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Dr. Amir Assili | Dr. David Baek | Dr. Hoan Dang | Dr. Jon Dillard | Dr. Svetlana Malinsky | Dr. David Siegel

### NEW PATIENT PACKET

Basic Patient Information		
Patient Account Number (Office Use Only):	Date:	
Full Name (Last, First, Middle Initial):		
Preferred Name:		
Birthdate:	Age:	
Social Security Number (optional):	Biological sex:	
Street address:		
Provide your phone numbers below and check off which number is primary:		
<input type="checkbox"/> Home:	<input type="checkbox"/> Cell:	<input type="checkbox"/> Work:
Please indicate your preferred methods of receiving appointment reminders:		
<input type="checkbox"/> Phone call at the numbers above	<input type="checkbox"/> Text message to cell number above	<input type="checkbox"/> Email address (indicate below)
Other Patient Information		
Primary Care Physician and location:		
Who referred you to this practice?		
RX Pharmacy and location:		
Employer:		
If the patient is a minor, indicate designated guardian and relation:		
Primary language:		
Email address (write legibly):		
Web-enable for the patient portal using above email?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have an advanced directive (living will)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you give permission to access your RX history?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you Hispanic or Latino?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Which category best describes you?  <i>One or more may be marked, this is not by any means to discriminate against any single person and/or race and will not seter the treatment you receive in our office. This information is collected to ensure that we can provide the highest quality of care for all patients.</i>	<input type="checkbox"/> Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Black or African American <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Declined to Specify <input type="checkbox"/> Other (specify): _____	
Emergency Contact Information		
Name of primary emergency contact:		
Relationship of primary emergency contact:		
Phone number of primary emergency contact:		
Name of secondary emergency contact:		
Relationship of secondary emergency contact:		
Phone number of secondary emergency contact:		

Insurance Information			
Primary Insurance:		Secondary Insurance:	
Policy ID#:		Policy ID#:	
Subscriber's name:		Subscriber's name:	
Subscriber's date of birth:		Subscriber's date of birth:	
Subscriber's relationship to patient:		Subscriber's relationship to patient:	
Subscriber's employer:		Subscriber's employer:	
Patient Medical History			
What is the main reason for your visit today?			
Approximately when did your symptoms begin?			
Please check off all applicable conditions to the patient from the lists below:			
<input type="checkbox"/> Diabetes Type 1 / Most recent A1C and date:			
<input type="checkbox"/> Diabetes Type 2 / Most recent A1C and date:			
If you have diabetes type 1 / type 2, who is your endocrinologist?			
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chronic Thrombophlebitis	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Arteriosclerosis Obliterans	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> HIV / AIDS	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dermatologic issue	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Peripheral neuropathy (feet)
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Peripheral vascular disease
<input type="checkbox"/> Blood thinner:	<input type="checkbox"/> Gastrointestinal disease	<input type="checkbox"/> Kidney disorder	<input type="checkbox"/> STI:
<input type="checkbox"/> Buerger's disease	<input type="checkbox"/> GERD / Acid reflux	<input type="checkbox"/> Liver disorder	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Blood thinner:	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Other:
<input type="checkbox"/> Cancer:	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Neurological issue	
<input type="checkbox"/> Cardiovascular disease	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Obesity	
List of your surgical history: <i>IE: 2015 – right ACL surgery</i>			
List of past hospitalizations: <i>IE: 2019 - infection</i>			
Provide the most recent list of medications or list them in the blank space to the right:			
List of allergies to medication: <i>Write NKDA if none.</i>			
Are you allergic to latex?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Are you allergic to adhesives?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Social History			
Are you a smoker?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If so, how much do you smoke?
Were you ever a smoker?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	When did you quit?
Do you drink alcohol?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	How often do you drink?
Family History			
Please check off AND indicate in the spaces below who in your immediate family has or had any of the following:			
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Cancer (what kind)

#### Patient Consent for Treatment

By signing below, I certify that the above information is true and correct to the best of my knowledge. I give permission to the providers of Shady Grove Podiatry, LLC, Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel to administer and perform the procedures they deem necessary upon discussion with me in the diagnosis and / or treatment with my consent.

X \_\_\_\_\_

Signature of Patient / Parent Guardian

\_\_\_\_\_ Date

#### Medicare Authorization (Medicare patients only)

Medicare will only pay for services that is determined as "reasonable and necessary" under section 1842(A) of the Medicare law. If Medicare determines that a particular service is not reasonable and necessary, payment will be denied. If Medicare should deny payment of services rendered, I agree to be personally responsible for payment by signing below. This agreement is valid for all services submitted to Medicare and subsequently denied including all non-covered Medicare services. I authorize the release of any medical and other information necessary to process the claims submitted. I also request payment of government benefits to Shady Grove Podiatry, LLC.

X \_\_\_\_\_

Signature of Patient / Parent Guardian

\_\_\_\_\_ Date

#### Consent and Release

By signing below, I certify that the information I have reported regarding my insurance coverage is correct and further authorize the release of any necessary information, including the information for this or any related claim to my stated insurance company. Either my insurance company or I may revoke this authorization at any time in writing. Regardless of my insurance coverage, there are some services which are not covered. Payments for these non-covered services are my responsibility and must be paid at the time of the visit. During treatment, durable medical equipment may be recommended. I authorize my insurance company to pay Shady Grove Podiatry, LLC directly. I understand that my insurance company will cover this item under the benefit plan if it is medically necessary, but that I am responsible for any non-covered services, deductibles, and co-insurances after insurance processing.

X \_\_\_\_\_

Signature of Patient / Parent Guardian

\_\_\_\_\_ Date

#### Receipt of Notice of Privacy Practices Acknowledgement

By signing below, I acknowledge that I have reviewed and / or received upon request the notice of privacy practices of Shady Grove Podiatry, LLC. This notice describes how Shady Grove Podiatry, LLC may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information in accordance with HIPAA and PHI regulations. The federal government now restricts Shady Grove Podiatry, LLC from discussing my health information with other family members or persons unless I specifically give written permission below. By signing below, I grant Shady Grove Podiatry, LLC permission to discuss and release my protected medical information to the following individuals (if you do not wish to list anyone, please sign your name below and leave the first two lines blank).

Authorized individual (full name and relation): \_\_\_\_\_

Authorized individual (full name and relation): \_\_\_\_\_

X \_\_\_\_\_

Signature of Patient / Parent Guardian

\_\_\_\_\_ Date

#### Cancellation Policy

To efficiently schedule appointments and in consideration of our other patients, we require 24-hours' notice if you must cancel or change an appointment. A \$50.00 charge will occur for the first missed appointment and an additional \$25.00 charge for subsequent missed appointments. We offer a 15-minute grace period from the scheduled appointment time. If you arrive later than the grace period, you will be charged the fee. If there is an emergency, please call at the earliest opportunity.

X \_\_\_\_\_

Signature of Patient / Parent Guardian

\_\_\_\_\_ Date

#### Form Fee Guidelines

Shady Grove Podiatry, LLC charges a fee for the completion of any form which requires medical information and/or a physician's signature. A fee will also apply for the release of medical records (to a patient or requesting party) unless the transmission of the medical records is to be sent to another physician's office. For disability and/or FMLA paperwork, Shady Grove Podiatry, LLC requires at least five (5) business days for completion. If the doctor(s) feels it is necessary to obtain additional information from the patient to complete the form(s), the patient may be required to make an appointment. Payment will be obtained at pick-up of the completed forms. Please further inquire with the front desk as necessary. By signing below, I acknowledge this guideline.

X \_\_\_\_\_

Signature of Patient / Parent Guardian

\_\_\_\_\_ Date

#### Deepscribe Dictating Service

Shady Grove Podiatry, LLC will be utilizing a HIPAA compliant transcribing dictation service that prepares medical notes by listening (never stored or shared) and allows more time for substantive work for clinicians. By signing below, I, the patient or patient representative, agree and understand the utilization of Deepscribe during my appointments at Shady Grove Podiatry, LLC.

X \_\_\_\_\_

Signature of Patient / Parent Guardian

\_\_\_\_\_ Date

## Notice of Privacy Practices

This notice describes how Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel may use and disclose your healthcare information and how you can obtain access. Please review it carefully.

Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel are required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographics information, either created by Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel or received by Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel from other healthcare providers. We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.<sup>1</sup>

Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel reserve the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided with a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

### Uses and Disclosures of Your Protected Health Information Not Requiring your Consent

Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment, and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

### Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one of more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies.

For example, Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel may determine that you require the services of a specialist. In referring to another doctor, Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel may share or transfer your healthcare information to that doctor.

### Payment Activities may include:

- Activities undertaken by Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for your services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization services to be provided to you.

For example, Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

### Healthcare operations may include:

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conduction outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide or assess the effectiveness of your treatment when compared to patients in similar situations.

Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel are permitted or required to use or disclose your protected health information without your consent or authorization. Examples including the following:

- As permitted or required by law: in certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred because of a crime. Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.
- For health oversight activities: we may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state government agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.

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<sup>1</sup> This notice is prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. § 164.520.

- For public health activities: we may release healthcare records, apart from treatment records to certain government agencies or public health authority authorized by law, open receipt of written requests from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure. We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food and Drug Administration when required by federal law. We may disclose healthcare records, except for HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.
- Judicial and Administrative Proceedings: patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.
- For activities related to death: we may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.
- For research: under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.
- To avoid a serious threat to health or safety: we may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.
- For worker's compensation: we may disclose your health information to the extent such records are reasonably related to any injury for which worker's compensation is claimed.

Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel have acted in reliance thereon. Any revocation must be in writing.

#### Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, apart from psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel deny any access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests from you.

You have the right to request that Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel amend portions of your healthcare records, if such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel for the six years prior to the date of the request, beginning with disclosures made after April 1, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive a paper copy of the Notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel, please contact the Privacy Officer at the following:

Privacy Officer  
Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel  
16220 Frederick Road, Suite #427,  
Gaithersburg, MD, 20877  
(301) 948-2995

It is the policy of Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel that no retaliatory action will be taken against any individual who submits or conveys a complaint or suspected or actual non-compliance or violation of the practice standards.

This Notice of Privacy Practices is effective July 17, 2017.  
This Notice of Privacy Practices was updated April 23, 2025.

(DRS. ASSILI, BAEK, DANG, DILLARD, MALINSKY, AND SIEGEL)