all requests, we are not required to agree to every restriction requested.

- **You have the right to request confidential communication:** You may request that we communicate with you using alternative methods or at alternative locations. For example, you may request that correspondence be sent to a different mailing address rather than your home address or specify which phone numbers we may use to contact you or leave messages. You are not required to explain the reason for your request; however, all requests must be submitted in writing with specific instructions.

- **You have the right to receive a paper copy of this notice:** Even if you have agreed to receive this Notice of Privacy Practices electronically, you may request a paper copy at any time.

Changes to This Notice

We reserve the right to change the terms of this Notice of Privacy Practices and to make the revised notice effective for all Protected Health Information we maintain. Updated copies of this notice will be made available upon request and posted in our office as required by law.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the United States Department of Health and Human Services. To file a complaint with our office, please submit your concern in writing to our Privacy/Compliance Officer at the address listed on the first page of this notice.

You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

Secretary of the U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201
Website: www.hhs.gov/ocr/hipaa
Phone: 877-696-6775

We will not retaliate against you for filing a complaint.

HIPAA Privacy Notice Acknowledgement

We are required by law to provide you with this Notice of Privacy Practices describing our legal duties and privacy practices regarding your Protected Health Information. We are also required to maintain the privacy of your information and to abide by the terms of the notice currently in effect. If you have any questions regarding this notice, please contact our HIPAA Compliance Officer using the information listed on the first page of this document.

Your signature below acknowledges that you have received this Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____