HB Medical & Wellness Care

Office Policy and Procedures

Verification

Patient's ID and insurance cards must be presented at each visit.

Insurances

All co-pays are due at the time of service (No Exceptions)

If your insurance is expired or has changed, it is your responsibility to inform the practice, prior to or at the time of your visit. Otherwise, you are responsible for charges incurred.

If you have a deductible, we require a payment of at least $100 at the time of your visit

Account Balances

Balances are due upon receipt of the bill. All balances must be paid prior to your visit. For balances 30 days past due an additional 20% charge will be incurred. We will turn accounts 90 days past due over to collections.

Appointments

Appointments can be done online via our website www.hbprimarycare.com.

Only patients who have a scheduled appointment are allowed in the exam rooms. If the provider needs to speak with the family/friend of the patient, they will make that request after first seeing the patient. This helps providers stay on schedule. Often times, family members are also seen at the practice and will discuss their issues and make request for refills, which is not appropriate when they are not the one scheduled for an appointment.

Due to the complexity of our patients, providers are often not running on schedule for your visit. Please be aware that emergencies do arise in which providers may have to speak with the hospital, another provider or radiologist. We appreciate your patience.

Patients are asked to limit their complaints to no more than 3 per visit. This helps keep the providers on schedule for all their appointments, as well as provide you the best of care.

Urgent/Acute Visits

We do allow walk-ins during regular business hours up to one hour prior to closing. Please know we will work you into the next available provider's schedule. These visits are disruptive to the provider's schedule, however we prefer seeing our patients than you going to an urgent care center.

HB Medical & Wellness Care

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We ask that you become familiar with our appointments. Well Woman Exams and General Physicals are not appropriate visits for acute or chronic disease management. If you have such complaints during a wellness visit the provider may change the visit to a follow up and ask you to reschedule your wellness exam or you may be charged additional fees for addressing these issues during a wellness exam. Our website provides a detailed explanation of visits to help you schedule appropriately.

Patients, who "No Show" three times for scheduled appointments, may be discharged from the Practice.

Late Policy

Patients arriving 10 minutes or later, may be asked to reschedule or moved to the next available appointment.

Cancellations of Appointments/No Shows

We require 24 hours notice to cancel appointments. Appointments canceled during the week less than 24 hours will incur a $50.00 No Show Fee. The fee for a No Show on a Saturday is $60.00. The fee will be added to your account and need to be settled prior to your next visit. Do not call the on call line to cancel appointments.

Prescription Refills

Please contact the pharmacy and request that the pharmacist contact the provider for refills. This will facilitate accurate medication, dosage and pharmacy of your choice. The majority of prescriptions are done electronically (except: narcotics). Please allow **72 hours for refills**. If you run out and need refills immediately, you will need to schedule an appointment.

We do not prescribe antibiotics or narcotics without a visit.

Medications prescribed for Hypertension, Diabetes, Anxiety, Insomnia etc. require a visit every three months, to maintain adequate refills. The providers **Will Not** do a courtesy refill. Refills when appropriate will be written for **90 days or 30 days with 2 refills**. It is best that you schedule your three-month follow up in advance of running out of your medications.

HB Medical & Wellness Care

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Referrals

Referrals require **72 hours notice**. Do not schedule an appointment with a specialist without having your referral. We do not generate referrals "on demand". It is not fair to the patients being seen in clinic for the provider to be interrupted for referrals. We do not give referrals not previously discussed with the provider. We do not back date referrals.

Labs

Labs take up to **10 days to return**. Providers will only call you with urgent lab results. We ask that you schedule a follow up visit to discuss results in details. Blood work done through Labcorp will be available to view through your account with Patient Fusion.

Pain Management

We do not participate in the management of chronic pain. We are happy to refer you to a Pain Management Specialist

Medical Forms/Letters/Record Request

There is a fee for these forms. They require a week to be completed. Fees are determined by the complexity of the forms.

Billing

Please do not call the clinic with billing issues. HLT does our billing. Their number is **301-885-2730**

HB MEDICAL & WELLNESS CARE

PATIENT REGISTRATION FORM

PATIENT NAME LAST	FIRST	MIDDLE		DATE OF BIRTH
ADDRESS	APT. NO.	CITY	STATE	ZIP CODE
OCCUPATION ☐ EMPLOYED ☐ RETIRED ☐ STUDENT	SOCIAL SECURITY #	MARITAL STATUS ☐S ☐M ☐D ☐W	SEX ☐M ☐F	CELL PHONE
EMPLOYER	EMPLOYER'S ADDRESS			WORK PHONE
SPOUSE (OR PARENT) NAME	SPOUSE (OR PARENT) EMPLOYER			OTHER PHONE:
EMAIL ADDRESS :				
REASON FOR VISIT:				

PRIMARY INSURANCE INFORMATION

SUBSCRIBER'S LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH
SOCIAL SECURITY NUMBER	HOME PHONE	RELATIONSHIP TO PATIENT	
PRIMARY INSURANCE COMPANY NAME			
ADDRESS			
CITY	STATE	ZIP	
ID OR POLICY #	GROUP / CODE	EFFECTIVE DATE	

SECONDARY INSURANCE INFORMATION

SUBSCRIBER'S LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH
SOCIAL SECURITY NUMBER	HOME PHONE	RELATIONSHIP TO PATIENT	
SECONDARY INSURANCE NAME POLICY ☐SPOUSE OR ☐INDIVIDUAL		ID OR POLICY NUMBER	GROUP/CODE#
ADDRESS			
CITY	STATE	ZIP	

PATIENT AUTHORIZATION

I, _____, hereby authorize **Dr. Kanika Hampton Bipat, M.D.,** to apply for benefits on my behalf for covered services rendered. I request payment from BC/BS National Capital Area, Blue Shield of Maryland, Medicare, and / or _____ Insurance Company, be made directly to the (Name of other insurance company) above named provider (or in case of Medicare Part B benefits, to myself or the party who accepts assignment).

I certify that the information I have reported with regarded to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and / or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the above-named provider for any services furnished me by that physician / supplier. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits payable for related services. (Name of Medigap Carrier)

_____ _____

DATE SIGNATURE OF SUBSCRIBER OR BENEFICIARY

ADULT HISTORY & ANNUAL PHYSICAL FORM **www.hbprimarycare.com**

NAME _____ **DOB** _____ **Today's Date** _____

MEDICATIONS (including OTC & herbs):		
Name:	Mg. / Dosage	Reason why you are taking?

If you have more medications or medical history than can fit on form, please write on back of this form.

LOCAL PHARMACY:
Phone #:
MAIL ORDER PHARMACY:
Address:
City/ ST/Zip:
Phone #: Member ID#:

PAST MEDICAL HISTORY	**Date**
1.	
2.	
3.	
4.	
5.	

Have you ever been hospitalized or had an operation? YES NO If yes, please explain with type of surgery and dates: _____

Adult Immunizations Review – Please list the Date of your Last Immunizations (write N/A if not applicable):
Flu: _____ Pneumonia: _____ Shingles: _____ TDaP (Tetanus, Diptheria & Pertussis): _____

REVIEW OF SYSTEMS:
Mark (X) if you have any of these conditions currently or in the past. If no medical complaints please circle: NONE

	Present	Past		Present	Past		Present	Past
1. GENERAL:			**6. CARDIOVASCULAR:**			**9. MUSCULOSKELETAL:**		
Weight loss			**Chest Pain**			**Joint Pain**		
Fatigue			**Irregular Heart Beat**			**Joint Swelling**		
Memory Loss			**Elevated Blood Pressure**			**Jaw Pain**		
			Heart Disease			**10. NEUROLOGICAL:**		
2. HEENT:			**Shortness of Breath**			**Blackouts**		
Headache			**Swelling of Limbs**			**Dizziness**		
Visual Loss						**Seizures**		
Decreased Hearing			**7. ENDOCRINOLOGY:**			**Stroke**		
Sinus Pain			**Diabetes**			**11. PSYCHIATRIC:**		
Hoarseness			**Excessive Thirst**			**Anxiety**		
Sore Throat			**Excessive Urination**			**Depression**		
Trouble Swallowing			**Libido Change**			**Sleep Issues**		
3. RESPIRATORY:			**8. GASTROINTESTINAL:**			**MALE/Genitourinary**		
Cough			**Bloody Stool**			**Urinary dribbling**		
Wheezing			**Constipation**			**Reduced flow**		
4. BREAST:			**Diarrhea**			**Nighttime urination**		
Breast Mass			**Heart Burn**			**FEMALE / Genitourinary:**		
Breast Pain			**Jaundice**			**Abnormal PAP smear**		
Skin Changes			**Kidney Stones**			**Urinary Complaints**		
5. HEMATOLOGY:			**Nausea**			**Blood in Urine**		
Anemia			**Vomiting**			**Menstrual Irregularities**		
Bleeding Issues								

ALLERGIES: Are you allergic to any of the following? ***(Circle all that apply)*** **None Aspirin Penicillin Codeine Metal Latex Local Anesthetics Other: _____**
If yes, explain the reaction: _____ Anaphylaxis: YES / NO

SOCIAL HISTORY:

Family / Household member (Everyone who lives in your household):

Name	Birth Year	Relationship	

Did you EVER or do you smoke cigarettes or use other tobacco products? ***(please circle)*** **YES NO**
Type:_____
Age started _____ Age quit _____ How many packs per day? _____
Do you use any marijuana, cocaine, or non-prescribed narcotics? ***(please check)*** **YES NO**
If so, please describe: _____
How many cups of caffeinated coffee, tea, or carbonated beverage do you drink daily? _____
How many beers, mixed drinks, or glasses of wine do you have weekly? _____

FAMILY HISTORY:

Please check if Mother, Father, Brother/Sister or Grandparents have had any of the following: For Grandparents, please indicate M for Mother's side of family or P for Father's side of family.

	Mother	Father	Brother/Sister	Grandmother	Grandfather	Age at onset
Alcoholism						
Allergies						
Diabetes						
Tuberculosis						
Heart Disease						
Stroke						
High Blood Pressure						
Depression / Anxiety / Bipolar						
Suicide						
Cancer						
High Cholesterol						
Thyroid issues						
Major medical problems						

WOMEN ONLY

Dates of last two Periods _____ _____

Current method of contraception _____

Number of previous:
Pregnancies _____ Miscarriages _____
Live Births _____ Terminations _____

AGE at Menopause _____

Date of Last: PAP Test: _____
Mammogram: _____
Dexascan: _____
Colonoscopy (50+): _____

MEN ONLY

Do you perform monthly testicular self-exams (TSE)?
Yes No

Date of Last PSA Test: _____

Date of Last Colonoscopy (50+) _____

HAMPTON BIPAT
MEDICAL & WELLNESS CARE

11315 Pembrooke Square, Ste 111 Waldorf, MD 20603
Phone: (240) 252-2150 Fax: (240) 252-2151

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Dr. Kanika Hampton Bipat, MD

Address: 11315 Pembrooke Square, STE 111

City: Waldorf State: MD Zip Code: 20603

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date Signed: _____

HB Medical & Wellness Care
Notice of Privacy Practices for Protected Health Information
Effective Date: 09/01/2011

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!

The HB Medical and Wellness Care is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of Your Health Information for Treatment Purposes are:

- A nurse obtains treatment information about you and records it in a health record.
- During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

Example of Use of Your Health Information for Payment Purposes:

We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of HB Medical & Wellness Care. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office -- we are not required to grant the request, but we will comply with any request granted;

- Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full—we must comply with this request;

- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office.

- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our office.

- Appeal a denial of access to your protected health information, except in certain circumstances;

- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office. We may deny your request if you ask us to amend information that:

    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

    - Is not part of the health information kept by or for the office;

    - Is not part of the information that you would be permitted to inspect and copy; or,

    - Is accurate and complete.

    If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;

- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant

to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.

- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office, except to the extent information or action has already been taken.

- Elect to opt out of receiving further fundraising communications from the office.

If you want to exercise any of the above rights, please contact Dr. Hampton Bipat, Medical Director, 240-252-2150, 11355 Pembrooke Square, suite 108A, Waldorf, MD 20603; in person or in writing, during regular, business hours. She will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities

The HB Medical and Wellness Care is required to:

- Maintain the privacy of your health information as required by law;

- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;

- Abide by the terms of this Notice;

- Notify you if we cannot accommodate a requested restriction or request; and,

- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact **Dr. Kanika Hampton Bipat, Medical Director, 240-252-2150.**

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to **Dr. Kanika Hampton Bipat**. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services, at www.hhs.gov

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from our office.

- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Notification

- Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Research

- We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief

- We may use and disclose your protected health information to assist in disaster relief efforts.

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA)

- We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

- If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

- As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse & Neglect

- We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Employers

- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

Correctional Institutions

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

- We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

Health Oversight

- Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

- We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat

- To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions

- We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Coroners, Medical Examiners, and Funeral Directors

- We may release health information 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 health information about patients of Covered Entities to funeral directors as necessary for them to carry out their duties.

Other Uses

- Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights."

Website

- If we maintain a website that provides information about our entity, this Notice will be on the website.

Notice of Patient Privacy Policy

I have read and understand how this practice may use and disclose my health records. I also understand that I may review this policy at anytime, either in the clinic as well as on their website, www.hbprimarycare.com

_____ _____

Signature Date

_____

Print Name

Notice of Office Policy and Procedures

I have read and understand that this practice has policies in place, to ensure the best of care for all their patients. These policies are in place to provide a mutual respect among it patients and staff.

_____ _____

Signature Date

_____

Print Name

No Show Policy

Each time a patient misses an appointment without providing proper notice, it prevents another patient from receiving care. We reserve the right to charge for these occurrences. We also reserve the right to dismiss patients from the practice who are repeat offenders. By signing below, you acknowledge that you have been informed of this notice.

_____ _____

Signature Date

_____

Print Name

_____ _____

Witness Date