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Silver Spring, MD 20901
Phone: (301) 593-6072 Fax: (866) 382-1197
www.myhealthysteps.net

Name _____SS#_____ Today's Date: _____

Street Address_____ D.O.B: _____

City: _____ State: _____ Zip Code: _____

Sex (circle): M or F Martial Status (circle): Married Domestic Partner Single Widow

Home Phone: _____ Work Phone: _____ Cell phone: _____

Email Address: _____

Emergency Contact:_____ Tel #: _____ Relationship:_____

Patient Employer: _____Occupation: _____

Employer Address: _____

How did you hear about us? _____

Insured Person If not Patient: _____ Phone: _____

SS# of Insured Person If not Patient: _____ Relationship: _____ D.O.B:_____

Primary Insurance: _____

ID#_____ Group_____ Provider Phone_____

Secondary Insurance_____

ID#_____ Group_____ Provider Phone_____

INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process the claim. I permit a copy of this authorization to be used in place of original.

Signature_____ Date_____

I hereby authorize Dr. Husna R.Baksh to apply for benefits on my behalf for covered services rendered by her. I request that payment from my insurance company be made directly to Dr. Husna R. Baksh.

This information is accurate and true to the best of my knowledge. I understand I am responsible to pay for services rendered, including reasonable attorney's fees and cost of collection in the event of default.

I permit a copy of this authorization to be used in place of original.

Signature_____ Date_____

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FINANCIAL POLICY

Welcome to Healthy Steps

Thank you for the trust you have put in us by choosing us as your healthcare provider. We are committed to providing you with the best possible care and to your treatment being successful. Your clear understanding of our financial policy, however, is important to our professional relationship.
Please understand that payment of your bill is considered part of your overall treatment. In order to keep your healthcare costs to an absolute minimum and to allow us to stay open to continue serving you, we have updated our Financial Policy. **Please read and sign prior to any treatment**.

Making and Keeping Appointments

If you have an outstanding balance of $350 or more, you must pay your balance in full or set up a payment plan within 30 days prior to being scheduled for an appointment. You can be seen for emergency situations within those next 30 days.

Initials _____

If you need to cancel or reschedule your appointment, we require a 24 hour advance notice in order to avoid our no show/cancellation fee. We have a high demand for appointments so keeping appointments and being on time is a critical factor for keeping our providers running on time. Not receiving the reminder call is not a valid reason for not coming to your appointment since this is a *courtesy* call to you. If you are 15 minutes late (or more), you have lost your appointment slot. If our schedule allows, we will add you to the day's schedule as an ***add-on*** or schedule you for a later appointment slot. If you cannot be added to the schedule, you will receive one of the charges below.

Fees: **$50** for appointments Monday – Friday
$100 for appointments on Saturday

This policy is necessary to allow us to accommodate patients who need to be seen emergently as well as hold our patients accountable for appointments made. *Excessive no shows may results in a charge being added to your account and you may also be dismissed from the practice.*

Fees and Payments

Fees are standardized and are based on the complexity of your visit or procedures done. Payment of copayment and any outstanding balance **is required at the time of service**. We accept cash, personal check, Visa, American Express, or MasterCard. While the filing of insurance claims is a courtesy that we extend our patients, all charges are your responsibility from the date that services are rendered. In order for us to file a claim, *you must present a current copy of your insurance card at each visit* and communicate any changes in your personal contact information.

Initials _____

Most insurances policies specify that some of the cost of the patient's care is the patient's responsibility. This can be accomplished through any combination of co-payments, coinsurance, or deductibles. Co-payments are due when you check in. For example, if your insurance is Blue Cross Blue Shield and your benefits indicate that your responsibility is 20% of the allowed amount, if your charge is $100 for that day's visit then $20 will be collected prior to your appointment. *Amounts will vary based on your insurance*. Please keep in mind that our staff will do their best to verify your exact benefits but ultimately, these amounts are an estimate. Once the claim has been

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processed by your insurance company and we are notified, we will add the appropriate charge or credit to your account. Please speak with our billing specialist if you have any questions regarding this policy

Insurance Plans

Your insurance coverage is a contract between you, your employer, and the insurance company; *we are not a party to that contract*. We must emphasize that as healthcare providers, our relationship is with you, not with your insurance company. Before your visit, please contact your insurance company to verify that the physician that you are scheduled with participates with your plan and that the services that you intend to receive are covered. In addition, because some insurance plans require either precertification and /or require referrals from a primary care provider before you can be seen, please ask if these are required and obtain them if necessary at the time of your visit. Not all services are a covered benefit in all plans, so it is very important that you understand the provisions of your individual policy. Some insurance companies arbitrarily select certain services they will not cover and so we cannot guarantee payment of all claims by your insurance company. If your insurance company pays only a portion of your claim or rejects your claim, they will notify you through an explanation of benefits. Reduction or rejection of your claim by your insurance company does not relieve you or your financial obligation.

Initials _____

Non- Payment of Outstanding Accounts

Accounts that are not paid within 90 days or those exceeding $350 may be sent to an external collections agency and reported to the credit bureaus. Being sent to collections and/or having an account over $350 not paid in full (or in a payment plan) within 30 days may cause you to be dismissed from the practice. *In addition to your outstanding balance, you may also be responsible for any fees or charges that we incur from the external collections agency while attempting to collect your balance.*

Initials _____

Payment Plans

It is critical that you communicate with us if you are experiencing financial hardships so that we know how to help you best. Please call us as soon as possible to set up a payment plan or set one up in the office directly. If you have a balance of over $350, you will receive a 5% discount on your balance if you pay in full. Payment plans are subject to a monthly interest rate of 5%.

Initials _____

Administrative Policies

Forms Policy:
If you need a form to be filled out and signed by any of our providers, we require a scheduled appointment for its completion. Per our philosophy about your overall care, all medical-legal forms are handled with the highest level of attention. Scheduling an appointment allows us to avoid mistakes and gives you the fastest turnaround time possible. It is your responsibility to bring us your form in a timely fashion since additional information and/or testing may be required prior to obtaining a provider signature.

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Medical Records Charge:
In accordance with HIPAA and Maryland State Law, if you would like a copy of your medical records, you must fill out our "Authorization for Release of Medical Record Information" form. The release of records is subject to copying fee (per page and shipping/handling if applicable). The per page fee schedule is available upon request. If

a collaborating physician (primary care or specialist) requests portions of your chart to assist in your care directly, there is no charge assessed.

Returned Checks Charge:
Non-Sufficient Funds (NSF) checks are subject to a $30 fee (in addition to fees from your bank).

I certify that I have read and understood the financial policy noted above, was given the chance to ask my questions and have them answered. I agree to abide by the policies set forth by Healthy Steps.

Signature: _____ Date: _____

Print name: _____

Staff Signature: _____

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KEYS TO SUCCESS AT HEALTHY STEPS AND IN YOUR OVERALL HEALTH CARE

1. Bring in a list of things you want to discuss and we will prioritize the items that can be covered in each visit. Another visit(s) MAY be needed to evaluate all your concerns. ON THE OTHER HAND, all the details you list may be associated with on specific problem and the details help us help you better.

2. Make time to schedule follow up appointments especially if tests are ordered.

3. Follow up on tests that were ordered.

4. Whenever you have questions, please let us know. Email or message via your patient Web portal is preferable because it is easier to track and easier to place your concerns into your medical records. **Call with questions if they are urgent or if you have no email.**

5. Sometimes you will hear us ask you the same question several times. We have found that asking the same question more than once helps the patient rethink their history and arrive at a more accurate answer. Sometimes, we need to be reminded of a detail about your health. We have found redundancy a key component of communication that is sometimes necessary to give you the best care.

6. If you have a test or see a consultant make a note of who you saw, what was done, when was the appointment and the contact information. A health calendar/folder is helpful not only to have a good record of your overall health but is also helpful if you or we need to locate results, which may not have been sent to us.

7. If you are a new patient, make sure your records get to us so we will be able to help you in the best way possible by reviewing old records. Reviewing your records during the time with you allows us to ask you questions of clarification to give you the best care.

8. If you are a current patient who was seen in the ER, an urgent care center, a specialist, radiology, or lab center…make sure those results are in our hands.

9. Let us know what would have made your visit better.

10. Let us know what you appreciated about your visit.

11. If there is any new information in your health (allergies, diagnosis or cancer, stroke, heart attack etc., in yourself or other family member) let us know by your patient web portal, letter or at your follow up visits.

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12. **NEVER ASSUME** that because you didn't hear from us that the test results are negative. We schedule appointments with you after tests are done so that nothing slips through the cracks. Please make sure you attend those appointments to close the circle on those questions that were raised during your visits.

13. BRING ALL your medication bottles to ALL you appointments to prevent doubling of medications and to check for interactions between medications.

At Healthy Steps we believe firmly in the active partnership of patients in their health care. Do the above and your health will be optimally covered. Please let us know if you have any other ideas or any questions about what has been written.

I understand and agree to the above "Keys to Success at Healthy Steps."

_____ _____
Patient Signature Date

_____
Patient Printed Name

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PRESCRIPTION REFILL POLICY

Medication errors are a significant cause of PREVENTABLE patient harm nationally.

To protect our patients, we require the following:

1) All prescription refills will be based on up to date labs or instructed follow up visits. If you are not up to date on labs or follow ups as requested by our providers, we will happily fit you into the schedule to make sure that there are no changes in your health.
2) All prescription refills are strongly encouraged to be done as part of your routine office visits after a careful review of your labs. Depending on your health profile, you may be required to draw labs periodically (ranging from every 30 days, 3-6 months or yearly).
3) We strongly encourage you to bring in all your medication bottles to your visits so that we can ensure that you are taking the right medications (dosing & instructions) and to ensure that you we provide you with enough refills so you do not run out before your next scheduled visit.
4) **Please do not wait to request a refill on your prescriptions once you have (or are about to) run out of your medications.** We have a standard 48-72 hour period in which your request will be reviewed and responded to.

When you agree to do the above:

1) You help us take better care of you.
2) You help us decrease medication errors.
3) You prevent lapses in your medication regimen.
4) You allow us to focus on scheduled patients in the office, rather than pull staff away to fax or call in approved prescription requests, which require significant time and evaluation as noted above.

Please help us respect the time all our scheduled patients take to come in for appointments and ultimately prevent lapses in your medication by adhering to the above policy.

I have read and agree to adhere to the Prescription Refill Policy outlined above.

_____ _____

Patient Name Date

_____

Patient Signature

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PRIVACY & PROPER COMMUNICATION

To decrease medical errors, and per the Institute of Medicine's mission, we are obtaining pictures of our patients for their charts. Please allow us to prevent insurance and identity theft by allowing your picture to be taken today. It will form part of your demographic information and will be available to internal office staff only for security purposes.

____ I am allowing my picture to be taken today for the security of my chart and health information

We also aim to protect your information through phone calls and messages left when our office staff tries to reach you. Please provide your preferred phone number where messages can be left regarding your health information.

____ I give permission for Healthy Steps to leave detailed messages with my medical information, if needed, at the following phone number(s) _____ (circle: home / work / cell).

____ I do not give permission for Healthy Steps to leave detailed messages with medical information, if needed, on any of my phone numbers on file.

APPROPRIATE COMMUNICATION METHODS:

We now have a secure online Patient Portal system that allows you to send us messages electronically with ROUTINE questions or concerns and gives you greater access to your health information. You will be able to request refill medications, appointments, speak to the clinical staff and see copies of your lab results. **This is a safe and secure way** to contact us and all communication becomes part of your medical chart. You can visit https://3119.portal.athenahealth.com/ to register.

Do NOT send **urgent** questions / concerns or request urgent appointments via the Patient Portal. These include those related to: chest pain, dizziness, shortness of breath, nausea/vomiting, diarrhea or any other reason that you, the patient, think is urgent.
For URGENT appointments or questions, please call 301-593-6072 to be connected to the clinical staff.

I acknowledge that I have read and fully understand this consent form. If I have any questions, I may inquire with my treating physician.

_____ _____
Patient Name Date

_____ _____
Patient Signature Email Address

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HEALTHY STEPS NOTICE OF PRIVACY PRACTICES

If you have any questions about this Notice, please contact our Privacy Officer [Husna R. Baksh, MD.]

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We may use or disclose your protected health information, however, in certain situations *without* your authorization or providing you the opportunity to agree or object. These situations include, if required and authorized by law, for the purpose of public health / communicable disease prevention and/or if we believe you have been a victim of abuse, neglect or domestic violence (to the proper authorities). If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make of your health information beyond the above normal uses.

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You have the right to transfer copies of your health information to another practice. Please see our medical records request policy for details on how to submit your request.

You have the right to see and receive a copy of your health information, with a few exceptions. Please provide us with a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information.

Please provide us with a written request to make changes. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information. You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room # 509-F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Husna R. Baksh, M.D., P.C. at (301) 593-6072.

Changes as of August 2011

To make your health care more thorough and efficient, we have decided to participate in CRISP (the Chesapeake Regional Information System for our Patients, Inc.), a statewide health information exchange. As permitted by law, your health information from local hospitals is shared with this exchange. Healthy Steps' participation will allow us to more quickly access your hospitalization information to provide you excellent care. You may "opt-out" and prevent searching of your health information available through CRISP by calling 1-800-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org
Please notify our front desk staff if you wish to opt-out and they will provide you with more information.

This notice goes into effect as of April 14, 2003. ***Amended August 9th, 2011***

Acknowledgement
I have read the Healthy Steps Privacy Practices notice. I will request a copy if necessary.

Date: _____

Signature: _____

Print Name: _____

If signing as a parent or guardian, please note the name of the patient

Thank you,

Healthy Steps Staff