

Shashank Srivastava, DPM
2401 Research Blvd, # 350
Rockville, MD 20850
301.330.0468
www.rockvillefootandankle.com
FINANCIAL POLICY AND MEDICAL INSURANCE

We would like to welcome you and thank you for selecting our office!

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our policy.

The patient is responsible for payment of their health care within a reasonable time, regardless of the processing time of your insurance claim. In circumstances where a claim is pending, or when treatment will be for an extended period of time, it is recommended that a payment plan be initiated. We accept cash, checks or all major credit cards for payment.

Balances older than 30 days are subject to \$5.00 per month fee. Patients that do not pay their co-pay at time of visit will be charged an additional \$5.00. Returned checks are subject to a \$25.00 fee. Missed appointments will be billed \$25.00 when cancelled without a 24-hour notice.

Late fees may accrue a monthly fee of 25\$ compounded continuously after 30 days from first bill sent.

YOU MUST REALIZE THAT:

- 1) Your insurance is a contract between you, your employer, and the insurance company. It is your responsibility to understand the benefits of your plan. We cannot guarantee payment of your claims. If your insurance company pays only a portion of your claim or rejects your claim, you and/or the policyholder should make any contact or inquiry. After **90** days from the date of service, you will automatically become responsible for the balance. **Payment delays or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.**
- 2) **MEDICARE PATIENTS** – Please understand that we participate with Medicare. However, you are responsible for your 20% co-insurance, deductible and any **non-covered** services. If Medicare has provided its reimbursement for services rendered and if your supplemental insurance does not respond within 30 days, then **you** become responsible for the balance.
- 3) Filings of insurance claims are a courtesy that we extend to our patients and all charges are your responsibility. We realize that temporary financial problems may effect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.
- 4) If you believe your insurance carrier has erred or not adequately addressed your claims, you may file a grievance or appeal with the Maryland Insurance Administration, 410-468-2244 and/or The Health Advocacy Unit of the Maryland Attorney General, 410-528-1840.

I have read and I understand the above financial policies. These policies are subject to change without prior written confirmation.

SIGNATURE

Date

NOTICE OF PRIVACY PRACTICES

**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 PRIVACY OF YOUR MEDICAL
INFORMATION IS IMPORTANT TO US.**

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **April 15, 2003**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes. You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Name of Contact Person: Dr. Shashank Srivastava

Telephone:301-330-0468 Fax: 301-330-3489

E-mail:

Address:2401 Research Blvd, #350 Rockville, MD 20850

**ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was offered/provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (please print) Date

Parent or Authorized Representative (if applicable)

Signature

NEXT PAGE PLEASE

**WELCOME TO OUR OFFICE. PLEASE ASK IF YOU NEED HELP WITH THIS FORM
PATIENT INFORMATION
(PLEASE PRINT)**

NAME		DATE		
ADDRESS		CITY	STATE	ZIP
HOME PHONE	CELL PHONE	SOCIAL SEC #		
DATE OF BIRTH	AGE	SEX M F	MARITAL STATUS	S M W D SEP
REFERRED BY	PERSONAL PHYSICIAN	E-MAIL		
PATIENT'S EMPLOYER	BUSINESS PHONE			
SPOUSE'S NAME	SPOUSE'S WORK PHONE			
EMERGENCY OR CONTACT PERSON		PHONE		

**PERSON RESPONSIBLE FOR BILL
(IF OTHER THAN ABOVE)**

NAME	RELATIONSHIP	BIRTHDATE
ADDRESS (IF OTHER THAN ABOVE)	HOME PHONE	
EMPLOYER	BUSINESS PHONE	

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY

1-

2-

**PLEASE ATTACH ALL INSURANCE CARDS TO THIS FORM FOR US TO COPY
PLEASE ATTACH ALL REFERRALS TO THIS FORM**

AUTHORIZATIONS

BENEFITS TO PHYSICIAN:

I hereby authorize payments directly to the physician of the surgical and/or medical benefits.

I also understand I am responsible for any portion of my bill not covered by my insurance company. HMO patients are subject to the coverage benefits of their program.

RELEASE OF INFORMATION

I hereby authorize release of information for insurance claim purposes.

The information authorized for release may include information which may be considered communicable or Venereal disease, including hepatitis, syphilis, gonorrhea, HIV, and AIDS.

I understand all of the above and hereby state that the information is correct to the best of my knowledge.

Date

Signed (Insured Person)

MEDICAL INFORMATION

This Information Is Important For Our Records And Your Health

Are you allergic to: Penicillin Codeine Sulfa drugs Aspirin Iodine
Novacaine Other: _____

Please list all medications you take regularly:

Please circle any of the following you have or have had a problem with:

Diabetes High Blood Pressure Heart Disease Heart Murmur Heart Valve Seizures
Asthma Rheumatic Fever Hepatitis Stroke Gout Stomach Ulcers
Anemia Liver Disease Circulation Cancer Infections Nerve Problems
Thyroid Kidney Disease Bleeding Scarring Tuberculosis HIV
Hormones Arthritis Other: _____

Have you had any serious illnesses? Please List: _____

Have you had any major surgeries? Please List: _____

Do you have any healing or scarring problems? Please describe: _____

Do you have any artificial joints? Yes No Which ones? _____

Do you have Heart Valve Implants? Yes No

Do you have a pacemaker? Yes No

Family History

Is there a family (blood relative) history of (Please circle all that apply):

Heart disease Arthritis Bleeding Disorder Neurologic Disorder Stroke
Bunions Flat feet Hammertoes Circulation problems in legs or feet
Diabetes Hypertension Other: _____

Social History

Do you smoke? Yes #packs per day _____ No

Previously smoke? Yes #of years _____ No

Do you drink alcohol or beer? Yes How Frequently? _____ No

What is your job description: _____

Employment Activity (Please Check All That Apply): Sitting Standing Walking Retired

Shoe Size _____ Current Weight _____ Height _____

NEXT PAGE PLEASE

PODIATRIC HISTORY

Describe your foot problems: _____

How long has it been bothering you? _____ Days _____ Weeks _____ Months _____ Years

What treatment has been given? _____

Any past problems with your feet and ankles? _____

Any past surgical procedures on your feet or ankles? (Describe) _____

Previous Foot Doctor: _____ Last Visit: _____

Is there any additional information you would like us to know about or would like to tell the doctor privately?

Signature: _____ Date: _____

PLEASE LET US KNOW IF YOU HAVE ANY SPECIAL NEEDS.

YOUR REFERRALS OF FRIENDS AND FAMILY ARE GREATLY APPRECIATED!

VISIT US ONLINE AT WWW.ROCKVILLEFOOTANDANKLE.COM

Shashank Srivastava, DPM, LLC
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You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures of your protected health care information that may occur. 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 a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. 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.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. 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 protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you the Maryland state mandated fee to locate and copy your protected health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2009, the accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your

protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services

Name of Contact Person: Shashank Srivastava, DPM

Address:2401 Research Blvd, Suite 350
Rockville, MD 20850

Phone: (301) 330-0468