Welcome New Patient

We at the Center for Integrative Medicine Clinic are looking forward to partnering with you to meet your health needs. Our physicians are board certified and trained in Integrative Medicine. We offer primary care services, as well as consultations and other therapies. We are excited to assist you in creating a plan for optimal health and to address your unique needs.

Your First Consultation
This appointment will last approximately 60 to 90 minutes. You will be asked to provide information regarding your past medical history and your current symptoms. Please remember to arrive 10-15 minutes early for your appointment, bring any supplements or prescriptions you are currently taking and your insurance card. After this appointment, your physician will make recommendations concerning further treatments and/or other options.

Attached you will find all of the paperwork necessary for your first visit. This paperwork should be filled out completely and brought with you to the clinic. Please see the attached directions to our clinic. Parking is free at Kernan Hospital. If you have any questions concerning the paperwork or our clinic call us at 410-448-6361.
By Car:
Parking is plentiful and free on Kernan’s campus. Handicapped parking is available near the main entrance. There also is a drop-off/pick-up area.

From the Beltway (695): Take exit 17 East onto Security Boulevard (Woodlawn). Approximately two miles east of the Beltway, turn left at the light onto Kernan Drive and follow it across Windsor Mill Road into the hospital driveway.

From I-70 (or Beltway exit 16): Follow “Local Traffic” to Security Boulevard. At the second light, turn right onto Kernan Drive and follow it across Windsor Mill Road into the hospital driveway.

From Rt. 40 West (Baltimore City): Make a right at Cooks Lane and follow onto Security Boulevard. Turn right onto Kernan Drive and follow it across Windsor Mill Road into the hospital driveway.

By Bus:
Westbound (from downtown Baltimore) The #15 bus (“Social Security/Social Security Square Mall”) goes past the main entrance of Kernan Hospital on Windsor Mill Road then turns left onto Kernan Drive. Get off at the first stop on Kernan Drive and walk back to the hospital

Eastbound (toward downtown Baltimore) The #15 bus (“Downtown”) goes up Kernan Drive. As you approach your stop, you will see the main entrance to Kernan Hospital straight ahead. Get off at the last stop on Kernan Drive before the bus turns right onto Windsor Mill Road.

By Cab:
Arrow Cab: 410-358-9696
Yellow Cab: 410-685-1212
County Cab: 410-788-8000

By Air:
Kernan Hospital is approximately a 30-minute drive from Baltimore Washington International Airport, approximately 60 minutes from Washington National Airport.

For more information, call the Mass Transit Administration at (410) 539-5000.
Integrative Medicine
No Show/Cancellation Policy

Effective: October 3\textsuperscript{rd}, 2013

\textit{Background}

When patients don’t show up or cancel on a same-day basis, we are unable to make the appointment available to someone else. This has a negative impact on our appointment availability, as well as what we have to charge for services. So, like many practices, we have implemented a No Show/Cancellation policy.

\textit{Policy}

If you fail to notify the practice of your need to cancel or reschedule an appointment, or if you fail to show up for a scheduled appointment, we will charge you for the visit. We will use a schedule of charges that is based on the usual charge for that visit type.

\textit{Expected Outcome}

We hope not to need to impose any charges under this policy. We understand that schedules change and there is a need to reschedule appointments. We are asking for sufficient notice of that to allow us to make the appointment available to another person.

Thank you for your attention to this policy change,

Administration
UNIVERSITY OF MARYLAND
CENTER FOR INTEGRATIVE MEDICINE, LLC
Kernan Hospital
2200 Kernan Drive
2nd Floor North
Baltimore, MD 21207

PATIENT HEALTH HISTORY QUESTIONNAIRE
(To be kept as part of your confidential Medical Records)

Patient’s Name:________________________Medical Record Number:________________________
Today’s Date:________________________Patient’s Date of Birth:________________________
Person completing this form:________________________
Do you have any allergies or have you had any reactions to any medications? □ YES □ NO
Please list medicines and reactions:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Do you have a living will? □ YES □ NO (if no please ask medical assistant for one)

Please list all medicine/vitamins/herbs you are currently taking:

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<tr>
<th>Name:</th>
<th>Strength (mg):</th>
<th>Taken how:</th>
<th>First started when:</th>
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PAST MEDICAL AND FAMILY HISTORY REVIEW:

Have you had or do you currently have: If a family member has suffered from this as well, please tell us how they are related to you:

Diabetes ("sugar") .................. □ YES □ NO
Glaucoma .............................. □ YES □ NO
Bleeding disorder or blood disease .... □ YES □ NO
Asthma or hay fever .................. □ YES □ NO
High blood pressure .................. □ YES □ NO
Stroke ................................ □ YES □ NO
Heart attacks or chest pain ........... □ YES □ NO
Seizures, convulsions, blackouts ...... □ YES □ NO
Cancer: type _____________________ □ YES □ NO
Ulcers, stomach or intestinal bleeding .. □ YES □ NO
Heart murmur/rheumatic fever .......... □ YES □ NO

Angry, or abusive times that result in violence with a household member? □ YES □ NO
Told that you snore loudly or seem to stop breathing in your sleep? □ YES □ NO

Please turn over
Surgeries: 

Hospitalizations (other than childbirth): 

Immunization Status:

Have you had a pneumonia shot? □ YES □ NO □ DON'T KNOW
When was your last tetanus vaccine/booster?
Other vaccines? If so, what vaccine and when?

FEMALES ONLY
Menstruation: Age of Onset: 
No. of pregnancies: 
No. of live births: ______ No. of miscarriages: ______
If having sex:
Birth Control Method: 
Brand of Birth Control Pills: 

MALES ONLY
Do you ever have trouble with erections? □ YES □ NO
Do you find it necessary to empty your bladder frequently, or notice difficulty in starting to pass your urine? □ YES □ NO
How many times do you awaken at night to empty your bladder, if at all? ______

SOCIAL LIFESTYLE
Tobacco Use? □ YES □ NO If yes, # of packs per day ______ for _______ years.
Are you an ex-smoker? □ YES □ NO If yes, how many packs per day did you smoke? _______
Alcohol User? □ YES □ NO If yes, type and amount per day _______
Do you have a regular exercise program? □ YES □ NO
Do you use "street drugs"? □ YES □ NO If yes, type and amount per day _______

PREVENTION AND SURVEILLANCE: When was the last time you:
Had a bowel movement test using a cardboard slide (hemocult) for hidden blood? _______
When was the last time you had an eye exam? ______ Had a dental exam? ______
If female: Had a mammogram? ______ Had a pap test? ______
Discussed breast self-exam with a doctor? ______
Had a breast exam by a doctor? ______
If male: had a prostate check? ______
Do you wear seat belts? □ YES □ NO

Do you see any other doctors, physical therapists, etc.? □ YES □ NO
If so, please list their name, phone number, and when you last had an appointment to see them.

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<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
<th>Last Appointment Date</th>
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Staff / clinician use only:
Action taken: Discussed at this visit ________ □ YES □ NO
Recommended patient make follow up visit to discuss ________

Reviewed by: ___________________ D.O./M.D. (Please circle)
**UNIVERSITY OF MARYLAND**  
**INTEGRATIVE MEDICINE, LLC**  
**2200 KERNAN DRIVE, 2ND FLOOR**  
**Baltimore, MD. 21207**  
**410-448-6361 (PH)  410-448-1873 (FAX)**  
**DATE: __________________**

**HOW DID YOU HEAR ABOUT OUR OFFICE? (PLEASE CIRCLE) INTERNET/ NEWSPAPER/ ADVERTISEMENT REFERRAL/ FRIEND: ___________ (NAME)/ OTHER: ___________**

**Patient Information**

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<tr>
<th>Last</th>
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<th>Middle Initial</th>
<th>Email Address</th>
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<th>SSN</th>
<th>DOB</th>
<th>Gender</th>
<th>Would you like to be on our mailing list? Yes / No (circle)</th>
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<th>Religion</th>
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**Preferred Method of Contact: Home # / Cell # / Work # / Email / Other: ___________**

**Emergency Contact Information**

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<th>Emergency Contact Name</th>
<th>Emergency Contact Address</th>
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**Referring Physician Information**

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<th>Referring Physician Specialty</th>
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**Primary Insurance Information**

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<th>Insurance Company Name</th>
<th>Insurance Company Phone #</th>
<th>Address to Submit Claims:</th>
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<th>Insurance Group #</th>
<th>Insurance Effective Date From</th>
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<th>Subscriber Gender</th>
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**Secondary Insurance Information**

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FINANCIAL POLICY

Our clinic participates with most major insurance companies including the following:

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<tr>
<th>Company</th>
<th>Insurer</th>
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<tr>
<td>AARP</td>
<td>KASSER PERMANENTE</td>
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<td>AETNA</td>
<td>MAMSI LIFE &amp; HEALTH</td>
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<tr>
<td>AFL-CIO</td>
<td>MARYLAND HEALTH INS. PLAN (MHIP)</td>
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<tr>
<td>ALLIANCE</td>
<td>MDIPA</td>
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<td>BLUE CHOICE</td>
<td>MEDICARE</td>
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<tr>
<td>BLUE CROSS/BLUE SHIELD QUALITY</td>
<td>NATIONAL CAPITAL PPO</td>
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<td>CAREFIRST BLUE CROSS/BLUE SHIEL</td>
<td>NATIONAL PROVIDER NETWORK (NPN)</td>
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<tr>
<td>CAREFIRST BLUE CROSS/BLUE SHIEL</td>
<td>NATIONAL PREFERRED PROVIDER NETWORK (NPPN)</td>
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<td>CIGNA</td>
<td>OPTIMUM CHOICE</td>
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<td>COVENTRY HEALTH CARE OF DELAWARE</td>
<td>PREFERRED HEALTH NETWORK (PHN)</td>
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<td>DELMARVA HEALTH PLAN</td>
<td>TRICARE PRIME</td>
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<td>FIDELITY BENEFITS</td>
<td>UNITED HEALTH CARE SELECT</td>
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<td>UNITED HEALTH CARE OF THE MID-ATLANTIC</td>
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<td>HUMANA-CHOICE CARE</td>
<td>USA MANAGED CARE NETWORK</td>
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<tr>
<td>INNOVATIVE HEALTH SERVICES</td>
<td>WESTERN MARYLAND HEALTH SYSTEM</td>
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The responsibility of providing complete and accurate insurance information to our office staff belongs to you, the patient. Please bring your insurance card with you each visit.

If you are covered by an insurance plan with which we do not participate or you are uninsured, payment will be expected at the time service is rendered.

MEDICARE

Physician Visits:
In some cases, we will ask you to make a decision to receive services that we expect may be denied by Medicare. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. The physician will explain why he/she feels you should receive the service. This will be done in writing on a form called an Advance Beneficiary Notice (ABN). The ABN will also provide you the opportunity to agree or refuse the services. It also explains that we will not know if the service is denied until Medicare processes the actual claim. If you have any questions, either our staff or your Medicare representative will be happy to assist you.

Acupuncture:
Acupuncture is not contractually covered by Medicare; however treatments may be covered by your secondary plan. We encourage you to contact them to verify coverage. If there is no coverage, we will ask for payment at the time services are rendered.

Please turn over
INDEPENDENT THERAPISTS
It is the responsibility of each independent therapist (massage therapist, reflexologist, shiatsu therapist) to inform you of their policy regarding insurance participation and payment options. Additionally, each independent therapist is responsible for the treatment he/she provides and scheduling his/her appointments.

REFERRALS
In some cases a referral is required from the primary care provider. It is the responsibility of the patient to contact their insurance carrier to obtain specific information regarding the necessity of a referral.

CO-PAYS, DEDUCTIBLES, AND COINSURANCE
Your insurance company may require us to collect a co-pay at the time of service. Legally we cannot waive co-pays, deductibles, or co-insurance amounts.

SUPPLEMENTS, HOMEOPATHIC REMEDIES, PATIENT EDUCATIONAL MATERIAL
Payment for these items is expected at the time of purchase.

ACCEPTABLE FORMS OF PAYMENT & PAYMENT PLANS
We accept the following forms of payment:
  • Cash  • Check  • Visa or Master Card  • Money Order

Payments should be mailed to:
University of Maryland Integrative Medicine, LLC
PO Box 64697
Baltimore, MD 21201

If you have any questions, please call 410-448-6361. Representatives are available Monday thru Friday from 8:30am to 4:30pm. Payment plans (charity care) are available under certain circumstances; however, advance notice and pre-approval is required. Please see our staff for details.

PAST DUE ACCOUNTS
Every attempt will be made, including the services of a collection agency, to collect past due accounts.

RETURNED CHECKS
A fee of $30 will be assessed to your account for each personal check returned by your financial institution for “non-sufficient funds”. Furthermore, all future appointments will be postponed until fee is paid.

MEDICAL RECORDS
We require written requests for copies of medical records. Our fees for providing this service are in accordance with Maryland state law. See the receptionist for more details.

FORMS COMPLETION
Payment for the completion of forms (disability forms, etc.) must be made at the time of service. The fees are based on the complexity of the form.

I, ____________________________, have both read, and fully understand the Financial Policy described above. My signature signifies that I accept the terms as set forth in this agreement.

______________________________  __________________________
Patient or Financially Responsible Person  Witness

__________________________  __________________________
Date  Date

If you would like a copy of this, please ask the receptionist. The original copy will be kept in your file.
**NOTICE OF PRIVACY PRACTICES ("NPP")**

**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.**

**Effective Date: September 23, 2013**

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**SCOPE OF OUR PRIVACY PRACTICES:** This NPP describes the privacy practices of University of Maryland Faculty Physicians, Inc. and its affiliated faculty practice groups listed on the last page of this NPP (collectively, "FPI"), the University of Maryland School of Medicine ("SOM"), and all healthcare professionals, employees, staff, students, volunteers and other personnel whose work is under the direct control of FPI and/or the SOM.

All FPI and SOM entities, individuals, sites and locations follow the terms of this NPP. In addition, these entities, individuals, sites and locations may share protected health information or "PHI" with each other, and with facilities affiliated with the University of Maryland Medical System Corporation, including the University of Maryland Medical Center ("UMMC") and the University of Maryland Rehabilitation & Orthopaedic Institute ("ROI") as part of an Organized Health Care Arrangement, for treatment, payment, or health care operations purposes as described in this NPP and otherwise permitted by law. Note, FPI, SOM, UMMC and ROI are separate legal entities, and each maintains its own medical record and billing systems. For this reason, you may need to contact FPI, SOM, UMMC and/or ROI separately to request copies of your medical record.

**HOW WE MAY USE & DISCLOSE YOUR PHI:** We are committed to protecting the privacy and security of your PHI. In this NPP, we describe different ways that we use and disclose such PHI, which may include, without limitation, information about your diagnosis, treatment, test results, and billing information. Not every use or disclosure will be listed, but all of the ways we are permitted to use and disclose information will fall in one of the categories listed. Sometimes special laws govern the use and disclosure of certain types of very sensitive PHI, such as mental health, substance abuse, and HIV/AIDS information.

**For Treatment Purposes.** We may disclose your PHI to physicians, nurses, technicians, students, or other individuals who are involved in taking care of you. For example, we may share your PHI to coordinate the different things you need, such as prescriptions, lab work, x-rays and follow-up care. To the extent permitted by law, we also may disclose your PHI to individuals outside FPI, the SOM, UMMC and ROI who may be involved in your medical care (such as family members, home health agencies and others providers of services that are part of your care).

**For Payment.** We may use and disclose your PHI to an insurance company or third party payor so that the treatment and services you receive from us may be billed to and paid by them. For example, we may need to give your health plan information about services you received so that your health plan will pay us or reimburse you for the services, or to obtain prior approval to determine whether your plan will cover the treatment.

**For Health Care Operations.** We may use and disclose your PHI for administrative and operational purposes. These uses and disclosures are necessary for our operations, and to make sure that all of our patients receive quality care. For example, we may use your PHI to review our treatment and services and to evaluate our performance in caring for you.

**Health Information Exchange (HIE).** A Health Information Exchange, or HIE, is a way of sharing your PHI among participating physician offices, hospitals, labs, radiology centers, and other medical care providers through secure, electronic means. The purpose is so that each of your participating caregivers can have the benefit of the most recent information available from your other participating caregivers when taking care of you. We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a Maryland-wide HIE. As a participant in CRISP, we may share and exchange information that we obtain or create about you for treatment and public
health purposes, as permitted by law. This exchange of PHI can provide faster access to critical information about your medical condition, improve the coordination of your medical care, and assist medical care providers and public health officials in making more informed treatment decisions.

You may opt-out of CRISP by calling CRISP at 1-877-952-7477, or by submitting a completed Opt-Out Form directly to CRISP by mail, fax, or through the CRISP website at www.crisphealth.org. When you opt-out of participation in CRISP, medical care providers will not be able to search for your PHI through CRISP while treating you. However, even if you opt-out, your PHI will remain in the exchange. Specifically, your physicians or other treating providers who participate in CRISP will still be able to receive your lab results, radiology reports, and other data sent directly from CRISP that they may have previously received by fax, mail, or other electronic communications. Public health reporting in accordance with law, such as the reporting of infectious diseases to public health officials, will also continue to occur through CRISP even if you decide to opt-out.

Appointment Reminders. We may contact you about an appointment for treatment or medical care. This may be by mail, telephone, answering machine, email or text message.

Treatment Alternatives, Benefits and Services. We may contact you about possible treatment options or alternatives and other health-related benefits and services.

Fundraising. FPI may disclose to the SOM Office of Development the following PHI for fundraising purpose without an Authorization: (1) demographic information (name, address, contact information, age, gender, or date of birth); (2) dates of health care provided to you; (3) Department of service; (4) name of the treating physician; (5) outcome information; and (6) health insurance status. Fundraising materials you may receive will contain the option to opt-out of future fundraising communications. The opt-out method will not be burdensome to you.

Business Associates. There may be some activities provided for FPI or SOM by outside businesses that perform work on our behalf under a contract that requires appropriate safeguards for PHI, such as medical transcription services, billing services, and collection agencies. We may disclose your PHI to our business associates so they may perform the job we have asked them to do.

Individuals Involved in Your Care or Payment for Your Care. We may release your PHI to family members, personal representative, or other persons who are involved in your medical care or help pay for your care, provided the PHI is directly relevant to their involvement and not inconsistent with the decedent’s previously expressed wishes that are known to us. Also, PHI of persons deceased for more than 50 years will no longer be considered PHI and therefore will not be regulated under HIPAA.

Deceased Persons. We may disclose PHI to family members or others involved in a decedent’s healthcare or payment for care when the disclosure is relevant to their involvement and not inconsistent with the decedent’s previously expressed wishes that are known to us. Also, PHI of persons deceased for more than 50 years will no longer be considered PHI and therefore will not be regulated under HIPAA.

Research. Under certain circumstances, without your authorization, we may use and disclose your PHI to researchers if the research has been approved through a special review process designed to protect patient safety, welfare, and the confidentiality of participants. This process might be used, for example, to conduct records research, when researchers are unable to use de-identified information and it is not practicable to obtain research participants’ authorization. We also may disclose PHI to researchers if:

- We have received representations from the researcher, either in writing or orally, that the use or disclosure of PHI is solely to prepare a research protocol or for similar purposes preparatory to research, that the researcher will not remove any PHI from FPI or SOM, and that the PHI for which access is sought is necessary for the research purpose. This provision might be used, for example, to design a research study or to assess the feasibility of conducting a study; or
- We have received representations from the researcher, either in writing or orally, that the use or disclosure being sought is solely for research on the PHI of decedents, that the PHI being sought is necessary for research, and, at the request of FPI or SOM, documentation of the death of the individuals about whom information is being sought.
In certain circumstances, we must obtain your authorization to use or disclose your PHI to researchers. Such authorization must be in writing, and we may combine such authorization with any other type of written permission, for example, a consent form to participate in such research study or an authorization for a different research study.

**As Required By Law.** We will disclose your PHI 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 your PHI when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person. Any disclosure would only be to someone able to help prevent or lessen the threat.

**Organ and Tissue Donation.** We may release PHI to organizations that handle and monitor organ procurement, donation and transplantation.

**Military & Veterans.** If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

**Workers’ Compensation.** We may release your PHI for workers’ compensation or work site safety laws such as OSHA and similar programs.

**Public Health Activities.** We may disclose your PHI for public health activities. These activities generally include the following: to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to notify the Food and Drug Administration of reactions to medications or problems with products; to notify individuals of recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; or to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence if the patient agrees or we are required or authorized by law to do so.

**Health Care Oversight Activities and Registries.** We may disclose PHI to a health care oversight agency for activities authorized by law, such as investigations, inspections, and licensure, and to patient registries for conditions such as tumor, trauma and burns.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.

**Law Enforcement.** We may release PHI if asked to do so by a law enforcement official: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person’s agreement; about a death we believe may be the result of criminal conduct; about criminal conduct at the offices or clinics of FPI or SOM; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

**Coroners, Medical Examiners and Funeral Directors or Morticians.** We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release PHI about our patients to funeral directors or morticians as necessary to carry out their duties.

**National Security and Intelligence Activities.** We may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law, for example, to provide protection to the President.

**Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official as authorized or required by law.

**Directory.** We may use or disclose your PHI (name, location, condition described in general terms, and religious affiliation) in a directory when you are receiving treatment at our facilities, and, for directory purposes, we may disclose such PHI to members of the clergy or, except for religious
affiliation, to persons who ask for you by name. We will inform you in advance of such use or disclosure and give you the opportunity to agree to or prohibit or restrict the use or disclosure.

**Immunizations.** We may use or disclose your PHI to provide proof of immunization to a school that is required by state or other law to have such proof. A parent, guardian or other person acting in loco parentis of the individual, if the individual is an unemancipated minor, must agree to the disclosure.

**YOUR RIGHTS REGARDING YOUR PHI:**

**Authorization.** We will not use or disclose your PHI for any purpose that is not listed in this NPP without your written authorization. Uses or disclosures of PHI requiring an authorization (in most circumstances) include, for example, the use or disclosure of psychotherapy notes, the use or disclosure of PHI for marketing (except communications made face-to-face or communications in the form of a promotional gift of nominal value), and the exchange of PHI in return for remuneration from the recipient unless permitted under HIPAA. Other types of uses or disclosures not described in this NPP require an authorization. If you authorize us to use or disclose your PHI for another purpose, you have the right to revoke the authorization at any time. For information about how to authorize us to use or disclose your PHI, or about how to revoke an authorization, contact your treatment provider. You may not revoke an authorization for FPI or SOM to use and disclose your information to the extent that FPI or SOM has taken action in reliance on the authorization. If the authorization is to permit disclosure of your information to an insurance company, as a condition of obtaining coverage, other laws may allow the insurer to continue to use your information to contest claims or your coverage.

**Right to Inspect and Copy.** You have the right to inspect and copy your PHI that we have in our health and billing records, except for information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, or PHI that may not be disclosed under the Clinical Laboratory Improvements Act of 1988. If you want to review or receive a copy of these records, you must make the request in writing to your treatment provider. We may charge a fee for the cost of copying, mailing and other supplies related to your request. You are not entitled to a copy upon demand, but rather, we will generally have thirty (30) days to respond. Under limited circumstances, your request may be denied, or you may instead receive a summary of the undisclosed portion of the medical record, such as when requesting certain psychotherapy notes or during ongoing clinical trials. In some cases, if your request is denied, you may request that the denial be reviewed.

If you request a digital copy of certain electronic PHI or direct us in writing to transmit a copy to another person/entity, we will try to produce the information in the format requested if readily producible. To protect the integrity of our systems, we will not allow any portable devices, such as your personal key drives, access to our systems. Consequently, we may not be able to accommodate all preferred methods of delivery, but we will do our best to supply a reasonable electronic alternative to meet your needs. IF YOU REQUEST AN ELECTRONIC COPY, WE HEREBY EXPRESSLY DISCLAIM ALL DUTIES AND RESPONSIBILITY FOR THE SECURITY AND PROTECTION OF SUCH INFORMATION ONCE TRANSMITTED TO YOU, AND WE HAVE NO CONTROL OVER ACCESS TO THAT INFORMATION AFTER THE TRANSMISSION TO YOU THEREOF. ALL PHI MAINTAINED BY US WILL CONTINUE TO BE SECURED AND PROTECTED AS REQUIRED BY APPLICABLE LAW.

**Right to Amend FPI or SOM PHI.** If you believe that the PHI that FPI or SOM has about you is incorrect or incomplete, you may request an amendment. You must request this amendment in writing to your treatment provider stating the reason why you believe the information is not correct or complete. We will act on your request within sixty (60) days of receipt of the request. We may extend the time for such action by up to thirty (30) days, if within the initial sixty (60) days we provide you with a written explanation of the reasons for the delay and the date by which we will complete action on the request. FPI or SOM may deny your request for an amendment and will tell you why the request was denied, your rights to submit a statement disagreeing with the denial, and an explanation of how to submit the statement.

**Right to an Accounting of Disclosures.** You have the right to request an accounting of certain disclosures made of your PHI for the six (6) years prior to the date of your request. This accounting will not include disclosures FPI or SOM made for treatment, payment, health care operations, disclosures you authorized, certain disclosures to national security, correctional or law enforcement
personnel, disclosures made to you, or incidental disclosures. To request an accounting of
 disclosures made by FPI or SOM, you must submit your request in writing to your treatment
 provider. Your request must state the name or names of your treatment provider, and a time period
 that may not be longer than six (6) years and may not include dates before April 14, 2003. We will
 act on your request within sixty (60) days of receipt of the request. We may extend the time for
 such action by up to thirty (30) days, if within the initial sixty (60) days we provide you with a written
 explanation of the reasons for the delay and the date by which we will complete action on the
 request. If you request more than one accounting in a twelve-month period, you will be charged for
 the costs of providing subsequent accountings after the initial accounting, which we will provide at
 no charge.

Right to Request Restrictions. You have the right to request that (i) we restrict the disclosure of
 your PHI to health plans if you or someone else paid for the relevant care in full outside of your
 health plan coverage; (ii) your treatment provider give you a paper prescription instead of an
 electronically transmitted prescription; (iii) we restrict how we use or disclose your PHI. With
 respect to Subsection (iii), we will consider your request, but we are not required to agree. If we do
 agree, we will comply with the request unless the information is needed to provide you with
 emergency treatment. We cannot agree to restrict disclosures that are required by law. To request
 restrictions, you must make your request in writing to your treatment provider. In your request, you
 must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure,
or both; and (3) to whom you want the limits to apply. FPI and SOM do not have the authority to
 bind each other to any restrictions to which FPI or SOM may agree, so you will need to make
 requests for restrictions to both FPI and SOM.

Right to Request Confidential Communications. You have the right to request that FPI or SOM
 communicate with you about health matters in a certain way or at a certain location. For example,
you can ask that FPI or SOM only contact you at work or by mail. To request confidential
 communications, you must make your written request to your treatment provider, specifying how
 or where you wish to be contacted. FPI and SOM will not ask you the reason for your request, and
 will accommodate all reasonable requests. If you request that your PHI be transmitted directly to
 another person designated by you, your written request must be signed and clearly identify the
 designated person and where the copy of the PHI is to be sent.

Right to a Paper Copy of This NPP. You have the right to a paper copy of this NPP. You may ask us
to give you a copy of this NPP at any time.

Right to Breach Notification. FPI will notify you if there is breach of your unsecured PHI by us or
our business associates or subcontractors.

CHANGES TO THIS NPP: We are required to abide by the terms of the NPP currently in effect. We
reserve the right to change this NPP. We reserve the right to make the revised or changed notice
effective for PHI we already have about you as well as any information we receive in the future. FPI
and SOM will post a copy of the current notice in the locations where you receive services and on
our website at http://www.fpi.umaryland.edu/.
QUESTIONS ABOUT YOUR PRIVACY RIGHTS & COMPLAINTS

For questions about your privacy rights, or to report a complaint:

Contact persons are listed below for University of Maryland Faculty Physicians, Inc. and the University of Maryland School of Medicine to (i) address questions you may have regarding your privacy rights; and (ii) to report complaints if you believe your privacy rights have been violated. All complaints must be submitted in writing. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

If you have questions about your medical care, please contact your treatment provider directly. The numbers below are only for matters relating to the privacy and security PHI.

University of Maryland Faculty Physicians, Inc.
Director of Legal Affairs & Privacy
250 W. Pratt Street, Suite 901
Baltimore, MD 21201
FPI HIPAA Hotline #: 410-328-8011
FPIHIPAAPrivacy@fpi.umaryland.edu

University of Maryland School of Medicine
Privacy Official
100 North Greene Street, Room 214
Baltimore, MD 21201
SOM HIPAA Hotline #: 410-706-0337
SOMHIPAAPrivacy@som.edu

University of Maryland Faculty Physicians, Inc.
List of Affiliated Clinical Practice Groups Subject to this NPP:

1. University of Maryland Anesthesiology Associates, P.A.
2. University of Maryland Dermatologists, P.A.
   d/b/a University of Maryland Family & Community Medicine
5. University of Maryland Physicians, P.A.
   d/b/a University of Maryland Medical Group
   d/b/a University of Maryland Cardiology Physicians
8. University of Maryland Obstetrical and Gynecological Associates, P.A.
11. University of Maryland Orthopaedic Associates, P.A.
12. University of Maryland Orthopaedic Trauma Associates, P.A.
14. University of Maryland Pathology Associates, P.A.
15. University of Maryland Pediatric Associates, P.A.
17. University of Maryland Radiation Oncology Associates, P.A.
18. University of Maryland Diagnostic Imaging Specialists, P.A.
19. Shock Trauma Associates, P.A.
20. University of Maryland Surgical Associates, P.A.
21. Maryland Medicine, P.A.
22. University Imaging Center, LLC
23. University of Maryland Community Physicians
ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of the

HIPAA 2013
Notice of Privacy Practices

from
University of Maryland Faculty Physicians, Inc. (FPI),
FPI's affiliated Clinical Practice Groups and/or
the University of Maryland School of Medicine

Signature of Patient or Patient's Authorized Representative     Date

Print Patient Name or Name of Patient's Authorized Representative

Relationship of Person Signing (if other than Patient)

If NOT signed, please indicate reason:

This acknowledgment is effective 9/23/13 and replaces earlier versions.
We’re inviting you to participate in a study

Why?
We are part of a national study of how integrative medicine affects physical and emotional health for various types of health conditions. The information from this study will help us learn, and will help you and your practitioner assess your progress and plan future care.

Who can participate?
All patients at least 18 years old are invited to participate.

What will I have to do if I participate?
You will be asked to complete an online survey at home. This will happen now, in 2 months, 4 months, 6 months, 12 months, 18 months, and 24 months. The survey asks questions about how you are feeling physically and emotionally. Each survey takes about 15 to 20 minutes to finish.

What are the questions like?
Survey questions are easy to complete. There are 7 survey categories: pain, anxiety, depression, fatigue, sleep, physical function, and social function.

What do I do to get more information?
Please talk with your practitioner, or call Research Coordinator Mei Zheng at 410 448-6462, or email her at mzheng@som.umaryland.edu

What do I do to participate?
Access the following website: https://redcap.ric.einstein.yu.edu/PRIMIER. There you will find information and a consent screen. If you consent, you will be prompted for your first survey. At appropriate times thereafter, you will get an email requesting that you again provide the survey information.

We are committed to learning about integrative medicine, and to using information about how you are feeling to plan your care. Thank you for helping us!