Chesapeake
HEALTH CARE

P.O. Box 1978
Salisbury, MD 21802-1978
Office 410-749-1015 Fax 410-749-1020

CHC OFFICE POLICY

Dear Patient:

Welcome. To help acquaint you with the office, we have prepared a few words about our policies and fee schedule. Please read this and sign below indicating that you understand the guidelines.

Your Appointment

Your appointment is set aside for you and your provider. Please understand that we allow a significant amount of time for each patient. Please notify us to cancel a day ahead. CHC will endeavor to contact patients 48 hours in advance to confirm your appointment. Reporting patient concerns: Chesapeake Health Care encourages you to bring any concerns or complaints about safety and quality of care to our attention. To contact us, call the CHC office telephone number where you receive care and ask to speak to the Administrator or designee.

FINANCIAL POLICY DISCLOSURE/PAYMENT AGREEMENT

GUARANTEE OF PAYMENT: Chesapeake Health Care will submit billing for medical services to your insurance company on file; however, the amount remains the responsibility of the guarantor/patient. Co-payments are expected at the time of service.

AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION: Patient hereby authorizes Chesapeake Health Care to release my diagnosis and other patient information to the third parties in order to secure payment for services rendered by the CHC provider and other healthcare providers.

Current Fee Schedule:

- Chesapeake Health Care has a set fee schedule for evaluations and management of patients as well as procedures.
- Patients are required to present their insurance card during all visits, if they have one. If you have a change of address or insurance, please notify us.
- If uninsured, a minimal payment is expected at the time of the visit, according to the CHC Sliding Fee Scale Policy.

Positive Account Balances and Proof of Income for Sliding Fee Scale Patients:
The Medical Receptionist will go over your balance privately. It is your obligation to provide evidence of income if you apply for the Sliding Fee Scale. If the undersigned fail(s) to present evidence of income after applying for the sliding scale, the undersigned will be paying the full price for the previous and subsequent visits. We reserve the right to collect unpaid balances.

I certify that I understand the contents of the CHC Policy and all information given is accurate and correct. A photocopy of this agreement will be valid.

Patient or Guardian (if a minor) -- *please print*	Witness -- *please print*
Patient or Guardian (if a minor) Signature	Witness Signature
Date	Date

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" PLEASE PRINT "

If label unavailable, Patient/Guardian: Please complete information below:

Patient Name_____

Patient Date of Birth_____

Authorization and Consent to Treatment

1. I consent to and authorize the administration of all routine ambulatory clinical care, the performance of all examinations, diagnostic procedures and treatment, including medical, surgical or X-ray procedures or treatment, which in the judgment of my attending physician/dentist/clinician, may be necessary or desirable for my medical care.

    a. I understand that in the event my attending physician/dentist/clinician believes treatment involving material risks to me or my health is indicated, he will explain those risks to me before such treatment is administered.
    b. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examination in the clinic.
    c. I understand that Chesapeake Health Care (CHC) participates in the training of medical students, nurses, and allied health students who may observe or participate in patient care while under the supervision of a credentialed provider.

2. I consent to the release of protected health information (PHI) for the purpose of carrying out treatment, payment, and health care operations. However, I have the right to request CHC to restrict the use or disclosure of protected health information (PHI) for treatment, payment and health care operations (TPO). Chesapeake Health Care is not required to agree to such restrictions.

3. I acknowledge that Chesapeake Health Care has provided me a copy of the Notice of Privacy Practice (NPP) on or after April 14, 2003, and has made me aware that I have the right to review such notice to giving consent. CHC reserves the right to change the terms of the NPP as necessary. The NPP may be revised at the direction of the Privacy Officer.

    Acknowledgement of NPP and CHC Patients' Rights Notice: _____ (Please initial)

4. To provide coordination and continuity of care, I consent to a query of my medication claims to my insurance company, allowing electronic entry of my prescribed medications in my chart. _____ (Please initial)

5. I also understand my rights and obligations in the physician-patient relationship I establish with CHC providers. I will follow up advice given by my provider and come for appointments as scheduled. If I decide to cancel my appointment, I will call CHC or inform them in writing.

6. Behavior deemed unacceptable (verbal/physical abuse, drug contract violation) by providers at CHC, will be addressed and may result in discharge from CHC. _____ (Please initial)

PLEASE CALL TO CANCEL APPOINTMENTS

7. This form has been fully explained to me and I certify that I understand its contents.

_____ _____ _____
Provider or Patient Service Rep. Signature | Patient or Legal Guardian Signature | Date

_____ _____ _____
Provider or Patient Service Rep. Name (printed) | Patient or Legal Guardian Name (printed) | Date

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PATIENT INFORMATION FORM

" PLEASE PRINT "

Date:_____

PATIENT INFORMATION

Name _____
Address _____
City _____
State _____ Zip_____
Social Security # _____
Date of Birth _____
Homeless_____ Migrant worker_____ Seasonal farm worker_____
Language best served _____
Usual provider_____

CHART # _____
Home Phone _____
Work Phone _____
Cell Phone _____
Pager _____
Race_____
Sex_____ Marital Status_____
Email Address:_____
Disaster Identifier_____

Are you a patient in any other department at TLC? (Please circle all that apply)

Pediatrics **Adult Medicine** **Ob/Gyn** **Dental** **Mental Health**

EMPLOYMENT INFORMATION

Employer _____ Phone _____
Address _____
City _____ State_____ Zip_____

PARENT / GUARDIAN / SPOUSE CONTACT

Parent/Guardian _____
Address _____
City _____
State _____ Zip_____

Home Phone _____
Work Phone _____
Cell Phone _____
Pager _____

Person to contact in case of an emergency_____
Relationship _____ Phone _____

INSURANCE INFORMATION

☐ Medical ☐ Dental ☐ Mental Health

Insurance Co. _____
Street Address _____
Subscriber Name _____
Cert/Mem ID # _____
Group Number _____
Subscriber Relationship to Patient _____
Effective date_____ Expiration date_____

City _____
State/Zip _____
Subscriber Employer _____
Subscriber D.O.B._____
Subscriber SSN _____
Subscriber Phone _____

Do you have additional Insurance? (Circle One) YES NO

If Yes, please complete the following:

Insurance Co. _____
Street Address _____
Subscriber Name _____
Cert/Mem ID # _____
Group Number _____
Subscriber Relationship to Patient _____

City _____
State/Zip _____
Subscriber Employer _____
Subscriber D.O.B._____
Subscriber SSN _____
Subscriber Phone _____

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PERMISSION TO DISCUSS MEDICAL CARE

" PLEASE PRINT "

I give permission for _____,
(Name)

_____, _____,
(Date of Birth) (Relationship to Patient)

_____ to discuss my medical care, including test results
(Phone)

ordered by this office, with Dr. _____ and

any member of the staff at Chesapeake Health Care.

_____ _____
Signature Printed Name of Patient

_____
Date

Chesapeake
HEALTH CARE

P.O. Box 1978 Salisbury, MD 21802
Medical Records Fax Nos:
Berlin 410-973-2843
PMD Peds 410-219-5976
Pocomoke 410-957-0152
Princess Anne 410-651-1077
Riverside MH 443-358-6194
Sweetbay MH 410-219-3446
Woodbrooke Adult Med. 410-546-2656
Woodbrooke GYN 410-742-6633

" PLEASE PRINT "

Authorization for Release of Medical Records

Patient's name_____ DOB_____ SS# _____

Address_____ Phone _____

1. **Persons or group of persons authorized to use/disclose this information and purpose:**

☐ Chesapeake Health Care Phone_____ Fax_____ Purpose: ☐ My personal health records
☐ Transferring to another provider
☐ Sharing information with another provider
☐ Other _____

☐ _____
Name of physician/provider

_____
Street State Zip

2. **Persons or group of persons authorized to receive this information:**

☐ Chesapeake Health Care Phone_____ Fax_____ ☐ Me

☐ _____
Name

_____ _____ _____
Street State Zip Telephone Fax

3. **Description of information to be used or disclosed:** *(Please mark box with an X)* **Date Range:**

☐ Copies by mail ☐ Records of health care ☐ Mental Health records ☐ HIV information ☐ Shot records
☐ Dental records ☐ X-ray & other images ☐ Lab Results

4. I understand that the person I am authorizing to use/disclose my protected health information may receive compensation for doing so. _____ (patient initials)

   I understand that I may refuse to sign this authorization and that if I do, it will not affect my ability to obtain treatment or payment or eligibility for benefits and that I may inspect or copy any information used or disclosed under this authorization. _____ (patient initials)

5. I understand that if the party receiving this information is not a health care provider or health plan subject to the federal privacy regulations that the information described above may be redisclosed and no longer protected by the privacy regulations.
   _____ (patient's initials)

6. I understand that I may revoke this authorization in writing at any time except to the extent that action on this authorization has not already occurred and that my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 and 164._____(patient's initials)

7. This authorization becomes effective _____ and will expire on _____.
   Date *Date*

_____ _____ _____ _____
Patient (or Representative) Signature *Patient (or Representative) Printed Name* *Relationship to Patient* *Date*

_____ _____ _____
Witness Signature *Witness Printed Name* *Date*

Chesapeake
HEALTH CARE

NOTICE OF PRIVACY PRACTICES

www.Chesapeakehc.org

We may use and disclose your personal health information for these purposes:

For Treatment: We may use and disclose health information about you to doctors, nurses, technicians, medical students, and others who are involved in your care.

For Payment: We may use and disclose health information about you to bill and collect payment for the treatment and services provided to you. We may also provide this information to your health insurance plan to process claims or get pre-approval for coverage of treatment.

For Health Care Operations: We may use and disclose health information about you to operate this clinic, to assist other providers involved in your care, to ensure quality care, and to evaluate the performance of our staff in caring for you.

Appointment Reminders & Health-Related Services: We may use and disclose health information about you to provide appointment reminders, or give you information about treatment alternatives or other health-related services that we offer.

Disclosures To Family, Friends, Or Others: We may release health information about you to a friend or family member who is involved in your health care or to the person who helps pay for your care.

Research: Under certain circumstances, we may use and disclose health information about you for research purposes, which would be subject to a special approval process.

For Purposes Of Organ Donation: We may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.

As Required By Law: We will disclose health information about you when required to do so by federal, state, or local law.

To Avert A Serious Threat To Health Or Safety: We may use and disclose health information about you if necessary to prevent serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military & Veterans: If you are a member of the armed forces or separated/discharged from military services, we may use and disclose health information about you as required by military command authorities or the Department of Veterans Affairs, as may be applicable.

Workers' Compensation: We may use and disclose health information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Public Health Activities: We may release health information about you to prevent or control disease, injury or disability and to report: births and deaths, child abuse or neglect, medication reactions or problems, product recalls, and to notify of exposure to disease. We also may notify the appropriate authority if we believe a patient has been the victim of abuse, neglect or domestic violence when required by law.

Health Oversight Activities: We may provide information to assist the government when conducting an investigation or inspection of a health care provider or organization.

Lawsuits and Disputes: We may use and disclose health information about you in response to a court or administrative order, a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request or obtain an order protecting the information requested.

Law Enforcement: We may release health information about you if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, or summons; or to identify or locate a suspect, fugitive, material witness or missing person; or under certain circumstances, about the victim of a crime or criminal conduct at the clinic.

For Specific Government Functions: We may use and disclose health information about you to authorized federal officials for intelligence and other legal national security activities; or provide protection to the President or foreign heads of state. We may also release health information about you to a coroner or health examiner.

Inmates: Only if a release of health information would be necessary for the institution to provide health care, to protect your health and safety, or for the safety and security of the correctional institution.

Other: Other uses and disclosures of your personal health information that are not described in this Privacy Notice, including psychotherapy notes, would require your prior written authorization. You can revoke this written authorization at any time in writing. We would not be able to take back any uses we had already made with your authorization prior to revoking it.

Fundraising Activities: We do not engage in using personal health information to raise funds for our organization.

Marketing: We do not use personal health information for marketing purposes.

Sale of Personal Health Information: We do not sell personal health information.

CRISP: We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide health information exchange. 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 all 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.

YOUR RIGHTS

Right To Inspect And Copy: You can inspect and copy your personal health information in your records, upon a written request. In certain very limited circumstances, your request may be denied; you can then request that the denial be reviewed. We will comply with the outcome of the review.

Right to Amend: If you feel information maintained about you is incorrect or incomplete, you can request an amendment to your record in writing, and it must contain a reason to support your request for an amendment. We may deny your request if it is not in writing or legible or if it was not created by us, is not part of the health information kept by or for the health center, is not part of the information which you would be permitted to inspect and copy, or if the information is accurate and complete.

Right To Receive An Accounting Of Disclosures: Any accounting will not include uses or disclosures that you have already consented to, such as those made for treatment or with a written authorization, those that went to a family member/friend involved in your care when you gave us permission to, or to law enforcement officials. The request needs to be in writing.

Right To Request Restrictions: You have the right to ask that we limit how we use and disclose your information, except disclosures we are legally required to make. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member. We are not required to agree to your request if it is not feasible for us to comply or if we believe that it will negatively impact our ability to care for you. If we agree, however, we will comply with your request except in emergency situations. Requests must be in writing.

Right To Receive Confidential Communications: You can request in writing that we communicate with you about health matters in a certain way. For example, you can ask that we contact you at work only, or by mail to a specified address. We will accommodate all reasonable requests and we will not ask you the reason for your request.

Right to a paper copy of this Notice: You have the right to receive a copy of this Notice at any time. Please request it from our Privacy Officer in writing.

Right to receive electronic copies of health information upon request.

Right to Restrict Personal Health Information Disclosures to a health plan concerning treatment for which the individual has paid out of pocket.

Right to receive notification in the event of improper personal health information disclosure.

Right to or will receive notifications of your unsecured patient health information.

OUR PLEDGE:

CHC is a multidisciplinary health center. We understand that health information about you and the care you receive is personal. We are committed to protecting your personal health information. When you receive treatment and other health care services from us, we create an electronic health record of the services that you received. We need this record to provide you with quality care and to comply with legal requirements. This notice applies to all of our records about your care, whether made by our health care professionals or others working in this office, and it tells you about the ways in which we may use and disclose your personal health information. This notice also describes your rights with respect to the health information that we keep about you and the obligations that we have when we use and disclose your health information.

We are required by law to:

1. Make sure that health information that identifies you is kept private in accordance with relevant law.
2. Give you this notice of our legal duties and privacy practices with respect to your personal health information.
3. Follow the terms of the notice that is currently in effect for all of your personal health information.

HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights or you disagree with a decision we made about access to your personal health information, you may file a complaint with the person listed below.

Privacy Officer
CHC
P. O. Box 1978
Salisbury, MD 21802
410-749-1015

You also may send a written complaint to the Regional Manager, Office of Civil Rights, U.S. Department of Health and Human Services, 150 S. Independence Mall, Suite 372, Philadelphia, PA 19106. We will take no retaliatory action against you if you file a complaint against our privacy practices.

This Notice went into effect
April 14, 2003.

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment.

Advance Directives Information Sheet

What You Should Know About Advance Directives

Everyone has the right to make personal decisions about health care. Doctors ask whether you will accept a treatment by discussing the risks and benefits and working with you to decide. But what if you can no longer make your own decisions? Anyone can wind up hurt or sick and unable to make decisions about medical treatments. An advance directive speaks for you if you are unable to and helps make sure your religious and personal beliefs will be respected. It is a useful legal document for an adult of any age to plan for future health care needs. While no one is required to have an advance directive, it is smart to think ahead and make a plan now. If you don't have an advance directive and later you can't speak for yourself, then usually your next of kin will make health care decisions for you. But even if you want your next of kin to make decisions for you, an advance directive can make things easier for your loved ones by helping to prevent misunderstandings or arguments about your care.

What can you do in an advance directive?

An advance directive allows you to decide who you want to make health care decisions for you if you are unable to do so yourself. You can also use it to say what kinds of treatments you do or do not want, especially the treatments often used in a medical emergency or near the end of a person's life.

1. **Health Care Agent.** Someone you name to make decisions about your health care is called a "health care agent" (sometimes also called a "durable power of attorney for health care," but, unlike other powers of attorney, this is not about money). You can name a family member or someone else. This person has the authority to see that doctors and other health care providers give you the type of care you want, and that they do not give you treatment against your wishes. Pick someone you trust to make these kinds of seridecisions and talk to this person, to make sure he or she understands and is willing to accept this responsibility.
2. **Health Care Instructions.** You can let providers know what treatments you want to have or not to have. (Sometimes this is called a "living will," but it has nothing to do with an ordinary will about property.) Examples of the types of treatment you might decide about are:
    a. Life support—such as breathing with a ventilator
    b. Efforts to revive a stopped heart or breathing (CPR)
    c. Feeding through tubes inserted into the body
    d. Medicine for pain relief

    Ask your doctor for more information about these treatments. Think about how, if you become badly injured or seriously ill, treatments like these fit in with your goals, beliefs, and values.

How do you prepare an advance directive?

Begin by talking things over, if you want, with family members, close friends, your doctor, or a religious advisor. Many people go to a lawyer to have an advance directive prepared. You can also get sample forms yourself from many places, including the ones given as examples at the end of this information

sheet. There is no one form that must be used. You can even make up your own advance directive document.

To make your advance directive valid, it must be signed by you in the presence of two witnesses, who will also sign. If you name a health care agent, make sure that person is not a witness. Maryland law does not require the document to be notarized. You should give a copy of your advance directive to your doctor, who will keep it in your medical file, and to others you trust to have it available when needed. Copies are just as valid as the originals.

You can also make a valid advance directive by talking to your doctor in front of a witness.

When would your advance directive take effect?

Usually, your advance directive would take effect when your doctor certifies in writing that you are not capable of making a decision about your care. If your advance directive contains health care instructions, they will take effect depending on your medical condition at the time. If you name a health care agent, you should make clear in the advance directive when you want the agent to be able to make decisions for you.

Can you change your advance directive?

Yes, you can change or take back your advance directive at any time. The most recent one will count.

Where can you get forms and more information about advance directives?

There are many places to get forms, including medical, religious, aging assistance, and legal organizations. Three places are shown below, but these are just examples. Any of these forms are valid in Maryland, but not all may be in keeping with your beliefs and values. Your advance directive does not have to be on any particular form.

Call the Maryland Attorney General's Office
410-576-7000 or 1-888-734-0023
www.oag.state.md.us/healthpol/adirective.pdf

Call Caring Connections (NHPCO)
1-800-658-8898
www.caringinfo.org

Call Aging with Dignity
1-800-594-7437
www.agingwithdignity.org

In an emergency situation, people may not be able to get to their medical records. The **Keep It With You (KIWY) Personal Medical Information Form** is intended to be a voluntary and temporary record that lists medical care and other health information for people who need care during disasters and similar situations. It is important for health care workers to have a simple and reliable way to learn information about past and new health concerns for people receiving help.

Directions: Please fill in as much information as you can on the form. It is okay if you don't fill out every space. You might want to use a pencil if some information will change such as your address. Some information will be filled out by a health care worker, like "Active Diagnoses" and "Health Care Encounters" information. If you have an Immunization Card listing the shots you have had recently, please staple it to this form. You can store this form in a plastic bag for safe keeping.

For Health Care Workers: The KIWY form is not intended to replace hardcopy or electronic medical records, but is an interim communication tool to assist people as they navigate a potentially complex system of temporary support, housing, and clinical services. Clinicians are encouraged to adapt this format and content as necessary. It is suggested that care providers **photocopy** the document after an individual receives care, in order to maintain a record of their treatment. The original form is intended to **remain with the individual** during the time they are displaced.

HOW TO CONTACT US

Chesapeake Health Care

BERLIN, MD

9956 North Main St., Suite #2
Adult Medicine
Pediatrics
Mental Health
410-973-2820

PRINCESS ANNE, MD

12165 Elm Street
Dental
410-651-5151

12145 Elm Street
Adult Medicine Pediatrics
Ob/Gyn Mental Health
410-651-1000

Pharmacy
410-651-5555

POCOMOKE CITY, MD

305 Tenth Street, Suite 104
Adult Medicine
Pediatrics
Mental Health
410-957-1852

SALISBURY, MD

1615 Tree Sap Ct.,
Dental Pharmacy
443-944-9600 410-677-0561

1813 Sweetbay Dr.
Mental Health
410-219-5483

560 Riverside Dr.
Suite A-204
Mental Health
443-358-6193

223 Phillip Morris Dr.
Pediatrics
410-548-1747

1665 Woodbrooke Drive
Adult Medicine
410-546-6650

1647 Woodbrooke Drive
Ob/Gyn
Maternal Fetal Medicine
410-546-2424

www.chesapeakehc.org

Chesapeake
HEALTH CARE

KEEP IT WITH YOU

PERSONAL MEDICAL INFORMATION FORM

FOR PEOPLE WHO NEED CARE DURING DISASTERS

This pamphlet can be kept in a plastic bag for safe keeping in case of an emergency

www.chesapeakehc.org

01.17.19

HEALTHCARE ENCOUNTERS

Date_____ Location_____
Symptoms/Diagnoses_____
_____
Tests/Results _____
Treatment/Follow-up Needs _____
_____

Date_____ Location_____
Symptoms/Diagnoses_____
_____
Tests/Results _____
Treatment/Follow-up Needs _____
_____

Date_____ Location_____
Symptoms/Diagnoses_____
_____
Tests/Results _____
Treatment/Follow-up Needs _____
_____

Date_____ Location_____
Symptoms/Diagnoses_____
_____
Tests/Results _____
Treatment/Follow-up Needs _____
_____

Date_____ Location_____
Symptoms/Diagnoses_____
_____
Tests/Results _____
Treatment/Follow-up Needs _____
_____

Notes:_____
_____
_____
_____

PERSONAL INFORMATION

Name_____
Date of Birth____/____/___ Male__ Female__
E-mail address_____
Home address _____
_____
City _____
State_____ Zip_____
Phone Number_____

Temporary Address _____
_____
City_____
State_____ ZIP_____
Phone Number_____

Previous evacuee center location(s):
Facility_____ City_____
Facility_____ City_____
Facility_____ City_____
Facility_____ City_____

ID Number/Case Number (if available):
_____
Parent/Guardian/Other Support Person:
Name_____
Phone # or other contact info _____
_____
Relationship_____

ACTIVE DIAGNOSES:

ALERTS:

DOCTOR OR CLINIC BEFORE EVALUATION (if known):

Name _____
City_____ State_____

ALLERGIES:

ACTIVE MEDICATIONS

Name of pharmacy chain (if known)
_____
Medication _____
Instructions_____
Medication _____
Instructions_____
Medication _____
Instructions_____
Medication _____
Instructions_____
Medication _____
Instructions_____
Medication _____
Instructions_____
Medication _____
Instructions_____
Medication _____
Instructions_____
Medication _____
Instructions_____
Medication _____
Instructions_____

Immunizations received since Evacuation_____
_____
_____
_____
_____
Attach immunization card if you have one.