8186 Lark Brown Road Elkridge MD 21075
10981 Johns Hopkins Road Laurel MD 20723
(410) 730-3399

RECEIPT OF NOTICE OF PRIVACY PRACTICE

YEAR: _____

WRITTEN ACKNOWLEDGEMENT FORM

We have the Patient Privacy Act/HIPAA notations in our office for your convenience. Please ask if you would like a copy.

My signature below indicated I, (print full name) _____ have been given the opportunity to read and review the policy and ask questions.

Patient Signature: _____ Date: _____

Date of Birth: _____

Signature of Parent or Legal Guardian: _____ Date: _____

Relationship to patient: _____

MISSED APPOINTMENT FEE

As a courtesy, we provide appointment reminder via call, text and/or email message. We require a **24-hour notice** in the event that you need to reschedule or cancel your appointment. This gives us time to schedule other patients who may be waiting for an appointment. Patients who do not attend a scheduled appointment or do not provide a 24-hour notice will be assessed a **fee of $35**. This fee cannot be billed to insurance. If you do not receive a reminder call, text and/or email message, this policy will remain in effect.

My initials indicate I have read and understand the missed appointment fee policy and agree to its terms._____ (Initials)

DOCUMENTATION FEE

If you are in need of forms to be completed by our Providers, there is a **24-hour turnaround time** and a **fee of $40** form completion charge. This includes any forms you present at the appointment as well, except a DOT physical.

My initials indicate I have read and understand the documentation fee policy and agree to its terms. _____ (Initials)

PRESCRIPTION REQUEST

All prescription approval may take up to **48-72-hour turnaround time**, so do not wait to submit your request. All prescriptions require a follow up appointment every 3 to 6 months. New prescriptions or symptoms require an office visit. In order to simplify the process, please have your pharmacy contact us.

My initials indicate I have read and understand the prescription request policy and agree to its terms. _____ (Initials)

We have chosen to participate in the Chesapeake Regional Information System for our patients (CRISP), a regional health information exchange serving Maryland and D.C. 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 competing 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.

For Office Use Only

- ☐ Patient/Parent/Guardian refused to sign.
- ☐ Patient was unable to sign because of: _____.
- ☐ Other: _____.

Printed name of staff: _____

Signature of staff: _____ Date: _____