LYNCH PRIMARY CARE
CONCIERGE MEDICINE

31 E. Lee Street, Bel Air, MD 21014
P: 410-638-5339 F: 410-638-8877

REASON FOR COMING TO LPC:
(check all that apply)

Primary care ____ HRT ____
Pediatrics ____ GYN ____

PATIENT REGISTRATION

DATE: _____

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____ **SOCIAL SECURITY NO:** _____ - _____ - _____

LOCAL ADDRESS: _____

CITY/STATE/ZIP CODE: _____

HOME PHONE: (_____) _____ - _____ **CELL PHONE:** (_____) _____ - _____

WORK PHONE: (_____) _____ - _____ **EMAIL ADDRESS:** _____

EMPLOYER: _____ **OCCUPATION:** _____

MARITAL STATUS: _____ **NAME OF SPOUSE/SIGNIFICANT OTHER:** _____

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact: _____

Relationship to Patient: _____

Home Phone: (_____) _____ - _____ **Cell Phone:** (_____) _____ - _____

DO YOU HAVE A LIVING WILL OR SOMEONE WHO MAKES MEDICAL DECISIONS FOR YOU? YES OR NO

IF YES, NAME _____

RELATIONSHIP _____ **PHONE** _____

PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: (_____) _____ - _____ **Pharmacy Fax** (_____) _____ - _____

HOW DID YOU HEAR OF LYNCH PRIMARY CARE? _____

WHICH DOCTOR ARE YOU HERE TO SEE? _____

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31 E. Lee Street
Bel Air, MD 21014

WOMEN'S CARE MEMBERSHIP AGREEMENT

This Membership Agreement (this "Agreement") is by and between Lynch Internal Medicine, LLC, a limited liability company that practices medicine ("Lynch Primary Care"), and _____ (the "Member"), and specifies the terms and conditions under which the Member may participate in the "Program" offered by Lynch Internal Medicine. This Agreement between Lynch Internal Medicine and the Member will become effective on the date this Agreement is signed by the Member and the first payment is received; provided, however, that such effective date shall not be before October 5, 2009.

I. The Program

In exchange for the Membership Fee (as defined below), Lynch Internal Medicine agrees to provide hormone replacement therapy and/or routine gynecological services. The member acknowledges that claims will not be sent to their health plan for reimbursement.

The Member acknowledges that these amenities are not covered by insurance and are not reimbursable by the Member's insurer or other health plan.

II. Membership Fee

Patients can become Members in the Program by paying the fee in full at the time of signing the Women's Care Membership Agreement. All payments may be made by using cash or most widely accepted credit cards. All payments are due at the time of service (see Exhibit A).

III. Renewals and Termination

The Initial Term of this Agreement shall be for one (1) year, and this Agreement shall renew automatically for successive one-year renewal terms (each a "Renewal Term") unless either party gives the other party written notice of intent not to renew in accordance with the provisions stated below.

Lynch Internal Medicine may terminate this Agreement for any reason with thirty (30) days prior written notice to the Member.

The Member may terminate this Agreement for any reason at any time with prior written notice. The first $300 of your membership fee and any payments made thereafter are non-refundable.

IV. Coverage

Lynch Internal Medicine will use other physicians or practitioners to cover patients during those infrequent times when our physicians are out of town or during such time as he/she may be unavailable by cell phone.

V. E-mail/Text Communications

If the Member wishes to send e-mail/text communications to, and receive e-mail/text responses from Lynch Internal Medicine or its agents or representatives, the Member should be aware that e-mails/texts are not a secure medium for sending or receiving sensitive personal health information. Lynch Internal Medicine will take steps to keep your communications confidential and secure in compliance with state and federal laws governing the confidentiality of medical records and protected health information. The Member acknowledges and understands that e-mails/texts are not a good medium for urgent or time-sensitive communications. In the event a communication is time-sensitive, the Member agrees to communicate with Lynch Internal Medicine by telephone or in person. The Member acknowledges and understands that e-mail/text communications may become part of the Member's permanent medical record. We ask that all members please call the office first before calling or texting the physician's cell phone as there may be important on-call information given.

VI. Miscellaneous

1. The Agreement may not be assigned by the Member and may not be assigned by Lynch Internal Medicine without the Member's prior written approval. No amendments or additions to this Agreement shall be binding unless set forth in writing and signed by the parties. Any waiver by either party of any breach of any provision of this Agreement shall not be considered as, or constitute a continuing waiver or waiver of any other breach of any provision of this Agreement.

2. In the event any term or provision of this Agreement is rendered invalid or unenforceable by any federal or state law, rule or regulation or is held by any court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions of this Agreement shall remain in full force and effect.

3. Any communication required or permitted to be sent under this Agreement shall be in writing and hand delivered, sent overnight delivery by a nationally recognized courier or sent via certified mail, return receipt requested. Any notification to Lynch Internal Medication shall be sent to the office address listed on this agreement, and any notification to the Member shall be sent to the Member's address on file. Any change in address for either party shall be communicated to the other party in writing in accordance with this Section VI.3.

4. This Agreement shall be binding upon and inure to the benefit of the parties and their respective heirs, legal representatives, successors and assigns.

5. This Agreement constitutes the entire Agreement between the parties and supersedes all prior discussions, representations, understandings or agreements whether oral or in writing between Lynch Internal Medicine and Member pertaining to the subject matter of this Agreement.

6. Nothing in this Agreement shall be deemed to influence or construed to influence or affect a physician's independent medical judgment on behalf of the Member.

VII. Change of Law

If there is a change of any state or federal law, regulation, or rule that affects this Agreement or the activities of either party under this Agreement, or any change in the judicial or administrative interpretation of any such law, regulation or rule, and either party reasonably believes in good faith that the change will have substantial adverse effect on that party's rights or obligations under this Agreement, then that party may, upon written notice, require the other party to enter into good faith negotiations to renegotiate the terms of this Agreement. The parties shall use their best efforts during a thirty (30) day period thereafter to mutually agree to such amendments. If after such thirty (30) day period the parties are unable to agree to amend this Agreement, this Agreement shall automatically terminate. If the change in law, regulation or interpretation is effective immediately, then either party may immediately terminate this Agreement by written notice to the other party.

VIII. Governing Law

This Agreement shall be governed by, and construed in accordance with, the internal laws of the state of Maryland.

IN WITNESS WHEREOF, the parties have agreed to execute this Agreement as of the date set forth below.

Lynch Internal Medicine, LLC

By: _____ _____
Kendal E. O'Hare, M.D. Date
Treating Physician

_____
Member's Name (Printed)

_____ _____
Member's Signature Date

_____
Date of Birth

LYNCH INTERNAL MEDICINE, LLC

Exhibit A – Women's Care Fee Schedule

1. Patients can become Members in the Program by paying the fee in full at the time of signing the Women's Care Membership agreement.

2. All payments may be made using cash, check, Visa, Mastercard or Discover cards. All payments are due at the time of service.

GYN and HORMONE REPLACEMENT THERAPY MEMBERS:

First visit to begin HRT (hormone replacement therapy)	$300
Follow up visits to manage new HRT	$250
Follow up visits for patients already established on HRT regimen	$150
GYN visits	$150

NOTE: HRT patients need to be seen approximately 2 to 4 times per year for consistency of care.

By signing below, I agree to the payment amount and schedule indicated above.

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Patient or Legal Guardian

LYNCH PRIMARY CARE, LLC
31 E. Lee Street
Bel Air, MD 21014
Lynchprimarycare.com

P: 410-638-5339
F: 410-638-8877

AUTHORIZATION to RELEASE MEDICAL RECORDS

I, _____, authorize the release of my medical records from the

office of _____

_____

_____

To be sent to: **Lynch Primary Care**
31 E. Lee Street
Bel Air, MD 21014

Upon receipt of this document, please send the following information:

_____ Problem List
_____ Medication List
_____ Office Notes (past year)
_____ Discharge Summaries
_____ Cardiac Procedures
_____ Dexa Scans (last 2)
_____ Consultation Notes (past 5 yrs)
_____ History & Physical (most recent)
_____ Laboratory Data (past 2 yrs)
_____ X-ray Reports (past 5 yrs)
_____ Pathology Reports

I am aware that these records may contain information relating to psychiatric or psychological testing or treatment, biofeedback training and/or alcohol/drug abuse.

This consent is subject to written revocation by the undersigned at any time, except to the extent that action has been taken, and if not earlier revoked, this consent shall become invalid six months from the date of signature.

I understand that I have the right to receive a copy of this authorization upon my request.

PATIENT SIGNATURE: _____ **DATE:** _____

PATIENT NAME (Please print): _____

PATIENT DATE OF BIRTH: _____

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you acknowledge that the providers of Lynch Primary Care has provided you access to a copy of its Privacy Notice which explains how your health information will be handled in various situations. By law, we are required to have you sign this form on your first date of service with us. If your first date of service with us was due to an emergency, we must try to provide you access to this notice and have you sign this form as soon as we can after the emergency.

Please specify by checking the appropriate answer below how we may BEST contact you or leave a message for you:

Home and/or answering machine	____ YES	____ NO
Work	____ YES	____ NO
Cell Phone	____ YES	____ NO
Personal E-mail	____ YES	____ NO

****Please note that if the above section is not completed, we will assume that we have your approval to contact you using any one of the above methods.**

THE PRACTICE HAS PROVIDED ME ACCESS TO ITS PRIVACY NOTICE. I UNDERSTAND I MAY REQUEST A COPY FOR MY PERSONAL USE.

THIS PRACTICE HAS CHOSEN TO PARTICIPATE IN THE CHESAPEAKE REGIONAL INFORMATION SYSTEM for our PATIENTS , INC. (CRISP), a statewide health information exchange. For more information on CRISP, please see our Notice of Privacy Practices.

_____ _____
Print Name **Date**

_____
Signature

****

FINALLY: The Federal Government now restricts this OFFICE and the providers of Lynch Primary Care from discussing your health information and condition with other family members or persons - unless you specifically give your written permission.

By my signature below, I grant the office of Lynch Primary Care permission to discuss my protected medical information with the following individuals:

1. _____ 2. _____

SIGNATURE OF PATIENT: _____
(parent/guardian if a minor)