DCEndocrine

Stephanie Aleskow Stein, MD

Patient Information

First Name: Middle: Last: Suffix: Male ☐ Female ☐ Date of Birth:

Marital Status: (please circle)
Single/Married/Separated/Divorced

Race:
☐ Asian
☐ Black/African Am
☐ White
☐ Am Indian or Alaskan Native
☐ Native Hawaiian /Pacific Islander

Ethnicity:
☐Hispanic or Latino
☐Non-Hispanic or Latino

Primary Language(s) Spoken:
☐ English
☐ Other:

Social Security #:

Address: City: State: Zip Code:

Home Phone: Work Phone: Cell Phone: Email Address:

Primary Insurance Name: Primary Insurance ID#: Group #: Copayment:

Responsible Party: (First Name, Last) Male ☐ Female ☐ Date of Birth: Social Security #:

Secondary Insurance: Secondary Insurance ID#: Group #:

Responsible Party: (First Name, Last) Male ☐ Female ☐ Date of Birth: Social Security #:

Pharmacy Name: Address: City, State, Zip Code: Phone #:

May we request Pharmacy Benefits on your behalf? Yes ☐ No☐

Other Physicians You May Have:

Patient Consent and Acknowledgement:

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations.

I have been given access to Stephanie A. Stein, M.D., PLLC NOTICE OF PRIVACY PRACTICES and understand its contents.

Dr. Stein does not participate with any insurance carrier or Medicare. The expenses for today's visit will be your responsibility. The estimated cost of today's visit will range from $75.00 to $475.00.

Please also understand that if you do not show-up for an appointment or if you cancel an appointment within 24 hours of your appointment time there is a $100.00 no show fee. In addition, certain phone calls for lab and diagnostic test interpretation outside of a regular visit may incur a $75.00 fee.

Policy Concerning Payment of Medical Bills

Payment is to be made at the time services are rendered unless other arrangements have been made. I understand and agree that I am ultimately responsible for the balance on my account. I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any and all charges for the patient names above.

Preferred Method of Payment: CASH CHECK CREDIT CARD

X

Patient's Signature **Date**

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Patient Medical History

PATIENT NAME: _____ **DATE:** _____

Past Medical History: (check all that apply)

☐ Anemia	☐ Gallbladder Disease	☐ Lung Problems	☐	☐
☐ Asthma	☐ Headaches	☐Seizures	☐	☐
☐ Back Problems	☐ Heart Disease	☐Skin Problems	☐	☐
☐ Blood Transfusion	☐ Head Injury	☐ Substance Abuse	☐	☐
☐ Bowel Problems	☐ Hepatitis	☐ Thyroid Disease	☐	☐
☐ Breast Disease	☐ High Blood Pressure	☐ Ulcers	☐	☐
☐ Cancer	☐ High Cholesterol	☐ Other: (please list)	☐	☐
☐ Depression	☐ Kidney Disease	☐	☐	☐
☐ Diabetes	☐ Liver Disease	☐	☐	☐

Surgical History:

Type of Surgery:	Location of Procedure:	Place and Approximate Date:
1.		
2.		
3.		
4.		
5.		

Family History: ***Please specify any relative with the following conditions***

☐ Patient Adopted	Mother	Father	Daughter	Son	Sister	Brother	Runs in Family
Living	☐	☐	☐	☐	☐	☐	
Deceased	☐	☐	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	☐	☐	☐
Breast Disease	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐	☐
Emotional Problems	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure (Hypertension)	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐

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Social History:

Marital Status:	Employment:	Tobacco History:	Alcohol History:	Illegal Drugs:
☐ Single	☐ Currently Employed	☐ Current Every Day Smoker	☐ Never drinks alcohol	☐ Never used illegal drugs
☐ Married	☐ Retired	☐ Current Some Day Smoker	☐ Currently drinks alcohol	☐ Currently uses illegal drugs
☐ Divorced	☐ Student	☐ Former Smoker	☐ Quit	☐ Quite less than 3 years ago
☐ Separated		☐ Never Smoker		☐ In the past only
☐ Widowed				

Medication History: *Please list all of the medications you currently take, including prescription strength and directions. (Example: Lipitor, 10 mg, 1 time daily)*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Allergies: *Please list your allergies, or check box if none.*

Food:	Drug:	Environmental:
☐ No Food Allergies	☐ No Drug Allergies	☐ No other allergies

Immunizations: *Please provide us with a copy of the patient's Immunizations if done elsewhere.*

For Women Only:

Menstrual History		Birth Control
Age at first menstruation: _____	Last Pap Smear: _____	☐ None
Age at Menopause: _____	Results: _____	☐ Type used: _____
Last Menstrual Period: _____		

Additional Questions:

Last Colonoscopy Date:		Do you wear seatbelt?	☐ Yes ☐ No
Last Dexa/Bone Scan Date:		Do you have a living will?	☐ Yes ☐ No
Last Mammogram Date: Last Pap Smear Date:		Do you have a smoke detector and is it regularly checked?	☐ Yes ☐ No

Patient Name & Signature: _____ **Date:** _____

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STEPHANIE ALESKOW STEIN, M.D.
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

◯ I_____ acknowledge that I have received a
(Name of Patient)

copy of STEPHANIE ALESKOW STEIN's Notice of Privacy Practices.

_____
(Signature of Patient) (Date)

◯ I_____ do not wish to receive a copy of
(Name of Patient)

STEPHANIE ALESKOW STEIN's Notice of Privacy Practices.

_____
(Signature of Patient) (Date)

_____

Emergency Contact/Consent to discuss personal medical information: Please provide us with the name of an Emergency Contact. Additionally if desired, *check box and sign below if we have your permission to discuss confidential medical information with the individual named below.*

Name:_____Relationship_____Phone:_____

____ I consent that Dr. Stephanie Stein and staff may discuss personal and confidential information
(INITIAL) related to my health with the person listed above.

____ I consent to Dr. Stephanie Stein and staff leaving detailed messages on contact numbers and
(INITIAL) emails that I have on file.

____ I understand that I must call one week after my appointment for the results of any test
(INITIAL) performed.

Print Name & Signature: _____ **Date:** _____

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Stephanie Aleskow Stein, MD

NOTICE OF PRIVACY PRACTICES

Stephanie Aleskow Stein MD PLLC

5530 Wisconsin Avenue Suite 527

Chevy Chase, MD 20817

Stephanie Stein MD Privacy Officer 301-941-3090

Effective Date: 8/3/20

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

TABLE OF CONTENTS

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart [and on a computer][and in an electronic health record/personal health record]. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. [*Participants in organized health care arrangements only should add*: We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.]

4. [Optional]: Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.]

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to

agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law

enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept

or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Jamie Rahn Ballay, Acting Regional Manager

Office for Civil Rights

U.S. Department of Health and Human Services

801 Market Street, Suite 9300

Philadelphia, PA 19107-3134

Customer Response Center: (800) 368-1019

Fax: (202) 619-3818

TDD: (800) 537-7697

Email: ocrmail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.