Dedicated Medical Care
Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed and how you get access to this information. Please review it carefully.
If you have any questions about this notice please contact our office.

This notice of privacy describes how we may use and to whom we would disclose your protected health information. It also describes your rights to access and control your health information. Protected health information is information about you, including the information given on your registration form and any past, present, or future physical and mental health condition.
We are required by law to abide by the terms of this Notice of Privacy. We may change the terms of this notice, at any time. The new notice will be effective for all protected health information that we have at that time. Upon your request, we will provide you with a revised Notice of Privacy.

1. Uses and Disclosures of Protected Health Information

Uses and disclosures of protected health information based upon written consent.

Treatment: We will use or disclose your health information to provide, coordinate or manage your health care and any related services. This includes any third party that has obtained your permission to have access to this information, as well as any physician or health care provider who at the request of your physician becomes involved in your care.

Payment: Your health information will be used, as needed, to obtain payment for your health care services. This includes providing information to your insurance plan for consideration of payment for services we recommend for you. If you pay out of pocket in full you have the right to request restricted access to your health plan

Healthcare Operations: We may use or disclose, as needed, your health information in order to support the business activities of our practice. This includes:

1. The use of a sign in sheet indicating your name and the name of your physician
2. Calling your name in the waiting area when the doctor is ready to see you.
3. To confirm your appointment

We will share your health information with a third party that provides services to the practice. Whenever an arrangement between our office and a business associate involves the disclosure of your health information, we will have a written contract that contains terms that will protect the privacy of your information.

Uses and Disclosures of Protected Health Information Based upon Specific written Authorization

Other uses and disclosures of your health information will be made only with your written authorization unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that the practice or physician has taken an action relying on the authorization. We may use your health information in the following instances. You have the opportunity to agree or object to the disclosure of all or part of your information. If you are not present or able to agree or object to the disclosure then your physician may determine whether the disclosure is in your best interest.

Others involved in your healthcare: We may use or disclose all or part of your information to a family member or friend if requested by you in writing. We may disclose information to notify or assist in notifying a family member or personal representative or any other person responsible for your care of your location, general condition, or death. We may disclose your information to an authorized public or private entity to assist in disaster relief efforts.

Emergencies: We may use or disclose your information in an emergency treatment situation. If

this happens, your physician will try to obtain your consent as soon as reasonably practical after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and is unable to obtain your consent, he or she may still use or disclose your health information to treat you.

Communication Barriers: We may use or disclose your health information if we are unable to obtain consent due to substantial communication barriers and the physician determines that you intend to consent to the use under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your health information in the following situations without your consent or authorization. The disclosure will be made in compliance with the law and limited to the requirements of the law. You will be notified of any such uses.

Public Health: The disclosure will be made to a public health authority that is permitted by law to collect the information for the purpose of controlling disease, injury or disability.

Communicable Disease: We may disclose your information if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Over site: We may disclose your information to a health over site agency for activities authorized by law. Over site 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 information to a public health authority that is authorized to receive reports of abuse or neglect.

Food and Drug Administration: We may disclose your information to a person or company required by the Food and Drug Administration to report adverse events.

Legal Proceedings: We may disclose information in the course of any judicial or administrative proceeding in response to an order of a court or other lawful process.

Law Enforcement: We may disclose information for law enforcement purposes including Legal processes, identification and location, pertaining to victims of a crime, suspicion that death has occurred as a result of criminal conduct, in the event that a crime has been committed on the premises of the practice, a medical emergency and it is likely a crime occurred, or to prevent or lessen a serious threat to the health or safety of another person.

Coroners, Funeral Directors: and Organ Donation: We may disclose information in a reasonable anticipation of death.

Military Activity or National Security: We may disclose your information for activities deemed necessary by appropriate military command authorities.

Workers Compensation: We comply with workers compensation laws and may disclose your information as needed.

Sale of protected health information: We must have authorization from you before any protected health information is sold.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a description of how you may exercise these rights

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of your medical information for as long as we maintain the information. You may not however inspect or copy information compiled in anticipation of a civil, criminal or administrative action or proceeding. In certain circumstances, a decision to deny access may be reviewed.

You have the right to request restriction of your protected health information. You may ask us, in writing, not to use or disclose any part of your health information for the purpose of treatment, payment or healthcare operations. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician does agree to the restriction, we may not disclose your information in violation with that restriction unless it is needed to provide emergency treatment.
You have the right to have your physician amend your protected health information. You may request an amendment to your health information for as long as we maintain the information. We may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us.
You have the right to receive an accounting of certain disclosures we have made of your protected health information. This right applies to disclosures for purposes other than treatment payment or healthcare operations as described in the first section of this notice. The right to receive this information is subject to certain exceptions, restrictions and limitations.
You have the right to be notified following a breach of unsecured protected health information.
You have the right to opt out of any fundraising communications.

We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. 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 [3]opt-out[2] and disable 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 atwww.crisphealth.org<http://www.crisphealth.org/>. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

3. Complaints

You may complain to the Secretary of Health and Human Services or us if you believe your privacy rights have been violated by us. You may file a complaint with us by contacting our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Contact, Jeannette Smith at 301-897-8550 for further information about the complaint process.

Dedicated Medical Care, LLC Policies

1. I understand that I am responsible for charges not covered by my insurance company. I agree, in the event of non-payment, to assume the costs of all interest and fees due to collection legal action. One statement will be sent to you as a courtesy. For each additional statement sent due to non-payment, a $10 billing fee will be added to your account. Payment for self-pay patients is due at the time of service.

2. I authorize my insurance carrier to release information regarding my insurance coverage to DRS Feldman and Galotto, LLC. I also authorize agents of any hospital, treatment facility or previous physicians to furnish DRS. Feldman and Galotto, LLC copies of any and all records of my medical history. I authorize the release of my medical records to any federal, state or accreditation agency. I agree to a review of my records for purpose of internal audits, research and quality assurance reviews within the office.

3. My right to payment for all procedures, tests, supplies and services including major medical benefits are hereby assigned to DRS. Feldman and Galotto, LLC. This assignment covers any and all benefits under Medicare, all government sponsored programs, private insurance companies, and other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment for services. In the event my insurance carrier does not accept assignment of benefits, or if payments are made directly to my representative, or me, I will endorse such payments to DRS. Feldman and Galotto, LLC.

4. I understand that when paying by check to DRS. Feldman and Galotto, LLC, I will be responsible for a $25 fee if a check is returned. This does not include any other fees applied by your bank.

5. I understand that I am responsible for any fees not covered by my insurance. In the event that my account becomes delinquent and is forwarded to an attorney or agency for collection, I am responsible for the fees including court costs.

6. **I acknowledge receipt of the Notice of Privacy Policies provided by DRS. Feldman and Galotto, LLC. I am responsible for reviewing all information.**

7. I authorize DRS. Feldman and Galotto, LLC to contact me for the following reasons:
    - Permission to call me at home, office, or mobile to confirm or reschedule an appointment, to provide me with test results, or to return my message(s).
    - Permission to leave appointment reminders or appointment cancellation notifications on an answering machine, voice mail, with a family member, secretary, or household employee.
    - Permission to leave "your test results were normal" on an answering machine.

I understand that missed appointments and appointments canceled without 24 hours notice are subject to a $25 fee.

Name of Patient and/or Guardian (please print):____

Signature of Patient of Guardian: ____

Date: ___________________________