Welcome to Our Practice

Total Women's Health of Baltimore is pleased to participate in your medical care. Thank you for choosing us! Our goal is to provide you with the best medical care possible. The following information is provided to you in hopes of making your experience the best one possible.

SCHEDULING, CANCELLATIONS, NO-SHOWS

- All appointments are scheduled through our front desk at (443) 471-3288. If subsequent care is needed, please schedule as soon as possible in order to have the best options to meet with Dr. Oliver.
- Reminder calls via an automated system are place 2 days prior to your appointment, please keep your contact information with us updated.
- We recognize there will be situations that will cause for rescheduling, in that event, please call us 24 hours in advance to avoid a $25 no -show fee.

INFORMATION NECESSARY FOR YOUR VISIT

- Please bring your most current insurance card and photo identification to each visit.
- Your co-payment will be requested at the time of your visit. Please be prepared to pay that amount. Acceptable methods of payment are cash, check, Visa, and Mastercard.

TEST RESULTS, TELEPHONE CALLS, MESSAGES

- Pap and culture results are usually in our office within 10 days. Bloodwork results are usually completed 1 week after it's drawn. If you have not heard from Dr. Oliver or her MA after 10 days, your test results are considered normal. Telephone calls will be placed when any results require attention.
- All messages are triaged by our MA. There will be an attempt to return all phone calls within 24 hours. Medical emergencies should call 911 immediately.
- Please check with your insurance company before your visit to find out your lab benefits before your visit to avoid unnecessary costs.

PRESCRIPTION REFILLS

- We will gladly accept faxed refill requests from your pharmacy. Please allow 24 hours for us to fulfill these requests. Requests for refills will not be taken after 12 noon on Friday, during weekends, or holidays. Please plan accordingly.
- All patients must be active with our office (been seen in the last 12 months) in order to receive a refill.

Thanks and we look forward to building this relationship with you and giving you the best care possible.

Total Women's Health of Baltimore

Notice of Privacy Practices
Total Women's Health of Baltimore

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.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

This notice describes our privacy practices. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

A. Treatment, Payment, Health Care Operations
Treatment
We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physician, Dr. Dionne Oliver, MD, in this practice is a specialist. When we provide treatment, we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.
Payment
We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you. For example, we may complete a claim form to obtain payment from your insurer of HMO. That form will contain medical information, such as a description of the medical services provided to you, that your insurer or HMO needs to approve payment to us.
Health Care Operations
We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care I delivered. Our office makes every effort to comply with regulation 45 CFR-164.501 concerning health care operations.

B. Disclosures That Can Be Made Without Your Authorization
There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization.

Public Health, Abuse or Neglect, and Health Oversight
We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

Because Maryland law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Maryland law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections, which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement
We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided:

- The information is released pursuant to legal process, such as a warrant or subpoena;
- The information pertains to a victim of crime and you are incapacitated;
- The information pertains to a person who has died under circumstances that may be related to criminal conduct;
- The information is about a victim of crime and we are unable to obtain the person's agreement;
- The information is released because of a crime that has occurred on these premises;
- The information is released to locate a fugitive, missing person, or suspect.

We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.

Maryland law requires us to be ready to provide copies or a narrative within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost-based fee. This office charges 72 cents per page.

Amendment of Medical Information
You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons:

- The information wasn't created by this practice or the physician in this office.
- The information is not part of the designated record set.
- The information is not available for inspection because of an appropriate denial
- The information is accurate and complete.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information of issue in your medical record. If we refuse to allow an amendment, we will inform you in writing.
If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we now have the incorrect information.

Accounting of Certain Disclosures
HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person at the end of this document. Your first accounting of disclosures (within a 12-moth period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge, we will notify you, and you may choose to withdraw or modify your request before any costs are incurred.

D. Appointment Reminders, Treatment Alternatives, and Other Benefits
We may contact you by (telephone, mail, email or all three) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

E. Complaints
If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U. S. Department of Health of Human Services. We will not retaliate against you for filing a complaint with us or the government.

F. Our Promise to You
We are required by law and regulation to protect the privacy of your medical information to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

G. Question and Contact Person for Requests
If you have any questions or want to make a request pursuant to the rights described above, please contact:
Christine Blout, Office Manager, 6080 Falls Rd. Ste 204, Baltimore, MD 21209; 443-471-3288.

This notice is effective December 12, 2018.

Total Women's Health of Baltimore

General Consent for Treatment and Payment

I, _____, knowing that I am experiencing a condition that requires diagnostics, medical or surgical treatment do hereby voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and specific instruction of Dr. Dionne Oliver, MD, or her designee as is necessary to her judgement. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments or examination by Dr. Dionne Oliver, MD.

I understand that Dr. Dionne Oliver, MD is accepting me as a patient and that I am responsible for knowing what my benefits cover and for paying for any the services I receive if they are not included in my benefit plan. These could be services such as lab costs, surgery, and/or minor office procedures or if my plan has a pre-existing waiting period or deductible that has not been met.

_____
Patient/Guardian (please print)

_____ _____
Patient/Guardian Signature and Date

_____
E-Mail Address

_____
Office Staff Witness

This consent is for a digital photograph to be taken at the time of your visit to place into our electronic medical records for identification purposes. The digital picture is to be used in our medical office for the physician and the staff.

Please check one

☐ I consent to the picture.

☐ I do not consent to the picture.

_____ _____
Patient Signature and Date

This consent is good for 1 year from the date of signature. If this consent is to be voided sooner than one year, request must be submitted in writing.

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES ☐ NO ☐

May we leave a message on your answering machine at home or on your cell phone? YES ☐ NO ☐

May we discuss your medical condition with any member of your family? YES ☐ NO ☐

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____