



PATIENT INFORMATION: (Please fill in all information completely)

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: _____ Work: _____ Cell: _____

Email Address: _____

Date of Birth: _____ SS#: _____ Marital Status S M D W

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician (first and last name): _____

Referring Physician (first and last name): _____ Phone: _____

How did you first learn about the Hanover Parkway Surgery Center?
_____ Doctor Referral _____ Insurance Web Site _____ Internet Search _____ Friend/Family
_____ Advertisement _____ Hospital Referral _____ Seminar _____ Other

Did you sustain an injury at work? Y N Are you covered under an employer or union policy? Y N

Are your injuries accident related? Y N Are you under Worker's Compensation? Y N

INSURANCE INFORMATION: (Please fill in all information completely)

Primary Insurance Company Name: _____ Co-Pay \$ _____

Address: _____

ID#: _____ Group#: _____

Policy Holder's Name: _____ Relationship: _____

Policy Holder' DOB: _____ Policy Holder's SS#: _____

Policy Holder's Employer: _____

Secondary Insurance Company Name: _____ Co-Pay \$ _____

Address: _____

ID#: _____ Group#: _____

Policy Holder's Name: _____ Relationship: _____

Policy Holder' DOB: _____ Policy Holder's SS#: _____

Policy Holder's Employer: _____

PATIENT AUTHORIZATION:

I authorize the Hanover Surgery Center (HPSC) (Dr. Tesfayohannes/Dr. Kiefer) to apply for benefits on my behalf for services rendered. I certify that the information I have reported with regards to my insurance coverage to be true and correct and further authorize the release of any necessary information (to include medical information) for any related claims. I further understand that if my insurance plan requires me to obtain a referral and I do not have the necessary referral with me at the time of service, or if my referring physician will not issue a referral, I am responsible for paying all fees for services owed to HPSC. I understand that if I do not have out-of-network benefits under my insurance plan and if an HPSC attending physician is not a participating provider under my insurance, I am responsible for all fees for services rendered by the physicians of HPSC. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me in writing. I understand that nothing herein relieves me of the insurance carrier made to me for services provided by any member of HPSC will be surrendered to HPSC. This includes office visits, surgery or other procedures.

Signature _____ Date _____

I have received a copy of the Hanover Parkway Surgery Center's Financial Policy & Notice of Privacy Practices _____ (initials)



PLAN OF CARE AGREEMENT

Cash payment at the time of appointment guarantees full evaluation by the doctor. The evaluation may include medication management, referral to spine intervention, physical therapy, or referral to detoxification. Cash payment does not guarantee the continued prescription of medication prescribed by other healthcare providers.

There will be no refunds given after payment

Patient's Name: (Print) _____

Patient's Signature: _____

Date: _____



PHYSICIAN INFORMATION

Primary Care Physician

Name: _____

Phone No.: _____

Office Address: _____

Referring Physician

Name: _____

Phone No.: _____

Office Address: _____

MRI/CT/CX

Name: _____

Phone No.: _____

Location: _____

Payment for visit does not guarantee previously prescribed medications

Payment includes: Evaluations
 In House Testing

There will be no refunds after evaluation begins

I understand the above policy.

Patient Signature

PATIENT RIGHTS

1. You have the right to personal privacy and care in a safe setting free from all forms of abuse, harassment, discrimination or reprisal.
2. You have the right to accurate and easily understand information about your health plan, treatment, health care professionals and health care facilities. If you speak another language, have a physical/mental disability or just do not understand something, help should be given so you can make informed health care decisions prior to your treatment or procedure.
3. You have the right to choose health care providers who can give you high quality health care.
4. You have the right to know what patient support services are available, including access to an interpreter if language is a problem.
5. You have the right to know your treatment options and take part in decisions about your care. Parents, guardians, family members or surrogates that you select can represent you if you cannot make your own decisions according to state law. If a patient is adjudged incompetent under applicable state health and safety laws by a court of proper jurisdiction, the rights of the patient are to be exercised by the person appointed under state law to act on your behalf.
6. You have the right to considerate, respectful care from your doctors, health plan representatives, and other health care providers that does not discriminate against you.
7. You have the right to talk privately with health care providers and to have your health care information protected. You also have the right to read and copy your own medical records. You have the right to ask your doctor to change your record if it is not correct, relevant, or complete. Unless authorized by law, you have the right to approve or refuse record release.
8. You have the right to a fair, fast and objective review of any complaint you have against your health plan, doctors, hospitals or other health care professional without fear of reprisal. This includes complaints about waiting times, operating hours, the actions of health care personnel and the adequacy (or lack of) of treatment or care.
9. Contact information if you feel as if any rights were violated is as follows:
Office Care Quality Unit: Ambulatory Care Programs, Spring Grove Hospital Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, Maryland 21228
Website: <http://www.dhmh.maryland.gov/ohcq> PH (800) 492-6005
10. You have the right to submit a grievance either verbally or in writing to: Administrator of the Hanover Parkway Surgery Center, 7300 Hanover Drive, Suite 204, Greenbelt, Maryland 20770, PH (301) 477-3959. You will receive a written notice of decision within 30 calendar days describing the steps taken to investigate the results and the completion date.



PATIENT RESPONSIBILITIES

1. You have the responsibility to provide, to the best of your knowledge, accurate and complete health information.
2. You are responsible for following the treatment plan recommended.
3. You are responsible to participate in your plan of care and provide an Advance Directive, if you have one.
4. You are responsible for making known whether or not you clearly understand the medical treatment.
5. You must have a responsible adult to provide you transportation and assist with your care for the first 24 hours post op.

ADVANCE DIRECTIVE

Advance Directives will not be honored at our surgery center. We will do everything to stabilize you, the patient, and arrange for immediate transfer to a nearby hospital. If indeed a need did arrive, we will try any life saving measure to stabilize you for transport. If you do not have an Advance Directive and would be interested in completing one, we are happy to supply you with information. All patients are asked if they have an Advance Directive, which is placed in their medical record. Patients are also informed that an Advance Directive will not be honored while a patient at Hanover Parkway Surgery Center.

FINANCIAL INTEREST/OWNERSHIP: Dr. Hagos (50%); Dr. Nestsere Tesfayiohannes (50%)

PRIVACY NOTICE

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION CAREFULLY

- Your confidential healthcare information may be released to other healthcare professionals within Hanover Parkway Surgery Center for the purpose of providing you with quality care.
- Your confidential healthcare information may be released to your insurance provider for the purpose of Hanover Parkway Surgery Center receiving payment for providing you with needed healthcare services.
- Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your confidential healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).



- Your confidential healthcare information may NOT be released for any other purpose than that which is identified in this notice.
- Your confidential healthcare information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.
- You may be contacted by Hanover Parkway Surgery Center to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.
- You may be contacted by Hanover Parkway Surgery Center for the purposes of raising funds to support the organization's operations.
- You have the right to restrict the use of your confidential healthcare information. However, Hanover Parkway Surgery Center may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive confidential communication about your health status.
- You have the right to review the photocopy of any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your confidential healthcare information and for what purpose.
- You have the right to possess a copy of the Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- Hanover Parkway Surgery Center is required by law to protect the privacy of its patients. We will keep confidential, any and all patient healthcare information and will provide patients with a list of duties or practices that protect confidential health information.
- Hanover Parkway Surgery Center will abide by the terms of this notice. The organization reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.
- You have the right to complain to Hanover Parkway Surgery Center if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to:

ATTN: Haddis T. Hagos, M.D.
Hanover Parkway Surgery Center
7300 Hanover Drive, Suite 204
Greenbelt, Maryland 20770



- All complaints will be investigated. No personal issue will be raised for filing a complaint with the organization.
- For further information about this Privacy Notice, please contact Haddis T. Hagos, M.D. at (301) 220-2333.
- This notice is effective as of Date of Effectiveness. This date must not be earlier than the date on which the notice is printed or published.

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

As required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1966 (HIPAA)

- I have received a copy of the Notice of Privacy Practices
- I understand that if changes are made to this Notice of Privacy Practices, a revised copy of the notice will be posted in the office.
- I also understand that if I wish to receive additional copies of this Notice of Privacy Practices in the future or if I have any questions with regards to this Notice of Privacy Practices, I may contact:
 - Dr. Netsere Tesfayohannes, M.D.
Medical Director
Tel: 301-718-1082
Fax: 301-718-1084

In order to ensure your privacy, please indicate below how would you like us to contact you in regards to your healthcare. Please initial each one that applies.

- Home Number: _____ Work Number: _____
- Cell Number: _____
- You may leave information regarding my health with:
 - Spouse (name): _____
 - Other: _____
 - Message on answering machine/voice mail

This authorization is good for 1 year unless noted: _____

Patient/Guardian signature: _____ Date: _____

Print Name: _____

Witness: _____

FOR PRACTICE USE ONLY:

Date acknowledge denied by patient: _____

Reason denied by patient: _____

Name of person reviewing: _____ Date: _____



TREATMENT AGREEMENT

This is an agreement between (Patient Name) _____ and _____ regarding the diagnosis of _____ for which the following medication(s) have been prescribed (narcotics): _____

I understand that there is alternative treatment which includes: _____

The goal of my therapy is to reduce my pain to a level that is tolerable and will allow me to improve my ability to perform daily activities. I understand that daily use of narcotics increases certain risks, which include, but are not limited to:

- Addiction
- Allergic reactions, overdose and/or fatal complications
- Breathing problems
- Drowsiness, dizziness and/or confusion
- Impaired judgment and inability to operate machines or drive motor vehicles
- Nausea, vomiting of tolerance

I agree to the following guidelines:

1. I will take this medication only as prescribed and I will not change the amount or frequency without authorization from my physician. Unauthorized changes may result in my running out of medication early, and early refills will not be allowed.
2. I understand that due to the high potential for abuse of these medications, the following rules apply:
I will not be allowed to obtain early refills or receive replacement of lost or stolen medication.
Refills will only be provided during regular office hours.
3. I will obtain ALL of my prescriptions through _____, and I will fill ALL of my medications at (pharmacy name) _____. In an acute emergency, another provider may prescribe medication for me. If this occurs, I will notify my primary care physician or nurse practitioner as soon as possible.
4. I will submit to random urine or blood tests if requested by my physician or nurse practitioner to assess my compliance.
5. I agree to see _____ for ongoing case management and will keep regularly scheduled appointments as long as I am taking this narcotic medication.
6. If I do not follow the guidelines, I understand that my treatment will be terminated.

I have discussed the risks, benefits and alternatives to narcotics treatment with my provider. I have had an opportunity to ask questions and receive answers to those questions to my satisfaction.

Patient Signature: _____

Date: _____

Physician Signature: _____

Date: _____