Potomac Grove Psychiatry
LOUIS E. KOPOLOW, M.D., DLFAPA,ACP, Clinical Director

Cynthia Turner-Graham, M.D.
8915 Shady Grove Court
Gaithersburg, MD 20877-1302
Telephone (301) 963-0060
Facsimile (301) 258-7482

It is my pleasure to welcome you to Potomac Grove Psychiatry. We will do our best to provide you with quality care and understanding during each visit. Thank you for choosing us!

My choice of profession and practice grows from a heartfelt concern for the burdens that so many quietly bear. Mental illness and poor coping with the demands of our modern world are 'quiet epidemics' with rising rates of depression, anxiety, and stress-related disorders, to name a few. It is my belief that persons can overcome unhealthy, enduring patterns of behavior that mental disorders can be treated and suffering effectively relieved.

In order to get off to a smooth start, please attend to the following:

1. Plan to arrive 15 minutes prior to your appointment time.
2. Be sure to bring your insurance card if using insurance, and a referral if needed, so that the visit is covered. Potomac Grove Psychiatry only participates with United Healthcare, United Behavorial Health (MAMSI Life and Health, MDIPA, Optimum Choice Preferred and Optimum Choice Direct).
3. Please bring this completed packet with you at the time of your first visit.
4. If you are unable to keep your appointment, kindly call us no less than 48 hours in advance so that another patient can be contacted to fill this slot.
5. Payments and co-payments for services are due the day services are provided; **credit cards and checks** are our only forms of payment.

ALL MANAGED CARE (INSURANCE) PATIENTS PLEASE READ

1. Co-payments are due at the time of service
2. **VERY IMPORTANT**! Contact your insurance carrier, and ask specifically what your mental health benefits are, what deductible and co-payments charges you are required to pay, and how many visits your plan authorizes per calendar year.
   a. Mental health and medical benefits are not usually the same, and the same deductibles do not necessarily apply.
   b. If an authorization/certification is required, please coordinate with your Primary Care Physician.
   c. Be sure to ask what the "beginning and ending dates" are for your authorization for mental health treatment.

SELF-PAY PATIENTS AND THOSE WITH INSURANCE PLANS THAT WE DO NOT ACCEPT

1. We accept patients with or without insurance coverage.
2. Those patients who are insured by a plan that we are not participating with (we accept only MAMSI insurances) are required to pay full fee at the time of service unless prior financial arrangements are made.
3. We will give you a "Superbill" at the conclusion of your session. You should submit this paperwork to your insurance carrier for direct reimbursement of our charges.

Potomac Grove Psychiatry

Louis E. Kopolow, M.D., DLFAPA, ACP, Director

Last Name:_____First Name : _____ MI : _____

Address: _____

City: _____ State: _____ Zip code: _____

Primary Care Physician (PCP): _____PASSWORD:_____

Referral Dr: _____ Sex (M/F): _____ Status: ____ S M D W

Birthday: _____/_____/_____ Social Security Number: _____ - _____ - _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Email: _____ Cell Phone: (_____) _____

Emergency Contact: _____ Emer Phone: (_____) _____

=== Primary Insurance Coverage ====== Secondary Insurance Coverage ==========

Company: _____ Company: _____

Insured Name: _____ Insured Name: _____

Relationship: _____ DOB: _____ Relationship: _____ DOB: _____

Member/ID #: _____ Member/ID #: _____

Group #: _____ Group #: _____

=== Guarantor Information for Minors ==========

Guarantor (Parent/Legal Guardian): _____

Address: _____

City: _____ State: _____ Zip code: _____

Telephone Number(s): (_____) _____ , (_____) _____

Patient's Authorization

I authorize LOUIS E. KOPOLOW, M.D., P.A. to apply for benefits on my behalf for services rendered by LOUIS E. KOPOLOW, M.D., P.A. I request payment from my insurance company be made directly to LOUIS E. KOPOLOW, M.D., P.A. I certify that the information I reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

_____ _____

Signature of Subscriber or Beneficiary **Date**

Potomac Grove Psychiatry

Louis E. Kopolow, M.D., DLFAPA, ACP, Director

Last Name:_____ First Name:_____ MI:____
PRINT NAME PRINT

Date of Birth: _____ **Last 4 digits of your SS#:**_____ (kept confidential)

The FTC issued regulations known as the "Red Flags Rule". This was written in an attempt to prevent identity theft. The request for last 4 digits of SS# is for your personal protection.

Please fill out the section below and give us your instructions for how Potomac Grove Psychiatry may contact you by telephone/mail.

TELEPHONE CONTACT

☐ If you cannot reach me directly, you may leave a message for me at the following telephone number(s):

☐ Home _____ ☐ Work _____ ☐ Cell _____

☐ You may send communications to my home address. (appointment communications, billing statements, etc) I understand the name of the practice is not included on the envelope, for privacy purposes.

How would you like us to address the call:
☐ "This is a message from the doctor's office."

☐ Other: _____

_____

You may leave a message about: (circle those that apply)
Scheduling_____ Prescriptions_____ Other _____

☐ Do not leave me a message.
☐ You have permission to speak with _____
(Name of: Family member, friend, or partner)

☐ You may **NOT** have permission to speak with _____

Signature: _____ **Date:** _____
PATIENT/GUARDIAN

We would like you to learn about the policies at Potomac Grove Psychiatry so that there will be no misunderstandings and to assist you in becoming an active partner in your treatment program.

Please read the following carefully and initial each item.

_____You are ultimately responsible for all treatment charges. Preauthorization is not a guarantee of payment. If we participate will your insurance carrier we will bill your insurance carrier. We cannot and will not guarantee that they will pay for your treatment.

_____Potomac Grove Psychiatry is not responsible for obtaining your initial authorization for care. You must coordinate care with your primary care physician/internist for your initial appointment.

_____ Potomac Grove Psychiatry does not submit claims for secondary insurance carriers. At the time of visit, please request a Super Bill to submit to your secondary carrier(s).

_____**Cancellation Policy**: We have a ***2 BUSINESS DAYS*** cancellation policy. You MUST call our office AND speak to the appointment coordinator to receive a cancellation number if you are canceling or rescheduling your appointment. Without proper notice and without obtaining a *cancellation number*, you will be charged the amount of your scheduled appointment. These charges are your responsibility. Your insurance will not cover these charges.

_____Two consecutive late cancellations of appointments may result in termination from the practice.

_____Patients on a medication monitoring program agree to be seen at least once every three months.

_____ Administrative fees and office visit charges are subject to change.

_____ Please note that administrative fees and co-payment for treatment services are not covered by insurance and are your responsibilities.

_____Payment in full is expected when services are rendered.

I have read and initialed the above policies. I understand and accept these policies.

_____ _____

PATIENT/GUARDIAN'S SIGNATURE Date

_____

PRINTED NAME

ATTENTION NEW PATIENTS:

(IF YOUR INSURANCE IS **MDIPA** OR **OPTIMUM CHOICE**)

A PRIMARY CARE PHYSICIAN REFERRAL IS REQUIRED FOR INITIAL EVALUATION TO SEE THE PSYCHIATRIST AT TIME OF SERVICE.

IF YOU DO NOT HAVE A REFERRAL FROM A PRIMARY CARE PHYSICIAN, YOUR APPOINTMENT WILL BE RESCHEDULED.

THANK YOU,
PGP

Patient History Form

Patient's Name: _____ Date: _____

Present Complaint or Illness:_____

Duration of Symptoms: _____

Event(s) preceding/causing illness: _____

How long since you have been well: _____

Personal Health Goal: _____

Have you had any of the following? If so, when?

Accidents: _____

Surgery: _____

What are your current medications/dosages:_____

Medication Allergies: _____Or None_____

Patient and Family Medical History: Please check all that apply-

Relatives	**Arthritis**	**Asthma**	**Atherosclerosis**	**Cancer**	**Diabetes**	**Epilepsy**	**Glaucoma**	**Gout**	**High Blood Pressure**	**Heart Disease/ Stroke**	**Hypothyroidis**	**Kidney Disease**	**Neurological Disease**	**Obesity**	**Periodontal Disease**	**Senility**	**Stomach Ulcer**	**Tuberculosis**
You																		
Father																		
Mother																		
Brothers																		
Sisters																		
Spouse																		
Child(ren)																		
Grandfathe																		
Grandmoth																		

Check any other illnesses that you have now or have had:

- o Abscesses
- o Acne
- o AIDS
- o Alcohol Addiction
- o Allergies
- o Alopecia
- o Anemia
- o Attempted Suicide
- o Arteriosclerosis
- o Back Problems
- o Benign Breast Tumor
- o Bleeding Gums
- o Bronchitis
- o Candida Albicans
- o Cataracts
- o Chest Pains
- o Chicken Pox
- o Cirrhosis
- o Crohn's Disease
- o Depression
- o Diphtheria
- o Diverticulitis
- o Drug Addiction
- o Ear Infection
- o Eczema
- o Emphysema
- o Endometriosis
- o Excessive Fatigue
- o Eye Disease
- o Fainting/Dizzy Spells
- o Gall Stones
- o Gastritis
- o Gingivitis
- o Goiter
- o Gonorrhea
- o Hay Fever
- o Hearing Problems
- o Hemorrhoids
- o Hepatitis
- o Hernia
- o Herniated Disc
- o Herpes
- o High Blood Pressure
- o Hives
- o Insomnia
- o Jaundice
- o Kidney Stones
- o Liver Disease
- o Low Blood Pressure
- o Lupus
- o Major Surgery
- o Malaria
- o Measles
- o Mononucleosis
- o Multiple Sclerosis
- o Mumps
- o Myopia
- o Nervousness
- o Neuralgia
- o Night Blindness
- o Numbness
- o Pancreatitis
- o Persistent Cough
- o Pneumonia
- o Polio
- o Psoriasis
- o Rheumatic Fever
- o Rheumatoid Arthritis
- o Scarlet Fever
- o Sciatica
- o Skin Ulcers
- o Skipped Heart Beat
- o Stroke
- o Syphilis
- o Thyroid Disease
- o Ulcerative Colitis
- o Vision Problems
- o _____

Louis E. Kopolow, M.D., DLFAPA, ACP, Director

MINI Patient Health Survey

Patient's Name: _____ Date: _____

SECTION I

NO	YES	
O	O	1. Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks?
O	O	2. In the past two weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time?

If your answer to both questions above is "NO", please proceed to Section II without answering question 3.

3. Over the past two weeks, when you felt depressed or uninterested:

O	O	a. Was your appetite decreased or increased nearly every day? Did your weight decrease or increase without trying intentionally (i.e. by +/- 5% of body weight or +/- 8 lbs or +/- 3.5 kg for a 160 lb/70kg person in a month) (If yes to either, please check YES).
O	O	b. Did you have trouble sleeping nearly every night (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively)?
O	O	c. Did you talk or move more slowly than normal or were you fidgety, restless or having trouble sitting still almost every day?
O	O	d. Did you feel tired or without energy almost every day?
O	O	e. Did you feel worthless or guilty almost every day?
O	O	f. Did you have difficulty concentrating or making decisions almost every day?
O	O	g. Did you repeatedly consider hurting yourself, feel suicidal, or wish that you were dead?

SECTION II

NO	YES	
O	O	1. In the past 12 months, have you had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions?

If your answer to this question was "NO", you have completed Section II. Please proceed to Section III without answering question 2.

2. In the past 12 months:

O	O	a. Did you need to drink more in order to get the same effect that you got when you first started drinking?
O	O	b. When you cut down on drinking did your hands shake, did you sweat or feel agitated? Did you need to drink to avoid these symptoms? (If yes to either, please check "YES").
O	O	c. During the times when you drank alcohol, did you end up drinking more than you planned when you started?
O	O	d. Have you tried to reduce or stop drinking alcohol, but failed?
O	O	e. On the days that you drank, did you spend substantial time obtaining alcohol, drinking, or recovering from the effects of alcohol?
O	O	f. Did you spend less time working, enjoying hobbies, or being with others because of your drinking?
O	O	g. Have you continued to drink even though you knew that it caused you problems?

SECTION III (Page 2 of 2)

NO	YES	
O	O	1. Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way? Did the spells peak within 10 minutes? (If yes to either, please check "YES").
O	O	2. At any time in the past, did any of those spells or attacks come on unexpectedly or occur in an unprecedented or unprovoked manner?

If your answer to both questions above was "NO", please proceed to Section IV without answering any other questions below in Section III.

O	O	3. Have you ever had one such attack followed by a month or more of persistent fear of having another attack, or worries about the consequences of the attack?
		4. During the worst spell that you can remember:
O	O	a. Did you have skipping, racing or pounding of your heart?
O	O	b. Did you have sweating or clammy hands?
O	O	c. Were you trembling or shaking?
O	O	d. Did you have shortness of breath or difficulty breathing?
O	O	e. Did you have a choking sensation or a lump in your throat?
O	O	f. Did you have chest pain, pressure, or discomfort?
O	O	g. Did you have nausea, stomach problems or sudden diarrhea?
O	O	h. Did you feel dizzy, unsteady, lightheaded, or faint?
O	O	i. Did things around you feel strange, unreal, detached or unfamiliar, or did you feel outside of or detached from part, or all of your body?
O	O	j. Did you fear that you were losing control or going crazy?
O	O	k. Did you fear you were dying?
O	O	l. Did you have tingling or numbness in parts of your body?
O	O	m. Did you have hot flashes or chills?
O	O	5. In the past month, did you have such attacks repeatedly (2 or more) followed by persistent fear of having another attack?

SECTION IV

NO	YES	
O	O	1. In the past month, were you fearful of or embarrassed by being watched or being the focus of attention, or fearful of being humiliated? This includes things like speaking in public, eating in public alone or with others, writing while someone watches, or being in social situations?
O	O	2. Is this fear excessive or unreasonable?
O	O	3. Do you fear these situations so much that you avoid them or suffer through them?
O	O	4. Does this fear disrupt your normal work or social functioning or cause you significant distress?

Cynthia Turner-Graham, M.D.
8915 SHADY GROVE COURT
GAITHERSBURG, MD 20877
301-963-0060(OFFICE) 301-258-7482(FACSIMILE)

October, 2007

IMPORTANT NOTICE FOR ALL PATIENTS

In order for me to continue providing the quality of care I believe to be consistent with optimal treatment outcomes, it has become necessary to make changes in prescription call-in policies. The volume of requests has increased to the point that it has become increasingly difficult to keep up with the demand. I know this is frustrating, especially if there is a delay in addressing an authentic clinical need due to the time taken to keep up with prescription requests between appointments. Thus, *effective the day you receive copy of this letter*, the following policies governing prescriptions between appointments will be effective:

1. At the end of your appointment, I will inform you of the length of time your prescription with refills will last

2. When making a return appointment, you will be responsible to make sure you return in sufficient time that your medications do not run out prior to your return visit

3. For any prescription call-in requests or faxes from pharmacies between appointments, there will be a charge of $40; insurance does not cover this charge thus you will be responsible for this balance charged to your account

There will be a notation made on your chart when on the day you receive this letter; until then, you will not be held accountable to uphold a policy for which you had no notice.

I thank you for understanding. Please let me know if you have questions.

Sincerely,

Cynthia Turner-Graham, MD

Cynthia Turner-Graham, M.D.

RECORDS/INFORMATION RELEASE

TO: _____
CLINICIAN'S NAME

I, _____, give permission for you to
PATIENT'S NAME OR GUARDIAN'S NAME

_____Discuss information pertaining to my diagnosis, treatment, prognosis, recommendations, as well as other data pertinent to treatment, with

_____
DOCTOR'S NAME OR FAMILY MEMBER'S NAME

_____
ADDRESS

_____

_____
PHONE NUMBER

_____Release information in my medical records pertaining to my treatment to _____
DOCTOR'S NAME OR FAMILY MEMBER'S NAME

_____
ADDRESS

_____

_____
PHONE NUMBER

I understand that I may decide to revoke this permission at any time by notifying _____ in writing of my decision.
NAME

_____ (SEAL) _____
FIRST & LAST NAME DATE

_____
PRINT FIRST & LAST NAME

LACK OF REFERRAL AGREEMENT
*
UPDATED INSURANCE REQUIREMENT

A valid referral from your Primary Care Physician (PCP) is required for the services I will receive with:

POTOMAC GROVE PSYCHIATRY

(Rendering Facility or Doctor Name)

This is a requirement from your insurance company. Without a referral my insurance company will not consider or pay for the services I receive in this practice.

It is my responsibility to ensure the correct referral is obtained and maintained throughout my treatment and provided to the facility rendering the services.

Additionally, it is my responsibility to alert the facility of new insurance. If I do not give my new information to the facility, I will be expecting to pay out of pocket for the expenses at the time of the visit and submit for reimbursement on my own.

I understand these requirements for referrals. I agree to accept full liability for all charges rejected by my insurance due to lack of referral.

I further understand that without a proper referral for my visit. I will not be seen in this facility.

_____ _____

Patient signature and date PGP Representative signature and date

PROVISION OF CLINICAL SERVICES

I,_____ , acknowledge the following:

1. That medical and/or treatment services are being provided by CYNTHIA TURNER-GRAHAM, M.D.

2. That Louis E. Kopolow, M.D., P.A. trading as Potomac Grove Psychiatry, is not rendering medical and/or treatment services to me.

3. That Louis E. Kopolow, M.D., P.A., trading as Potomac Grove Psychiatry has no ownership interest in my medical records. My medical records are the sole property CYNTHIA.TURNER-GRAHAM, M.D.

_____ (SEAL) DATE:_____
PATIENT'S SIGNATURE DATE

_____
IF PATIENT IS A MINOR, GUARDIAN'S PRINTED NAME.

_____(SEAL) DATE:_____
GUARDIAN'S SIGNATURE DATE

Please complete this form <u>after your visit</u>
Potomac Grove Psychiatry provider.

TREATMENT SATISFACTION QUESTIONAIRE

WE CARE ABOUT MAKING YOUR VISIT WITH US A POSITIVE AND HELPFUL EXPERIENCE. PLEASE LET US KNOW HOW WE'RE DOING.

1. I am treated in a welcoming, courteous and respectful manner.

UNSATISFIED SATISFIED
0----------1----------2----------3

2. My clinical treatment is helpful.

UNSATISFIED SATISFIED
0----------1----------2----------3

3. When I have concerns or complaints, I am listened to respectively and my problems are addressed.

UNSATISFIED SATISFIED
0----------1----------2----------3

4. If you have any problems or concerns with this office please tell us:

_____

_____

_____

_____

_____
Name

_____
Date

PATIENT RESPONSIBILITY ACKNOWLEDGEMENT, BILLING CONSENT AND AUTHORIZATION OR ASSIGNED BENEFITS
(Page 1 of 2)

1. My provider, CYNTHIA TURNER-GRAHAM, M.D. Has informed me that LOUIS E. KOPOLOW, M.D., P.A., trading as Potomac Grove Psychiatry (PGP), will seek reimbursement for her clinical services.

2. I hereby authorize CYNTHIA TURNER-GRAHAM, M.D., and Potomac Grove Psychiatry to apply for benefits on my behalf for services rendered by DR. TURNER-GRAHAM. I request that payments from Medicare and /or any independent carrier that PGP contractually participates with or any other insurance company be made directly to PGP.

3._____I certify that the insurance information I have provided is correct and that I will
INITIALS inform Potomac Grove Psychiatry, in writing, of any changes in my insurance coverage, and if the services by my provider are not reimbursable by my insurance carrier, I will be responsible for payment of charges for services. PGP will provide me a Statement of services rendered so that I might file for reimbursement with my insurance company.

4._____I understand that I , and not my insurance provider, am responsible for all co-payment
INITIALS fees. Further, I understand that my co-pay for treatment sessions may increase as I continue my treatment sessions. If my co-pay increases, I will be billed on a monthly basis for the additional co-pay charges. I agree to pay this bill in full promptly

OR

_____ If I am receiving services on a fee for service basis, I understand that my "Out of
INITIALS Pocket" financial responsibility for this service may be greater than it would be if I received care through my in-plan coverage. I also understand that I am responsible for 100% of the charges for professional services provided by CYNTHIA TURNER-GRAHAM, M.D.

5._____I am also responsible for any fees incurred by my late cancelation of appointments
INITIALS and fees incurred by my not showing up for a scheduled appointment. I understand that I, not my insurance provider, am responsible for paying in full the charges for the missed appointment and/or no show.

6. If I am a patient on a fee for service basis, I understand:

_____That I am responsible for 100% of the professional services provided by DR.
INITIALS CYNTHIA TURNER-GRAHAM.

_____That I will pay this fee in full at the time of my appointment.
INITIALS

PATIENT RESPONSIBILITY ACKNOWLEDGEMENT, BILLING CONSENT AND AUTHORIZATION OR ASSIGNED BENEFITS
(Page 2 0f 2)

7._____I also understand that if a check I use to pay my financial obligation to PGP is refunded for lack of funds, I will be obligated to pay administrative fees to Potomac Grove Psychiatry.
INITIALS

_____
PRINT NAME OF PATIENT

_____ DATE:_____
SIGNATURE OF PATIENT (SEAL)

_____ DATE:_____
SIGNATURE OF PARENT IF MINOR CHILD (SEAL)

I have reviewed this Authorization with

_____
Signature of patient or parent of minor child.

_____ DATE:_____
CYNTHIA TURNER-GRAHAM, M.D.

Potomac Grove Psychiatry

Louis E. Kopolow, M.D., DLFAPA, ACP, Director

Use and Disclosure of Protected Health Information
PATIENT ACKNOWLEDGEMENT & CONSENT FORM

Acknowledgement of Notification

The educational pamphlet entitled **"Notice of Privacy Practices"** provides information about how your doctor/therapist may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Notice of Privacy Practices states that your doctor/therapist reserves the right to change the terms described. Should this happen, you will be notified on your next visit to our office.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions; but if we do, we are bound by our agreement with you.

By signing below, you acknowledge receipt of our Notice of Privacy Practices.

_____

Patient's Signature Date

Consent for Use and Disclosure of Information

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to **Potomac Grove Psychiatry** for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and it's agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

Patient's Signature_____

Date

Print Full Name_____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices

acknowledgement, but was unable to do so as documented below.

Date _____
Initials _____

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have questions or would like additional information, please contact the HIPPA Policy Officer for this practice. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.-

DIRECTIONS TO OUR OFFICE

Potomac Grove Psychiatry is located in the Shady Grove Professional Park (brown brick townhouses) just off Shady Grove Road in Gaithersburg. We are situated at the intersection of Comprint Court and Shady Grove Road on the same side of the street as Burger King.

From I-270:

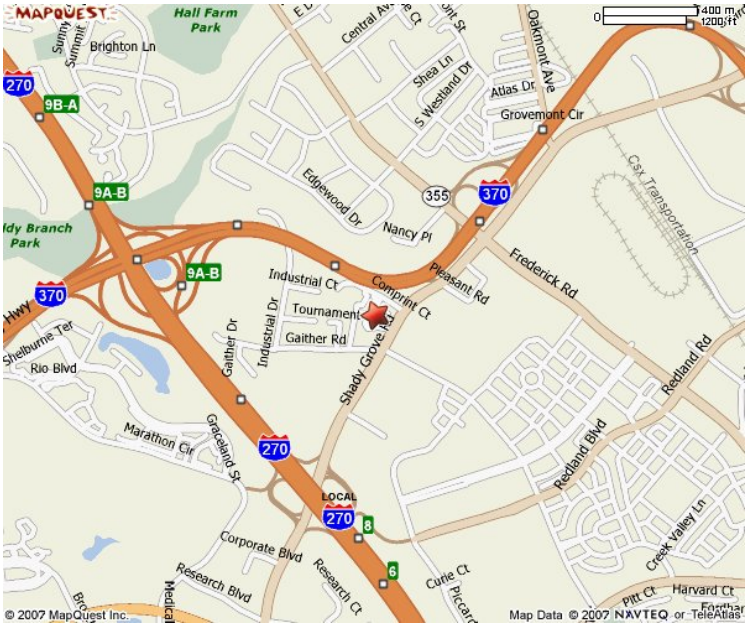
- Take the exit for Shady Grove Road, going East towards Gaithersburg.
- At the traffic light at Comprint Court, make a left onto Comprint Court.
- Make an immediate left onto Shady Grove Court.
- Turn left to come around to the office, which is #8915.
- Parking is available in front of the office (and on the lower parking area).

From 355, Rockville Pike:

- Turn onto Shady Grove Road, going West toward I-270.
- Turn right onto Shady Grove Court, just past the Comprint Court intersection.
- Turn left to come around to the office, which is #8915.
- Parking is available in front of the office (and on the lower parking area).

From Metro Center:

- Take the Red Line train to Shady Grove.
- Get off the train and take the stairs to the parking lot.
- RideOn bus # 43 will bring you to Shady Grove Road and Comprint Court.



VOLUNTEER WAIVER OF HMO BENEFITS

(Signing this document will alter your legal rights under Maryland Law. Please read carefully and do not sign unless you understand the document.)

I, _____(patient name)

Am seeking medical treatment from_____("My Physician")

Check One

_____I am not a member of a Health Maintenance Organization ("HMO") and will be responsible for the payment, during the time of my visit, of any amount owed to My Physician for services provided.

OR

_____I am a member of an HMO but I have been informed that My Physician is not a participating physician with that HMO and that if My Physician provides services to me I will pay the services rendered in full, at My Physicians usual rate, during the time of the visit.

_____I understand that if, instead of receiving treatment form My Physician, I had elected to INITALS obtain treatment from a health care provider participating in my HMO and the HMO determined that the service was covered under my benefit plan, I would be entitled to have this service as set forth in that plan;

Therefore, this means that

1. I will be solely responsible for My Physician's charges;
2. My Physician will not seek payment from my HMO.

_____ _____

Patient Signature Date