Teresa Hoffman, MD & Associates, LLC
Obstetrics & Gynecology

6610 Tributary Street, Suite 206
Baltimore, Maryland 21224

Phone (410) 633-6300
Fax (410) 633-6736

Dear Patient,
We are honored that you have chosen Teresa Hoffman, M.D. and Associates, LLC as your obstetrical and/or gynecologic care. All of our physicians maintain privileges exclusively at Mercy Medical Center. We strive to provide the highest level of care in a friendly, nurturing environment. Please visit our website, www.hoffmanobgyn.com to find out more about our practice.

You will find enclosed three pages:
- Insurance and Billing Sheet;
- Permission for Treatment and Release of Information

Please carefully review all policies listed, as they must be adhered to when you become a patient with our practice.

LOCATION
We have three offices:

Dundalk	Mercy Medical Center	Catonsville
6610 Tributary Street	301 St. Paul Place	7001 Johnnycake Road
Suite 206	POB, Suite 818	Suite 105
Baltimore, MD 21224	Baltimore, MD 21202	Windsor Mill, MD 21244

OFFICE HOURS
The office is open Monday through Thursday 9:00am to 4pm and Friday 8:00 am to 2 pm, excluding Holidays. A physician is available 24 hours a day. **However, the hours outside of normal office hours are for emergencies and deliveries only**. Please be aware it may be necessary to cancel or move your appointment due to emergencies.

PRESCRIPTION REFILLS
Please request prescription refills during your appointment. If you need a prescription, please call the office and utilize the option for prescriptions or email your request to info@hoffmanobgyn.com. Please leave all requested information including pharmacy fax number. We DO NOT call in prescriptions, only fax them. This gives us a written copy of what we do. If any information is missing, there will be delay in your prescription request being processed. We will make every effort to process it within 1 business day. New patients must be seen before a prescription will be written.

If at any time you have questions regarding our practice, please contact our practice manager, Dale Andersen. We are very excited to have you in our practice and look forward to a long relationship.

Teresa Hoffman, MD   Kate Abello, MD   Carol Phillips, MD   Erika Nichelson, DO

Insurance and Billing

Payment:
Payment is due at the time services are rendered. We accept cash, credit cards, and checks. Per our contracts with the insurance companies we must collect all co-pays prior to your office visit, or your visit will need to be rescheduled. Our office will bill your primary insurance company as a service. If you have questions about your bill **please** ask for our Billing Specialist so we may provide answers and a resolution to your concerns. We are unable to **verify and confirm coverage due to the overwhelming patient load**; you will only be responsible for your co-pay and deductible at the time of your visit. **Please note: You will be considered responsible for all visits, labs, and procedures not covered by your insurance. You are responsible to know your policy's terms!**

Missed Appointments:
There may be a $20 charge for repeated missed appointments. We require at least one business day notification if you are unable to keep your appointment. If you are running late, please notify the office as soon as possible. Without notification, you may not be able to be seen for your appointment.

Returned Check Policy:
Any returned checks will require complete payment in cash or certified funds for the amount of the check PLUS a $35 fee.

Completing Forms and Copying Charts
There is a $10 charge for completing any form other than disability forms relating to surgery or pregnancy. We ask for 7 days to complete the form. Expedited (24 hour) service is available for $25 per form. We charge $10 for the copying of records in comparison to Maryland Law of $18.16 for procurement and $.60 a page.

Deductibles:
If your deductible has not been met you will need to pay for our charges until the deductible is met. If there is an overlap in payments we will issue a refund upon request, or it will be applied to future visits.

Percentages due (co-insurance):
If your insurance policy only pays a percentage of your visit or surgery an estimate of your amount owed will need to be paid the day of your visit or prior to your surgery. The percentage is based upon the allowed amount. If there is an over payment we will refund the difference to you upon request or it will be applied to future visits.

Billing Invoices:
If you receive a bill from Teresa Hoffman, M.D. and Associates, LLC the amount due is to be paid immediately. Payment plans are available if necessary, please contact the billing office.

No Insurance Coverage:
All payments are due at the time of service. Any questions, please ask the receptionist.

Collections:
Bills not paid after 120 days will be sent to a Collection Agency unless you have contacted the office for a payment plan. A $35 processing fee will be assessed on any account referred for collection. If you are sent to collections, our office will no longer be able to provide routine services to you.

PERMISSION FOR TREATMENT AND PAYMENT PROCEDURES,

PRIVACY NOTICE, DESIGNATED RELATIVE

I acknowledge that payment for services and supplies are due in full at the time services are rendered. In consideration for the Provider (Teresa Hoffman, M.D. and Associates, LLC) not requiring me to pay all charges for care and services rendered during my visit, I hereby assign to Provider any and all rights to receive insurance benefits otherwise payable to me for products or services provided by Provider. I understand that my signature requests that payment by my insurance carrier be made directly to Provider. I authorize Provider to appeal denied insurance authorization and/or benefits on my behalf. I agree to cooperate with the requests of the Provider for assistance in efforts made by the Provider to assist me in filing and collecting claims for coverage.

If my insurance carrier does not accept an assignment of benefits, I understand that all correspondence and payments to Provider may be sent directly to me. I agree that when and if any such payments are received, I will hold them in trust for Provider and promptly and immediately transmit them to the Provider for payment of my bill. I acknowledge that this assignment of benefits in no way absolves me from financial responsibility for ensuring that the Provider is promptly paid in full for all charges for care, services and supplies regardless of the availability or lack of insurance coverage for such charges. I am responsible for the deductible, co-insurance, and non-covered services as well as any other charges not promptly paid by my insurance carrier. I agree that I will be financially responsible for and promptly pay the Provider for any claim or portion of claim thereof, due to Provider for supplies and/or services not covered by my insurance policy as of the date that care, service or supply was rendered. If my insurance company denies coverage or within 45 days of billing by the Provider has failed to pay for all or any billed charge, I will promptly pay the provider for the full amount of any such charges.

If my insurance coverage changes, I will promptly notify the Provider. I understand that Provider has a legal obligation to seek payment from me for co-insurance amounts owed and that this agreement supersedes and will prevail over any other agreement to the contrary. Any modification, deletions, or changes to this form are void and will not be honored. I understand that I am responsible for any charges incurred if my account is sent to a collection agency, for missed appointments, or for any returned checks.

I certify that I am the patient or the patient's duly authorized representative and that the information given by me to Provider in applying for payment under Medicare and/or Medicaid programs, insurance plans, or other protection is correct and complete. I understand, acknowledge and agree to the terms set forth above.

Signature: ____ **Date:** ______________________

Patient Name (Print) ___________________________________ **Witness:** ____________________

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

❒ Home Telephone ______________________
- ❒ OK to leave message with detailed information
- ❒ Leave message with call-back number only

❒ Work Telephone ________________________
- ❒ OK to leave message with detailed information
- ❒ Leave message with call-back number only

❒ Mobile Telephone ______________________
- ❒ OK to leave message with detailed information
- ❒ Leave message with call-back number only

❒ EMail ______________________________
- ❒ Ok to send detailed information
- ❒ Send e-mail with call-back number only

❒ Written Communication
- ❒ OK to mail to my home address
- ❒ OK to mail to my work/office address
- ❒ OK to fax to this number

____

Please keep in mind, if you check **leave message**, you will get a message that says, "Please call the Doctors' Office at 410-633-6300". The on-call Doctor (evenings & weekends) will not have access to the reason why the phone call was placed nor any results. You may return the call during normal business hours and will have to wait for that information to be given to your doctor who will then return your call.

_______________________________________ _______________________

Signature of Patient Date

_______________________________________ _______________________

Print Name Date of Birth

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax Number	(1)	Description/Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type Key: T = Treatment Records; P = Payment Information; O = Healthcare Operations
(3) Enter how Disclosure was made: F = Fax; P = Phone; E = Email; M = Mail, O = Other