Philip G. Henjum, M.D.
Diplomate, American Board of Internal Medicine
Diplomate, American Board of Hospice and Palliative Medicine

Patient Name____

Home Address_______________________________________
____

Alternate Address____________________________________
____

Date of Birth________________

Telephone Numbers:

Home:_______________________

Work:________________________

Cell:_________________________

Email:________________________

Pharmacy Preference__________________________________

Insurance Information *(for referral purposes only)*
____
____
____

If you are a Medicare patient or participate with an HMO you will be asked to sign an additional form.

Anything else you may want us to know about you?
____
____
____

*Today's Date*___________________________________

18109 Prince Philip Drive, Suite 200 ♦ Olney, Maryland 20832
Telephone 301-774-7115 ♦ drhenjum@drhenjum.net

Philip G. Henjum, M.D.
Diplomate, American Board of Internal Medicine
Diplomate, American Board of Hospice and Palliative Medicine

VOLUNTARY AFFILIATION AGREEMENT

I, _________________________________ ("Patient") wish to affiliate with Philip G. Henjum, M.D. as my medical doctor. This includes usual Internal Medicine services, including but not limited to, diagnosis, treatment, office visits, hospital care, referral to other physicians when appropriate, return of telephone calls, e-mails, faxes, etc. on a timely basis. When necessary, Dr. Henjum will arrange on-call physician back-up at all times.

- The annual professional retainer fee for this association, which I voluntarily choose to pay, is between $2100 and $2300, dependent on the number of installments I choose to pay the annual fee.
- I understand that this is intended as a commitment for one-year, to be renewed annually by mutual agreement.
- I understand that Dr. Henjum will not submit bills to my insurance company, or to Medicare. Additionally, I understand that I cannot submit to Medicare for services rendered by Dr. Philip Henjum as he has opted out of the Medicare program.
- The annual fee serves as the practice's sole method of reimbursement, and as such must be paid on time. A delay or late payment of more than 30 days will be taken as a wish to leave the practice, and will result in discharge from the practice. In that event, a list of other skilled physicians will be recommended, emergency care rendered for one month or until another physician is selected (whichever occurs first), and records will be transferred to the new physician.
- I understand that Dr. Henjum reserves the right to discharge patients from his practice for improper, unethical, or illegal behavior, as determined by him on an individual basis, and at his sole discretion.
- I understand that I will not submit any claim to my insurance company or to Medicare for reimbursement that is not permitted under my agreement with that organization. I also understand that any reimbursement I submit which is a violation of that agreement, or of any law, is my own responsibility, and further that this was not encouraged or sanctioned in any way by Dr. Henjum.
- I understand that the payment of this fee applies only to Dr. Henjum, and does not include care or services provided by any other physician, hospital, laboratory, radiology office, or other entity.
- **I UNDERSTAND THAT IN FORMING THIS AFFILIATION I AM NOT PURCHASING MEDICAL INSURANCE, AND THAT I AM NOT BEING ADVISED TO SURRENDER ANY INSURANCE I PRESENTLY HAVE. I HAVE BEEN ADVISED TO MAINTAIN MEDICAL INSURANCE IN FORCE.**

Signed ____ Date ___________________
Patient or PoA

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Retainer Fee Agreement

Please note your preferred method of payment

☐ Personal check, made payable to *Philip G. Henjum, M.D., L.L.C.*

☐ Send a bill to my home (Not accepted for first payment)

☐ Credit Card (MasterCard , Visa or Discover)
Circle type of card used

Card # ______________________________Security Code_________ Expiration________

Please check your preferred schedule of payment

Office Care

- ☐ Paid annually, in full, before the start of the first visit. *One payment of $2100 [Total $2100]*
- ☐ Paid semi-annually, 50% of the retainer fee before the start of the first visit, and 50% of the retainer fee six months later. *Two payments of $1100 [Total $2200]*
- ☐ Paid quarterly, 25% before the start of the first visit, then equal portions of the balance every 3 months. *Four payments of $575 [Total $2300]*

Nursing Home Care /Assisted Living

- ☐ Paid annually, in full, before the start of the first visit. *One payment of $3000 [Total $3000]*
- ☐ Paid semi-annually, 50% of the retainer fee before the start of the first visit, and 50% of the retainer fee six months later. *Two payments of $1600[Total $3200]*

Homebound Care

- ☐ Paid annually, in full, before the start of the first visit. *One payment of $3750 [Total $3750]*
- ☐ Paid semi-annually, 50% of the retainer fee before the start of the first visit, and 50% of the retainer fee six months later. *Two payments of $2000 [Total $4000]*

Note: Each child of an adult member, 13 years old through their 25th birthday are charged at *half* the adult rate ($1050). All other terms applying to adults apply to children. Dr. Henjum recommends that children under the age of 13 be followed by a pediatrician. All individuals under age 21 must have at least one parent in the practice.

Signed ___________________________________ Date ____________________________

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PHILIP G. HENJUM, M.D., LLC
PRIVACY PRACTICES ACKNOWLEDGEMENT
And
PATIENT INFORMATION UPDATE SHEET

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

In accordance with the **HIPAA** (Health Insurance Portability and Accountability Act Privacy regulations enacted by the Federal Government and effective April 2003, I hereby authorize that Philip G. Henjum, M.D. LLC, it's physicians and employees, may contact me or return my calls by the following means:

Please check all that you wish to authorize:

_____May contact me at home. My home number is: _______________

_____May leave a message at my home.

_____May contact me at work. My work number is: ________________

_____May leave a message at work.

_____May contact me on my cellular phone. My cell number is:________________

_____May speak with my family members regarding my condition. If so, list which family members and their phone numbers directly below:

____
Names of Family Members and Phone Numbers, if box above is checked

Name of Patient_________________________________**Birthdate** _______________

Signature of Patient or PoA ____

Today's Date____

This information constitutes Protected Health Information (PHI) as defined under HIPAA and as such will be used only by persons needing to use this information to provide patient care, for billing, or for other purposes only with your written authorization as required by law. It shall remain in effect unless/until patient makes revisions.

This privacy policy is effective April 14, 2003 and is in effect indefinitely, unless our practice's privacy policies change.

Philip G. Henjum, M.D.

Diplomate, American Board of Internal Medicine
Diplomate, American Board of Hospice and Palliative Medicine

<u>Medicare Private Contract for Philip G. Henjum, MD</u>

Philip Henjum, MD is excluded from accepting Medicare insurance payments through October 1, 2024 and a minimum of two years thereafter.

I, ______________________________________, ("Patient") accept full responsibility for payment of Dr. Henjum's charges for all services furnished by him. Payment arrangements are detailed under a separate agreement entitled Financial Terms for Patients Under Medicare.

I, or my legal representative, understand that Medicare limits do not apply to what Dr. Henjum may charge for items or services furnished by him.

I, or my legal representative, agree not to submit a claim to Medicare or to ask Dr. Henjum to submit a claim to Medicare.

I, or my legal representative, understand that Medicare payment will not be made for any items or services furnished by Dr. Henjum that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

I, or my legal guardian enter into this contract with the knowledge that I, or my legal representative, have the right to obtain Medicare covered items and services from physicians and practitioners who have not opted out of Medicare, and that I am not compelled to enter into private contracts that apply to other Medicare covered services furnished by other physicians or practitioners who have not opted out.

I, or my legal representative, understand that Medicare plans do not and other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

I, or my legal representative, understand that this private contract may not be entered into by myself, or my legal representative, at a time when I may require emergency care or urgent care services.

I, or my legal representative, have a copy of this contract before any items or services were furnished to me under the terms of this contract.

________________________________ ___________________
Signature of Patient or PoA Date

________________________________ ___________________
Philip G. Henjum, MD Date

18109 Prince Philip Drive, Suite 200 ♦ Olney, Maryland 20832
Telephone 301-774-7115 ♦ drhenjum@drhenjum.net

PHILIP G. HENJUM, M.D.
Diplomate, American Board of Internal Medicine
Diplomate, American Board of Hospice and Palliative Medicine

Authorization to Release Medical Records

Patient's Name:_______________________________Date of Birth:___________

I hereby request and authorize____
Physician or health care facility

To release healthcare information of the patient named above to:

Philip G. Henjum, M.D.
18109 Prince Philip Drive, Suite 200
Olney, MD 20832

301-774-7115 (phone) 301-774-7968 (fax)

I request release of the following:

- ☐ Labs
- ☐ X-rays
- ☐ EKG
- ☐ Immunization records
- ☐ Entire medical record
- ☐ Other

I understand that my express consent is required to release any healthcare information related to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted disease, pregnancy, psychiatric disorders/mental health, or relating to drug and/or alcohol abuse or treatment. You are specifically authorized to release all healthcare information related to such diagnosis, testing or treatment.

_________________________________ ________________
Patient's Signature Date

This Authorization Expires 90 Days after the date signed.

Effective Date of this Notice: December 1, 2003

PHILIP G. HENJUM, M.D., LLC

18109 Prince Philip Drive, Suite 200
Olney, MD 20832

NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE DECEMBER 1, 2003
PRIVACY OFFICER: Michael Benedict

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducti ng our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IHII. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF **YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE** CONTACT:
Michael Benedict, Practice Manager, 301-774-7115

C. WE MAY **USE** AND DISCLOSE YOUR **INDIVIDUALLY IDENTIFIABLE HEALTH** INFORMATION **(IIHI)** IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your III-II in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice - including, but not limited to, our doctors and nurses - may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your III-II to others who may assist in your care, such as your spouse, children or parents.
Finally, we may also disclose your VIII to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatmen t. We also may use and disclose your III-II to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your III-II to bill you directly for services and items. We may disclose your III-II to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you rece ived from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment **Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health -related benefits or services that may be of interest to you.

7. Release of **Information** to Family/Friends. Our practice may release your VIII to a friend or family member that is involved in *your* care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take a child to the pediatr ician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required **By** Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. **USE** AND **DISCLOSURE** OF **YOUR IIHI** IN CERTAIN SPECIAL **CIRCUMSTANCES** The following categories describe unique

scenarios in which we may use or disclose your identifiable health information:

1. **Public Health** Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for purposes such as:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by la w. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actio ns; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government pr ograms, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your VIII in response to a discovery request, subpoen a, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtai n a court or administrative order protecting the information the party has requested.

4. Law Enforcement. We may release III-II if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices

- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue **Donation.** Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose *your* III-II for research purposes in certain limited circumstances. We will obtain your written authorization to use your III-II for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIIII to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' **Compensation.** Our practice may release your HI-II for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI You have the following rights regarding the IIHI that we maintain

about you:

1. Confidential **Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Michael Benedict, at this address, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your III-II to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required **to** agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to Michael Benedict at this address. Your request must describe in a clear and concise fashion:
   (a) the information you wish restricted;
   (b) whether you are requesting to limit our practice's use, disclosure or both; and
   (c) to whom you want the limits to apply.

3. **Inspection and** Copies. You have the right to inspect and obtain a copy of the VIII that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Michael Benedict, at this address, in order to inspect and/or obtain a copy of your IIIII. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Michael Benedict, at this address. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the III-II kept by or for the practice; (c) not part of the all which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Michael Benedict, at this address. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Michael Benedict, at this address.

7. Right **to** File **a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Michael Benedict, at this address. All complaints must be submitted in writing. **You will not be penalized for filing** a **complaint.**

8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your all may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the purposes described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Michael Benedict, at this address and telephone number.