OBSIDIAN
MEN'S HEALTH

PATIENT INFORMATION AND AGREEMENT

Date: _____ Patient's Name: _____

Date of Birth: _____ Last 4 of SSN: _____

Address:

_____

_____

Phone Number: _____ Email: _____

Emergency Contact: _____

Phone: _____ Relation: _____

Reason(s) for visit:

_____

Prescription Medicine:

_____

Drug Allergies:

_____

Preferred Pharmacy: _____

Primary Insurance: _____

Policy Number: _____ Group Number _____

I accept full responsibility for knowing the terms and conditions of my insurance coverage as Obsidian Men's Health does not participate with any insurance. I accept full responsibility for payment at the time of visit for services rendered. I understand that an unpaid balance after two weeks from date of service will result in the engagement of a collection agency. I agree to pay collection fees at this time of 35% of the amount owed.

_____ _____

Patient's Signature Date

OBSIDIAN
MEN'S HEALTH

MEDICAL RELEASE FORM

Patient's Name:

_____

Patient's Date of Birth:

_____

Patient's Address:

_____

_____

Patient's Phone Number:

_____

Patient's Social Security Number:

_____

The above identified patient is requesting the following information be made available to Physician(s) or for use to obtain records from your Physician(s):

Obsidian Men's Health

Dr. Geib and Dr. Richman

8200 Greensboro Drive, Suite 200, McLean, VA 22102

T 703.940.5815 F 571.921.9340

_____ _____

Signature of Patient Date

For Office Use Only

Name and title of person who needs released records:_____

How information was transferred: _____ Date: _____

Faxed to: _____ on _____

OBSIDIAN
MEN'S HEALTH

NO SHOW / CANCELLATION POLICY

At Obsidian Men's Health, we pride ourselves on the level of time, attention and privacy we give to our patients. Given that you're an Obsidian client, we think you appreciate that too. In order to provide that level of attention and privacy, we block out generous amounts of time for each appointment.

We understand that situations arise in which you must cancel your appointment. Please keep in mind the amount of time each doctor sets aside for each of your appointments. If you must cancel, please give us the courtesy of 48 hours notice. This will provide our staff enough time to shift the doctor's schedule, or allow another patient to fill your slot.

No-shows or cancellations with less than 48 hours notice will be subject to a $250 fee.

Patients who no-show two or more times in a 12-month period, may have their membership with Obsidian Men's Health terminated.

The cancellation and no show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We strongly believe in our model for healthcare: ample time, attention, privacy, and unparalleled expertise. We also believe in a strong doctor-patient relationship based on mutual trust, communication, and respect. Please provide us with the courtesy of a call should circumstances arise that cause you to need to reschedule your appointment.

_____ _____

Signature Date

OBSIDIAN
MEN'S HEALTH

NOTICE of PRIVACY POLICIES AND PRACTICES (HIPAA AGREEMENT)

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Federal law requires us to maintain the privacy of your medical information. This notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. PHI is information about you including demographic information, which may identify you and relates to your past, present or future health condition and related health care services.

Use and disclosures of protected health information Your PHI may be used and disclosed by your healthcare provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the practice and other use required by law. Once this authorization is granted (through acknowledging receipt of this notice) you may revoke in writing at any time. We will not use or disclose your health information for any reason except those described in this notice and related to your care.

Treatment We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a referring medical provider to ensure that the provider has the necessary information to diagnose or treat or treat you.

Healthcare Our office may use, disclose or discuss your medical information in connection with our ongoing healthcare operations. These include: quality assessment and improvement programs, peer review, accreditation, certification, credentialing activities and evaluation of provider performance.

Communication With Family We may, if we obtain your verbal or written permission, disclose information about your medical treatment to your family members for purpose of treatment, care, or communication. We may use our professional judgment to infer that it is in your best interest to allow a spouse or family member to be present while discussing your treatment and/or account.

Marketing Our office will not use your information for purposes related to marketing, sales or other non-treatment related activities without your written permission.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____

Signature Date