VIVEK PATIL, MD

COLORECTAL SURGERY OF MARYLAND AND WASHINGTON, DC

Dear New Patient:

I would like to take this opportunity to welcome you to my office.

Your visit has been scheduled. Please complete the enclosed registration forms and bring them with you to your first appointment. In addition, the following items will be needed:

- ☑ List of current medications
- ☑ Insurance card(s)
- ☑ Driver's license or picture ID
- ☑ Referral form (if required by your insurance company)
- ☑ Method of payment (we accept cash, check, VISA, Discover or MasterCard)

Please advise the front desk staff of any changes with your insurance, address or phone numbers.

If you have any questions, please do not hesitate to call before your appointment. We look forward to participating in your medical care.

Sincerely,

Vivek Patil, M.D.

9905 Medical Center Drive
Suite 330
Rockville, MD 20850
Phone: (240) 487-7522
Fax: (360) 597-1464

6420 Rockledge Drive
Suite 4200
Bethesda, MD 20817
Phone: (240) 487-7522
Fax: (360) 597-1464

VIVEK PATIL, MD
COLORECTAL SURGERY OF MARYLAND AND WASHINGTON, DC

Office Guide

Welcome: We are a colorectal surgery practice of a board-certified specialist. We have two offices in Montgomery County with admitting and consultation privileges at local hospitals. Our practice serves patients from the entire Washington, D.C. metropolitan area and nearby states.

Driving Directions:

6420 Rockledge Drive. Suite 4200, Bethesda, MD 20817 – Phone: (240)487-7522 Fax: 360-597-1464
From Frederick take I-270 S to exit 1 Rockledge Drive toward MD 187/Old Georgetown Road. From Baltimore I-495 N / I-95 N towards Silver Spring/Baltimore. Slight right at 1-270 N. Take exit 1B for Rockledge Drive. From Northern Virginia take I-495 towards Maryland. Slight left at I-270 N. Take exit 1 for Democracy Blvd. Turn right at Democracy Blvd. Turn left at Rockledge Rd. Make a U-turn at Bells Mill Rd to 6420 Rockledge Dr.

9905 Medical Center Drive, Suite 330, Rockville, MD 20850 (AQUILINO CANCER CENTER) - Same phone/fax numbers
From I-270 North take exit #8 (Shady Grove Rd). From I-270 South take Exit #8. Go West on Shady Grove Rd for five stop lights; at the fifth stop light make a right turn at Medical Center Way into the Shady Grove Medical Center Complex. At the first stop sign turn left onto medical Center Drive. Parking located in front of the Aquilino Cancer Center building.

Parking: Available

Office and Phone Hours: Monday through Friday from 8:00 AM to 4:00 PM

For all non-emergency calls or to schedule an appointment, please call the office during regular business hours. After 4:00 PM weekdays and on weekends, our physician can be reached *for emergencies only by calling 240-487-7522*. The answering service will contact the physician on call.

Insurance: We participate with a variety of HMO, PPO and indemnity insurance plans. We need your help to comply with your insurance company's rules and regulations. Please bring your insurance card, co-pay, and any necessary referrals to each appointment.

Appointments: All visits are by appointment only. Many appointments can be lengthy in duration. We encourage patients with special medical requirements to bring any necessary medications, food or drink to make themselves more comfortable during their visits. *Please arrive 15-minutes prior to each scheduled appointment time.*

Medical Forms and/or Copies of Medical Records: At times you are required by your employer, disability or life insurance company, etc, to have medical forms filled out and signed by a physician. We are happy to do this for you if applicable. There is a fee of $15.00 per form for this service. If medical records are required per form, there will be an additional copy fee of $.76 per page. If you request a copy of your medical records for your personal use or file, there will be a copy fee of $.76 per page.

Inclement Weather: We make every effort to keep our office open during the winter months. If inclement weather occurs, the office staff will contact you to make alternative arrangements for your appointments and follow-up care.

VIVEK PATIL, MD
COLORECTAL SURGERY OF MARYLAND AND WASHINGTON, DC

Phone: 240-487-7522 / Fax: 360-597-1464

PATIENT REGISTRATION
(PLEASE PRINT)

Patient's Account Number

Date	Patient's Last Name	First Name (Legal) & MI	☐ Male ☐ Female
			Marital Status:

We are required to obtain the following information in order to be compliant with the Federal Government Electronic Health Records Program:
Race: □ American Indian or Alaska Native □ Asian □ African American □ Native Hawaiian or Pacific Islander □ Other □ White **Ethnicity:** □ Hispanic or Latino □ Not Hispanic or Latino

Address: Street	City	State	Zip

Mobile Phone	Home Phone	Date of Birth	Social Security No.

Occupation	Employer's Name

Pharmacy – Local:	Local Pharmacy Phone#:	

Do you have the following Advanced Directives: Living Will: □ Yes □ No**; Medical or Health Care Power of Attorney:** □ Yes □ No**; DNR** □ Yes □ No **(see attached for more information)**

Emergency Contact Name	Relationship	Mobile Phone	Home Phone	

AUTHORIZATION OF PAYMENT

(Please read, sign and date below)

I request that payment of authorized Medicare/Insurance Carrier benefits be made on my behalf to Vivek A. Patil, M.D. for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents and/or other Insurance Carriers for which I have coverage, and any information needed to determine these benefits or the benefits payable for related services. I understand that I am fully responsible for obtaining any necessary referrals required by my Insurance Carrier and that these must be presented at the time of services. I can exercise my right to be seen without a referral, but must pay for all services in full at the time of service. All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements. Failure to provide complete and accurate insurance information in a timely manner may result in patient responsibility for the **entire** billed amount for services rendered.

SIGNATURE OF PATIENT ONLY:_____ **DATE:**_____

*****If you are NOT the patient, but are signing on behalf of the patient, please complete the following:

I, _____, confirm that I am the legal representative for the patient above and I have CHECKED my relationship to the patient below:

☐ Medical Power of Attorney ☐ Power of Attorney with Right to see medical records ☐ Court Appointment Guardian

☐ Registered Kinship Care Relative ☐ Legally Appointed Healthcare Agent ☐ Surrogate Decision Maker

REPRESENTATIVE'S SIGNATURE:_____ DATE:_____

(NOTE: You must have on file or attach proof of your authority to act on behalf of the patient as checked above (other than parent).

(Revised 9/2020)

VIVEK PATIL, MD
COLORECTAL SURGERY OF MARYLAND AND WASHINGTON, DC

Phone: 240-487-7522 / Fax: 360-597-1464

Medical Information

PATIENT NAME: _____ **Date of Birth:** _____

Referring Physician: _____ **Phone Number:** _____

Primary Care Physician: _____ **Phone Number:** _____

Please circle any of the following chronic medical problems you have:

Diabetes	Blood clots	Crohn's disease
Heart Disease	COPD	Ulcerative Colitis
Colon or Rectal cancer	Asthma	Reflux
Anal Cancer	High Cholesterol	Hypothyroidism
High Blood Pressure	Autoimmune disorders	Anxiety or Depression

Please list any other medical problems:

Please list any abdominal, heart, lung, or brain surgeries you have had:

Year	Type of Surgery	Hospital or Surgery Center

Do you have any allergies to medications? ☐ No ☐ Yes *(If yes, please list drug(s) and reaction(s) below)*

Drug	*Reaction*	*Drug*	*Reaction*

Please list all your current medications or attach a medication list: **(include all prescription drugs, supplements & over the counter medications)**

Drug Name	Dosage (e.g. mg)	Frequency (e.g. 1 pill 2 times/day)

Family History: **Ethnic Background:** _____

	Age	Past illnesses	Current state of health or cause of death
Parents:			
Mother			
Father			
Siblings:			

Family history of cancer? ☐ Yes ☐ No

Relationship	Type	Age at Diagnosis

	YES	NO		
a) Do you smoke cigarettes?			b) How many packs per day do/did you smoke:	What Year start/stop?
b) Drink alcoholic beverages daily?			b) How many drinks/day?	

When was your most recent:

Colonoscopy _____
Upper Endoscopy _____
CT scan of abdomen _____

VIVEK PATIL, MD
COLORECTAL SURGERY OF MARYLAND AND WASHINGTON, DC

Patient's Account Number

AUTHORIZATION TO DISCUSS HEALTH INFORMATION WITH DESIGNATED PERSONS

(Phone #: 240-487-7522 - Fax #: 360-597-1464)

NOTE: Healthcare information will not be released under any circumstances to any relative(s) (spouse, mother, father, sister, brother, etc), friend(s) or other person(s) unless specifically listed and authorized by the patient below

Patient Name: _____ Date of Birth: _____
(LAST) (FIRST) (MI)

Address: _____ Phone No.: _____
(STREET) (CITY) (STATE) (ZIP CODE)

For this authorization, "My Health Information" means any and all information relating to my course of examination, test results and treatment.

I authorize Dr. Vivek Patil, MD and Staff to discuss My Health Information, general information and inquires, arranging appointments, identifying medications, discussing billing and payment and any other related matters with:

Name: _____ Relationship: _____ Phone No: _____
Name: _____ Relationship: _____ Phone No: _____

Authorization for Use of Answering Machine and/or Voice Mail: Dr. Vivek Patil, MD and healthcare staff routinely are unable to contact patients directly during normal business hours. On these occasions our offices leave messages on communication devices provided by our patients. Due to the new federally mandated HIPPA Privacy Rule we must obtain your authorization to continue this mode of communication. Protected Healthcare Information that we may possibly disclose on your home, cell or work phone would include, but is not limited to: test/lab results, prescription/pharmacy information, appointment instructions for visits and procedures and surgical posting/scheduling information.

☐ **YES,** I authorize Dr. Vivek Patil, MD and healthcare staff to leave messages that include Protected Healthcare Information on the following communication devices: (***please check***) ☐ **mobile number** ☐ **home number** ☐ **work number**

☐ **NO,** I do not authorize Dr. Vivek Patil, MD and healthcare staff to leave messages that include Protected Healthcare Information on my home, work or cell phone.

I understand that:
- *** If I do not sign this authorization, Dr. Vivek Patil, MD will not disclose my health information.**
- *This authorization is voluntary. My treatment will not be impacted no matter if I sign this authorization or not.
- * I will receive a copy of this authorization upon signature (if requested).
- * This authorization is valid unless I revoke this authorization in or unless an earlier date is specified me: _____.
- * Once My Health Information is disclosed as requested, it may no longer be protected by federal and/or state privacy laws and could be re-disclosed by the person(s) receiving it. The medical information released may contain information related to HIV status, AIDS, sexually transmitted disease, genetic information, mental health and alcohol abuse, etc.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

SIGNATURE OF PATIENT ONLY: _____ **DATE:** _____

If you are NOT the patient, but are signing on behalf of the patient, please complete the following:

I, _____, confirm that I am the legal representative for the patient above and I have CHECKED my relationship to the patient below:

☐ Medical Power of Attorney ☐ Power of Attorney with Right to see medical records ☐ Court Appointment Guardian
☐ Registered Kinship Care Relative ☐ Legally Appointed Healthcare Agent ☐ Surrogate Decision Maker

REPRESENTATIVE'S SIGNATURE: _____ DATE: _____
(NOTE: You must have on file or attach proof of your authority to act on behalf of the patient as checked above (other than parent).

VIVEK PATIL, MD
COLORECTAL SURGERY OF MARYLAND AND WASHINGTON, DC

AUTHORIZATION TO OBTAIN AND/OR RELEASE PROTECTED HEALTH INFORMATION (PHI)

(Phone # 240-487-7522 Fax #: 360-597-1464)

I hereby authorize Vivek A. Patil, M.D. to obtain and/or release medical information concerning my medical treatment as required to physician(s) or and/or medical facility(ies) for the purpose of continued medical care. I authorize the release of the information designated below unless checked:

☐ Progress Note(s)	☐ Pathology Report(s)	☐ Other _____
☐ Lab Report(s)	☐ Consultation Report(s)	_____
☐ Imaging/Radiology Report(s)	☐ History & Physical Report(s)	_____
☐ Operative Report(s)	☐ Discharge Summary(ies)	_____
☐ Radiation Treatment Records (EOT)	☐ Chemotherapy Treatment Records	_____

If the patient wishes to release his or her PHI for reasons other than continued medical care, such as insurance/disability or legal indications, please specify to which entity here: _____

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric, genetic counseling and/or testing, alcohol and/or drug abuse, and/or testing which may include the result of an HIV test or the fact that an HIV test was performed. I consent to the release of information as designated above unless checked below or otherwise required by law: **(check all applicable)**

☐Genetic Counseling/Testing Information ☐HIV/AIDS ☐Mental Health ☐Drug/Alcohol Abuse ☐Other (please specify): _____

I understand that this authorization shall remain valid for one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization.

I understand that my protected health information (PHI) that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer by protected by law.

_____ _____

Patient Signature or Legal Representative **(see note)** Date

_____ _____

Printed Name of Patient or Legal Representative **(see note)** Relationship

_____ _____

Patient Address Patient Date of Birth

NOTE: Legal Representative must have on file or attach proof of your authority to act on behalf of the patient (other than parent).

VIVEK PATIL, MD
COLORECTAL SURGERY OF MARYLAND AND WASHINGTON, DC

Notice of Privacy Practices

UNDERSTANDING YOUR HEALTH RECORD AND INFORMATION: Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment and a plant for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment services as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS: Unless otherwise required by law your health record is the physical property of the healthcare practitioner or facility that compiled it; the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information and request amendments to your health record. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect and obtain a copy of your health record. You may obtain an accounting of disclosures of your health information, request communications of your health information by alternative means or at alternative locations, revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES: This organization is required to maintain the privacy of your health information, and in addition, provide you with notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. This organization must abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, and accommodate reasonable requests you may have to communicate health information by alternative means or by alternative locations. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have provided. If we maintain a Web site that provides information about our customer services or benefits we will post our new notice on the Web site. We will not use or disclose your health information without your authorization, except as described in this notice.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS

- ***Treatment.*** Information obtained by a healthcare practitioner will be recorded in your record and used to determine the course of treatment that should work best for you. By way of example, your physician will document in your record their expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations (example varies by practitioner type). We will also provide your other practitioners with copies of various reports that should assist them in treating you.
- ***Billing & Payment:*** A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you as well as your diagnosis, procedures and supplies used.
- ***Health Care Operations.*** The practice may use and disclose health and personal information about you to operate this medical practice. For example, the practice may use and disclose this information to review and improve the quality of care we provide or the competence and qualifications of our professional staff. We may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits including fraud and abuse detection, compliance programs, business planning and management. We may also share your health and personal information with our "business associates," who perform services for us. Our contracts with each of these business associates contain terms requiring them to protect the confidentiality of your health and personal information. The practice may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you when they request this information to assist them with their quality assessment or improvement activities, efforts to improve health or reduce health care costs, review of competence, qualifications and performance of health care professionals, training programs, accreditation certification and licensing activities or health care fraud and abuse detection and compliance efforts.
- ***Notification:*** We may use or disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your care, your location and general condition.
- ***Communication with family:*** Health professionals, using their best judgment, may disclose to a family member, other relatives, close personal friends or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
- ***Research:*** The practice may contact you regarding new clinical trials for your diagnosis or health status based on screening of practice records. You would then have the choice to get further information and possibly participate or decline to participate in any such new trials. The practice may disclose your health information to researchers conducting research with respect to which your written authorization is not required, as approved by an Institutional Review Board or privacy board, in compliance with governing law. The practice may also disclose your health information to staff and business associates for the purpose of "de-identifying" your patient records. That means that information such as your name, telephone number, address and other identifying information may be removed, coded, encrypted or otherwise eliminate or concealed so that the health information is no longer identifiable to the people using it for research. The practice may also receive compensation for providing such de-identified data for research purposes.
- ***Funeral Directors:*** We may disclose health information to funeral directors consistent with applicable law to carry out their duties.
- ***Organ Procurement Organizations:*** Consistent with applicable law, we may disclose health information to organ procurement organizations or to other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

- ***Marketing:*** The practice may contact you to give you information about products or services related to treatment, case management or care coordination, or to direct or recommend other treatments of health-related benefits and services that may be of interest to you or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.
- ***Food and Drug Administration (FDA):*** As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
- ***Public Health Risks:*** We may release medical information about you for public health activities. These activities generally include the following: 1) to prevent or control disease, injury or disability; 2) to report a death; to report abuse or neglect; 3) to report reactions to medications or problems with products; 4) to notify people of recalls or products they may be using; 5) 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; 6)to notify the appropriate legal or government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- ***Workers Compensation:*** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation and other similar programs established by law.
- ***Correctional Institution:*** Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals. An inmate does not have the right to the Notice of Privacy Practices.
- ***Law Enforcement:*** We will disclose medical information about when required to do so by federal, state or local laws. This includes, but is not limited to the following: 1) We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena, warrant, summons or similar process. We may also release information to Law Enforcement a) to identify or locate a suspect, fugitive, material witness or missing person; b) about the victim of a crime if under certain limited circumstances we are unable to obtain the person's agreement; c) about a death we believe may be the result of criminal conduct; d) about criminal conduct at the office; e) 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. 2) We may release medical information about you to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law. 3) Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.
- ***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.cripshealth.org.
- ***Other Uses and Disclosures:*** Other uses and disclosures of information not contained in this Notice or the laws that apply to us will be made only with your written permission. If you provide use permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided you.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU: Although your health record is the property of Vivek A. Patil, M.D., the information belongs to you. You have the following rights regarding your health information:

- **Right to Inspect and Copy**: With some exceptions, you have the right to review and copy your health information. Usually this includes medical and billing records. *You must submit your request in writing to Vivek A. Patil, M.D., attention Privacy Officer. We may charge a fee for the costs of copying, mailing or other supplies associated with your request.* We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request, in writing, that the denial be reviewed. Another licensed health care professional chosen by Associated in Oncology/Hematology will review your request and the denial. The person conducting the review will not be the person who previously denied your request. We will comply with the outcome of the review.
- **Right to Amend**: If you feel that health information in your record is incorrect or incomplete, you may ask us to amend the information. You have this right for as long as the information is kept by or for the Facility. *You must submit your request in writing to Vivek A. Patil, M.D., attention Privacy Officer. In addition, you must provide a reason for your request.* We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: 1) Was not created by us; 2) Is not part of the health information kept by or for our practice; 3) Is not part of the information which you would be permitted to inspect and copy; 4) Is accurate and complete.
- **Right to an Accounting of Disclosures**: You have the right to request an "accounting of disclosures". This is a list of certain disclosures we made of your health information, other than those made for purposes such as treatment, payment, or health care operations. *You must submit your request in writing to Vivek A. Patil, M.D., attention Privacy Officer. Your request must state a time period which may not be longer than six years from the date the request is submitted and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.*
- **Right to Request Restrictions**: You have the right to request a restriction or limitation on the health information we use or disclose about you. For example, you may request that we limit the health information we disclose to someone who is involved in your care or the payment for your care. You could ask that we not use or disclose information about a surgery you had to a family member or friend. (We *are not required to agree to your request.)* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. *You must submit your request in writing to Vivek A. Patil, M.D., attention Privacy Officer. 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, for example, disclosures to your spouse.*
- **Right to Request Alternate Communications:** You have the right to request that we communicate with you about medical matters in a confidential manner or at a specific location. For example, you may ask that we only contact you via mail to a post office box. *You must submit your request in writing to Vivek A. Patil, M.D., attention Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.*

Privacy Practices – (cont.)

- **Right to a Paper Copy of This Notice**: You have the right to a paper copy of this Notice of Privacy Practices even if you have agreed to receive the Notice electronically. You may ask us to give you a copy of this Notice at any time. To obtain a paper copy of this Notice, contact Associates in Oncology/Hematology.
- **Right to Breach Notification:** You have a right to be notified of any breach of your secured healthcare information.

CHANGES TO THIS NOTICE: We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the Facility and on the website. The Notice will specify the effective date on the first page, in the top right-hand corner. In addition, if material changes are made to this Notice, the Notice will contain an effective date for the revisions and copies can be obtained by contacting the Privacy Officer.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with Dr. Patil's office or with the Secretary of the Department of Health and Human Services. To file a complaint, contact Vivek A. Patil, M.D., attention Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

ACKNOWLEDGEMENT OF NOTIFICATION: The "Notice of Privacy Practices" provides information about how Vivek Patil, M.D. P.C. may use and disclose protected health information about you and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, you will be notified on you next visit to our office. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment or healthcare operations. We are not required to agree with your restrictions, but if we do, we are bound by our agreement to you.

CONTACT INFORMATION: For further information about matters covered by this notice, please contact the Privacy Officer at 301-424-6231.

By signing, I acknowledge that I have read and understand the Notice of Privacy Practices.

_____

Patient's Signature **Date**

Effective: April 2003; Revised: June 2016

Vivek A. Patil, M.D.

Patient Access Options for Medical Records

The policy of Dr. Patil's office is to protect individually identifiable health information and to provide patients access to their protected health information ("PHI") under HIPAA, other laws, rules, and regulations. Please read the following options below regarding access to your medical records or ("PHI").

☐ My Care Plus: Due to the Federal HIPAA and HITECH Acts and Meaningful Use Criteria, Dr. Patil's office now provides access to My Care Plus. Available from any computer with an internet connection, you or those people you authorize can access you medical information with My Care Plus. In order to provide you access, we will need a valid E-mail address and you will be sent information and instructions to set up your My Care Plus account. Please provide your e-mail address:

_____

☐ Printed Copies: You may request printed copies of your medical records. There will be a $.75 per page copy/print fee. If these records are mailed, the postage fee will also be charged. ***Please note: The fee must be paid before the records are released.***

☐ Fax: Your medical records can be faxed to you. However, please be aware that there are a few risks involved such as 1) misdirected faxes to unauthorized recipients, 2) faxes may be intercepted, or 3) faxes may be lost in transmission. The potential for breach of patient confidentiality exists every time your medical information is faxed. If you still prefer this method of access, please provide a fax number:

_____

I have read the above options and have checked the option I prefer to obtain my medical records.

_____ _____

Patient Signature Date

_____

Print Name

VIVEK PATIL, MD
COLORECTAL SURGERY OF MARYLAND AND WASHINGTON, DC

Financial Policy

Deductibles/Co-Insurances For Surgery:

Dr. Vivek Patil's office requires you to pay any copays, deductibles and/ or co-insurance prior to your scheduled surgery. Please ask our surgical coordinator for your estimated out of pocket costs. We do our best to estimate out of pocket costs as accurately as possible based on our network contracts with various insurance companies. In the event that the insurance explanation of benefits indicates an over or under payments, you will be refunded or billed accordingly. We accept Visa, MasterCard, Discover or personal checks. If paying by check, we must receive the payment no later than 3 days prior to your scheduled surgery.

Please Note: The fees collected and billed to your insurance carrier by our office are for your surgical procedures performed by Dr. Vivek Patil. Our fees do not include any fees you may owe to the facility (Hospital or Surgery Center), or fees for Anesthesia, Pathology, Radiology or Laboratory Services, which are billed separately from our surgeon's fees. We do not bill or collect deductibles and/ or co-insurances for any of the above-mentioned entities. If you have any questions regarding these fees, our office will provide you with the contact information for the other providers who will be involved in your care.

Pre-Authorization For Surgery:

Our office will contact your insurance company to obtain preauthorization for your procedure. However, this is not a guarantee that you insurance company will pay for your surgery. Patients are responsible for their benefits, coverage and payments for all services rendered by Dr. Vivek Patil. We encourage our patients to take this opportunity to understand their personal insurance benefits. If you have any questions, you should contact your insurance carrier, employer HR Department or insurance broker to verify your benefits, eligibility, and coverage

VIVEK PATIL, MD
COLORECTAL SURGERY OF MARYLAND AND WASHINGTON, DC

A Patient's Rights

As a patient being treated in our office you have a right to:

- Respectful care given by competent personnel.
- Consideration of your privacy concerning your own medical care.
- The Names of all physicians and/or staff directly assisting in your care.
- Have medical records pertaining to your medical care treated as confidential (except as required by law or third party contractual agreement).
- Know what rules and regulations in our practice apply to your conduct as a patient.
- Expect emergency procedures to be implemented without delay; if there is a need to transfer you to another facility the responsible person and the facility will be notified of your condition prior to your arrival.
- Good quality care and high professional standards are continually maintained and reviewed.
- Full information in layman's terms concerning diagnosis, treatment, prognosis and possible complications.
- Give an informed consent to the physician prior to the start of the procedure.
- Be advised of participation in a medical care research program or donor program. (You will be asked to give your informed consent prior to participation in such a program and you may refuse to continue in a program that you have previously given informed consent to participate in.)
- Refuse drugs or procedures and have a physician explain the medical consequences of your refusal.
- Medical and nursing services without discrimination based upon age, race, color, gender, religion, national origin, handicap, disability or source of payment.
- Have access to an interpreter whenever possible.
- Access information contained in your medical record unless access is specifically restricted by your attending physician for medical reasons or is prohibited by law.
- Expect good management techniques to be implemented that are considered effective use of your time and to avoid unnecessary discomfort.
- Examine and receive a detailed evaluation of your bill.
- Be informed at your request of your provider's credentials.

WE RECOGNIZE THAT YOU HAVE A CHOICE FOR HEALTHCARE SERVICES, AND WE ARE GRATEFUL THAT YOU HAVE CHOSEN US AS YOUR PROVIDER.

For more information or to report a problem: If you have questions or would like additional information, please contact the HIPPA Policy Officer for this practice. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Revised /2020