Mark H. Lowitt, M.D., LLC
Nicoleta Negoita MS, PA-C
Juan (Julia) Liu, PhD, MMS, PA-C

GBMC Physicians Pavilion North
(Tulip Parking Garage)
6535 N. Charles Street, Suite 200
Baltimore, MD 21204
Phone: 410-321-1195
Fax: 410-321-1197

Welcome to our practice!

Please complete the enclosed forms and bring them and your Medicare and insurance cards with you to your appointment. Completion of the forms in advance and arriving 15 minutes prior to your scheduled appointment time will speed your check-in process and will ensure that your appointment runs smoothly. Please have your forms completed before you arrive. If you wait until the time of your visit to complete your forms we will not be able to see you on time.

If your insurance requires a referral from your primary care physician, please be sure that you bring the referral form with you. **If your referral is not in our office at the time of your visit,** you will not be seen that day and you will have to reschedule your appointment.

If the patient is not competent to make medical decisions for him/herself, an individual with medical power of attorney must accompany the patient to the visit.

If the patient is hearing-impaired or does not speak English, we will gladly provide interpreting services at no charge. We do require however a minimum of 1 week notice to make arrangements.

As it can be difficult to find parking on the GBMC campus at certain times of day, please be sure to allow an extra 15 minutes to your anticipated travel time.

Missed Appointment Policy: Please notify us as soon as possible if you are unable to keep your appointment. Patients who miss three appointments without notifying us within 24 hours will be discharged from the practice.

If you are coming for a full skin exam or for a facial skin problem, please do not wear facial makeup.

If you have any questions or concerns, please do not hesitate to give our office a call.
We look forward to seeing you!

Sincerely,

Mark H. Lowitt M.D.

Mark H. Lowitt, MD, LLC **PATIENT NAME** _____

HEALTH SUMMARY

PRIMARY CARE PROVIDER _____

Preferred Pharmacy Name, address, phone _____

Are you allergic to any medications? ❒ Yes ❒No If yes, list below:

1._____ 2. _____ 3._____

Any bad/**allergic reaction** to: (Circle**) Latex / Lidocaine / Epinephrine /Betadine /Iodine/Adhesives /Bacitracin/Neosporin**

List all medications you are currently taking (including prescriptions, over-the-counter meds, Vitamins, and herbals):

1._____ 3._____ 5. _____

2. _____ 4. _____ 6. _____

PAST MEDICAL HISTORY	YES	NO			YES	NO	
Anxiety	❒	❒		**Pacemaker/defibrillator?**	❒	❒	
Arthritis	❒	❒		**Fainting with procedures?**	❒	❒	
Asthma	❒	❒		**Allergies / Hay Fever**	❒	❒	
Atrial fibrillation	❒	❒		**Hepatitis B / C / HIV**	❒	❒	
BPH (large prostate)	❒	❒		**Artificial Joint (when?)**	❒	❒	----------
Breast Cancer	❒	❒		**Artificial Heart Valve**	❒	❒	----------
Colon Cancer	❒	❒		Thyroid disease (hyper or hypo)? (circle)	❒	❒	----------
COPD	❒	❒		Leukemia/Lymphoma			----------
Coronary Artery Disease	❒	❒		Lung Cancer	❒	❒	----------
Depression	❒	❒		**MRSA**	❒	❒	----------
Diabetes	❒	❒		Prostate Cancer	❒	❒	----------
GERD (reflux)	❒	❒		Seizures	❒	❒	----------
Hearing loss	❒	❒		Stroke	❒	❒	----------
Hypertension	❒	❒		OTHER LIST BELOW	❒	❒	----------

List any other medical diseases or conditions:

List surgical procedures you have had:

	YES	NO	DETAILS
Have **you** ever had skin cancer?	❒	❒	Basal Cell Squamous Cell Melanoma (circle)
Has anyone in your **family** had skin cancer?	❒	❒	Basal Cell Squamous Cell Melanoma (circle)
Acne / actinic keratosis / eczema / precancerous moles / psoriasis? (please circle)			
Do you have problems with Bleeding / Healing/ Scarring? (circle)			
Fever / night sweats / joint pain / headache? (circle)			
Shortness of breath / cough / abdominal pain (circle)			

Do you drink alcohol? ❒ YES ❒ NO If YES_____ drinks per day
Do you use IV drugs? ❒ YES ❒ NO If YES, what? _____
Do you smoke? ❒ YES ❒ NO If YES, how much: _____
Are you: Single ❒ Married ❒ Separated/Divorced ❒ Widowed ❒ LGBT ❒
(Women) Are you pregnant? ❒ YES ❒ NO Due Date: ___/___/___
Occupation/School?_____ **Hobbies?** _____

Patient Signature and Date _____ **Reviewed by** _____

Mark H. Lowitt, M.D.

Office Financial Policy

Patient Name: _____ Date of Birth: _____/_____/_____

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

1. We are Medicare Participating providers. We will bill Medicare and Medigap carriers. You will be responsible at the time of service for payment of:
   a. The annual deductibles
   b. Copayments
   c. Charges for noncovered or cosmetic services (You will be asked to sign an Advance Beneficiary Notice of Liability (ABN) Form in the event that a service is provided which we know is not covered by Medicare.)

   You will be sent a statement indicating your responsibility. You will be expected to pay the balance within 30 days of receipt of the statement.

   If you have Medicare, as well as secondary coverage with a commercial plan that is not Medigap or is an insurance company with which we have no contract, we will file a claim to your secondary/supplemental carrier. If no payment is received from your secondary/supplemental carrier within 60 days after we file a claim, you will be sent a bill and will be responsible for the balance.

2. If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for all covered, medically necessary services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible at the time of service for payment of:
   a. The annual deductibles
   b. Copayments
   c. Charges for noncovered or cosmetic services.

   In the event that you, as the patient, or we, as the physicians, are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.

3. For non-Medicare patients who have insurance coverage with an insurance carrier with which we do not have a contractual relationship, please note the following:
   a. We will file both your primary and secondary insurance. If we receive payment from the primary, we will file a claim with your secondary. If we do not receive payment from your primary carrier within 60 days of filing, you will be billed for the entire amount. Payment is due 10 days after receipt of the statement.
   b. If you only have primary insurance (e.g., no secondary/supplemental coverage), you will be asked to pay 100% of the bill on the day of service. This can be done by cash, check, Mastercard, or Visa. We will still notify your insurer of the visit and the amount that you paid, which may therefore be applied to your deductable, or which may be refunded to you, in all or in part, should the insurer choose to do so based on your particular plan. Please understand that since we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits. Any balance remaining after your primary carrier has paid will be billed to you and is due and payable 10 days after receipt of the statement.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office. If in the event your account is turned over to a 3rd party for collections, you will be responsible for all fees incurred.

_____ _____

Patient signature ***Date***

Mark H. Lowitt, MD, LLC

A Message From Our Billing Service

Dear Patient,

Medical Billing Solutions has been retained by Dr. Lowitt's office to handle all billing and processing of claims to insurance companies. Please make payment to Dr. Lowitt, listed on the "Make Checks Payable To:" portion of your bill. Send your payment to the address noted on the statement.

If you have any questions about the status of your account, do not call the doctor's office--- Call us directly at 410-876-1115.

The office is open Monday – Friday, 9:30 am – 3:30 pm, Eastern Standard Time.

Should the answering machine answer your call, leave a message being sure to include your phone number with the area code. To expedite us returning your call, be sure to include the following:

1. Your name
2. The full name (clearly spell the name) of the patient
3. The patient's date of birth
4. Dr. Lowitt's name
5. The date of the office visit you are calling about
6. A brief statement of the problem
7. A daytime as well as a nighttime phone number.

For patients with secondary / supplemental insurance…

As a courtesy, our Billing Service will automatically file to your secondary/ supplemental insurance carrier after we receive payment from your primary insurance. If you receive a bill and have any questions, please call us at the number shown above to discuss the balance.

Medicare Patient Information

Patient Name: _____ Preferred Nickname_____

Date of Birth: ____/____/_____ Sex: ☐Female ☐Male Language preference _____

Race: ☐White / ☐Black / ☐Asian /☐ Other _____ Ethnicity ☐ Hispanic/Latino

Address: _____
Street

_____
City State Zip Code

Phones: Home _____ Work _____ Cell _____ Email _____

Please print your name as it appears on your Medicare Card: _____

Medicare Health Insurance Claim Number as it appears on your card. _____
(This is usually your Social Security number. Be sure to include the letter after the nine-digit number. It is important we have both the numbers and the letter.)

Referring Physician Name: _____ Phone # _____

Emergency Contact : Spouse/Relative/Friend: _____Phone: _____

Do you give our office permission to discuss your medical information with family or friends?

☐Yes ☐No If yes, please provide name(s) and phone number(s) below:

Name(s) (relationship), phone(s): _____

Please Sign So We May Have Your Medicare Authorization On File:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Date: ____/____/____ Signature: _____

Payment Policy

Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual $110.00 deductible and paying for the 20% copayment. We do file with secondary / supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.

Note: If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers.

Medicare Patient Information Page 2

Please read each of the following and answer as they apply to you. If it does apply to you, please check YES. If it does NOT apply to you, please check NO:

Yes	No	
☐	☐	Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?
☐	☐	Are you covered by a HMO / PPO which makes Medicare secondary?
☐	☐	Are you coming to this office for an illness or accident that has been covered or is authorized for coverage from the VA (Veteran's Administration)?
☐	☐	Do you or your spouse work and have coverage through the insurance at your job?
☐	☐	Are you eligible for any benefits under the Federal Black Lung Program?
☐	☐	Are you coming to this office for an illness, accident or injury that is the result of an automobile accident?
☐	☐	Are you coming to this office due to Medicare disability coverage?
☐	☐	Are you covered by the Federal End Stage Renal Disease Program?
☐	☐	Are you presently receiving Workers' Compensation?
☐	☐	Is the illness or injury you are coming to this office for the result of work-related causes?
☐	☐	Do you have medical assistance through Welfare or state-aid?

If you answered YES to ANY of the above questions, Explain: _____

Policy Number _____ Group Number _____

Name Policy Holder (Insured): _____ ☐Female ☐Male

Date of Birth: ____/____/____ Policy Holder (Insured) SS# _____

Supplemental (MEDIGAP) Insurance

In the event of a major procedure or hospitalization, we request secondary insurance information for our records (supplemental Medicare insurance information). Please fill out below if you are covered by a plan which covers the 20% NOT covered by Medicare (MEDIGAP coverage)

Name of Insurance Company: _____

Policy Number: _____ Group Number _____

Name Policy Holder (Insured):_____ ☐Female ☐Male

Date of Birth ____/____/____ Policy Holder (Insured) SS# _____

Please Sign So We May Have Your Supplemental Authorization On File:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Date: ___/____/____ Signature: _____

May we leave personal medical information on your voicemail?
┼YES ┼NO

May we email personal medical information to you?
┼YES ┼NO

Would you prefer appointment notification by phone, email, or text?
┼Phone ┼Email ┼Text

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I am a patient of Mark H. Lowitt. I acknowledge receipt of Mark H. Lowitt, MD, LLC's Notice of Privacy Practices.

_____ _____/_____/_____

Patient / Guardian Signature **Date**

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length Notice follows this summary.

Date of Last Revision: 9/21/2013
Effective Date: Immediately

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 that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your Protected Health Information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices that follows this summary):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and ensure all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

For more information about these rights, please see the detailed Notice of Privacy Practices that follows this summary.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;

- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alterative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of September 23, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing.

Discrimination is Against the Law

Mark H. Lowitt, MD, LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Mark H. Lowitt, MD, LLC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Mark H. Lowitt, MD, LLC Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact **Bobbi W., Front Desk Lead.**
If you believe that Mark H. Lowitt, MD, LLC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email with:

Mark H. Lowitt, MD
6535 N Charles St., Suite 200, Baltimore, MD, 21204
Ph. 410-321-1195
Fax 410-321-1197
bobbi@drmarklowitt.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Barbara Holland, Regional Manager Office for Civil Rights
U.S. Department of Health and Human Services
150 S. Independence Mall West Suite 372,
Public Ledger Building Philadelphia, PA 19106-9111
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818 TDD: (800) 537-7697
Email: ocrmail@hhs.gov