Dear Patient,

We all know the enormous challenges facing healthcare and we hope you see the many ways we're meeting these challenges. First and foremost, we treat you as an individual. We take the time to listen to you explain what's going on in your body. This attention to detail helps us develop the best course of treatment.

We're also doing everything to keep our doors open while responding to spiraling healthcare costs. That's why more than a year ago, in September 2019, Hopkins Medical Group adopted a **membership model**, something a growing number of medical practices have started as well.

Under this model, which we call **GenWell,** you pay an affordable monthly membership fee to remain a patient and maintain all of the services we provide. **We still accept and bill your medical insurance** for all services you receive with us (office visits, physical exams, injections). With this membership, you have access to our herbal medicine and supplements, nutrition and lifestyle consults – all at a discount. An added benefit is access to our informative Town Halls which were crucial to stay connected these past six months, along with group visits, online education, podcasts, and more.

Without this membership model, we would face a decision to either stop taking insurance or only focus on conventional medical approaches- two options that are not in anyone's best healthcare interests.

For many patients, **a "GenWell" membership pays for itself** each year through discounted supplements and skin care products. You can also save money by paying for your membership in one annual payment.

Here are our two methods of payment:

1. $240/year- set up a recurring monthly payment of $20 (cancel anytime with 30 days notice)
2. $199/year- pay upfront and receive a 17% membership discount (no refund for early cancellations)

To ensure there is no gap in your healthcare services, we ask that you **sign up and pay for your membership today** by visiting our website, phopkinsmd.com/membership

We look forward to continuing to serve you.

Thank you.

Dr. Patricia Hopkins and the team at Hopkins Medical Group

I understand that I have three months from the date of my initial appointment (initial appointment date: _____) to become a member of the practice in order to continue to receive care at Hopkins Medical Group.

_____ _____

Patient Signature Date

Patient: _____ **DOB:** _____

Reason for visit:

_____

_____

_____

_____

Pain Scale (0 out of 10) /10, Location _____

Quality: Burning. Achy. Throbbing. Sharp. Shooting. Dull. Pressure. Stinging

Occurs: Constant Intermittently. At Rest. At Night

Allergies:

_____

_____

Medications/Supplements: (Please List ALL)

_____

_____

_____

_____

If requesting medication refills, please circle them.

Pharmacy: _____

Did you receive the vaccine? Moderna Pfizer J&J

Other: Flu Prevnar 13 Pneumovax 23 Shingling

Last Physical Exam: _____

Who is your Primary Care Provider? _____

Any testing (labs/radiology/etc.) you would like to review with the Provider today?

_____

_____

Most recent surgeries?

_____

_____

Any questions for the Provider today write below:

Patient Registration Forms

Patient:		DOB:	Sex:
Marital Status:	Social Security:	Email:	
Address:		City/State/Zip:	
Home Phone:	Work:	Cell:	
Primary Care:		Telephone:	
Pharmacy:		Telephone:	
Emergency Contact:		Relationship:	Telephone:

Insurance Information

Primary Insurance:	ID:	Group #:
Address:	Telephone:	
Secondary Insurance:	ID:	Group #:
Address:	Telephone:	

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to including Medicare, Medigap, Private insurance and other health insurance plans to Dr. Patricia T. Hopkins.

The document will remain in effect until revoked in writing. A photocopy of this statement is to be considered as valid as the original. I understand that I am financially responsible for all charges weather or not paid by said assignees to release all information necessary to secure that payment.

Signature: _____ **Date:** _____

Printed Name: _____

Please check off if any apply:

	Migraines/Headaches		Asthma		Seizures		Fibromyalgia		Gout
	High Blood Pressure		Diabetes		Glaucoma		Kidney Stones		Depression
	Bladder Problems		Bipolar		Cataracts		Pneumonia		Cancer
	Bleeding Problems		Anemia		Stroke		Gallstones		
	Neurological Disorders		Angina		Blood Clots		Thyroid Disease		
	Irregular Heartbeat		Fevers		CAD		Stomach Ulcers		
	Muscle Disorder		TB		Hernia		Kidney Disease		
Other Health Problems:									

Please list any operations you have had in the past:

1. 4.

2. 5.

3. 6.

Social History: (Circle one)

Tobacco	Yes / No	Lives Alone	Yes / No
Alcohol	Yes / No	Seat Beat Use	Yes / No
Drugs	Yes / No	Employed	Yes / No
Exercise	Yes / No	Sexually Active	Yes / No
Children	Yes / No	Pets	Yes / No
Caffeine	Yes / No	Mobility Devices	Yes / No

Family History:

Grandfather: _____

Grandmother: _____

Father: _____

Mother: _____

Siblings: _____

Other Pertinent Information: (Please List Below)

Patient Payment Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

INSURANCE

We participate in most managed care plans and will bill your insurance plan as may be necessary. If we do not participate with your managed care plan, payment in full is required at the time of service, unless other arrangements have been made in advance. We may be able to bill your plan as a courtesy to you and credit your account if we receive any additional payment. Knowing your insurance benefits – including eligibility, covered benefits, and medically necessary procedures, is your responsibility; please contact customer services at your insurance company for questions you may have regarding your coverage. **You are responsible for any charges not covered by your plan**.

Proof of Insurance

All patients must complete and/or update our Patient Information Form at each office visit. You must furnish valid and up-to-date proof of insurance coverage and a copy of your driver's license. If you provide false or expired insurance information you will be responsible for the balance of the claim. Please notify us of any changes in insurance coverage prior to time of service. Insurance denials for termination of coverage will be automatically billed to you.

Co-payments and Deductibles

All co-payments and unsatisfied deductibles must be paid at the time of service. By contractual law your insurance company requires us to charge for, and you to pay for, all required co-payments, co-insurances, deductible and non-covered services.

Claim submission

We will submit your insurance claims and assist you in any way reasonable to help get your claim paid. Your insurance company may need you to supply information directly to them. It is your responsibility to comply with their request in a timely manner. Please be aware that the balance of your claim is your responsibility to pay whether or not your insurance company has paid. We are not a party to your insurance contract.

Referrals

If you have an **HMO** plan with which we are contracted, you **NEED** a referral authorization from your primary care physician. If we have not received an authorization prior to your appointment we ask you call your primary care physician to obtain it. **If you are unable to obtain the referral at that time, you will be rescheduled or responsible for payment.**

How May I Pay?
We accept payment by cash, check, VISA, MasterCard, American Express, Discover and etc.

Which Plans Do We Contract with?
We are contracted with mostly all commercial insurances. Medicare, Medicaid, AARP, Tufts Medicare Preferred, Harvard Pilgrim Enhanced, Neighborhood Health, Tufts Network Health and Blue Cross Blue Shield Medex we are only listed as a Specialist. It is always a good idea to call your plan before your appointment just to double check with your insurance.

I have read, understand, and agree to the above Financial policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Dr. Patricia Hopkins practice.

I authorize Dr. Patricia Hopkins to release pertinent medical information to my insurance company when requested, or to facilitate payment of claim.

Patient Name (Printed)	Patient Signature	Date

NOTICE OF PRIVACY PRACTICES

Patient Acknowledgement

PAITENT NAME: _____

DATE OF BIRTH: _____

I HAVE RECEIVED THIS PRACTICE'S NOTICE OF PRIVACY PRACTICES WRITTEN IN PLAIN LANGUAGE. THE NOTICE PROVIDES IN DETAIL THE USES AND DISCLOSURES OF MY PROTECTED HEALTH INFORMATION THAT MAY BE MADE BY THIS PRACTICE. MY INDIVIDUAL RIGHT, HOW I MAY EXERCISE THESE RIGHTS AND THE PRACTICE'S LEGAL DUTIES WITH RESPECT TO MY INFORMATION.

I UNDERSTAND THAT THIS PRACTICE RESERVES THE RIGHT TO CHANGE THE TERMS OF THIS NOTICE OF PRIVACY PRACTICES AND TO MAKE CHANGES REGARDING ALL PROTECTED HEALTH INFORMATION RESIDENT AT, OR CONTROLLED BY THIS PRACTICE. I UNDERSTAND AND I CAN OBTAIN THIS PRACTICE'S CURRENT NOTICE OF PRIVACY PRACTICES ON REQUEST.

SIGNATURE: _____

DATE: _____

IF SIGNED BY A PERSONAL REPRESENTATIVE OF PATIENT

NAME: _____ RELATIONSHIP: _____

GenWell. LLC

Patient Agreement and Consent for Services

As part of the care a patient receives at Hopkins Medical Group and through GenWell LLC, the healthcare practitioners may provide additional assessment beyond the scope of that often provided in a typical medical office. Most medical offices make some lifestyle recommendations and primarily use pharmaceutical interventions that are considered 'standard of care' and have been based on multiple peer-reviewed and/or randomized controlled scientific trials for which the FDA may/may not have granted an indication status.

At Hopkins Medical Group and in partnership with GenWell LLC we do offer many of these same assessments, recommendations, and treatments, however, at times we may also pursue clinical assessment, recommendations, and treatment courses that may be considered atypical, controversial, outside the scope of approved indications, or with a variable amount of supporting evidence. While some of these may be outside the 'standard of care' of conventional medical practice, we strive to make recommendations based upon the best available evidence whether from the conventional or integrative medical and health communities. We inform patients by way of writing in this agreement but also verbally of known and potential risks, possible benefits, and alternatives. Due to what may be considered incomplete or inconsistent evidence we may not be able to anticipate or communicate to a patient ahead of time of all potential risks or adverse effects from pursuing this wellness protocol. At no point is a patient obligated to pursue any particular evaluation, test and or healing regimen.

Examples of the testing that may be considered outside the context of typical conventional medical practice may include the following:

- Autonomic Response Testing. This is a physical exam technique in which practitioners can introduce "stresses" to a patient/client and observe how these stresses result in changes in muscle tone (by way of effects on the autonomic nervous system).
- Specialized stool analysis and/or parasite testing
- Specialized breath testing for small intestinal bacteria overgrowth or Helicobacter Pylori.
- Specialized blood or urine testing for Lyme and related infections
- Specialized blood testing for immune system markers and food allergy/sensitivity
- Nutritional or toxic status assessments including blood specimen analysis, urine testing, and spectrophotometry
- Provoked urinary heavy metals testing
- Other specialized urinary tests including but not limited to organic acid testing
- Hair mineral analysis

GenWell. LLC

Patient Agreement and Consent for Services

Examples of the recommended treatments or therapies that may be considered outside the context of typical conventional medical practice may include use of the following:

- Longer courses of antibiotics or other antimicrobials for Lyme, PANS/PANDAS, or other infections
- IVIg infusions
- Prescribed diets
- Supplements
- Intravenous nutrients
- Herbal tinctures, teas and/or other formulations
- Low Level Laser/Light Therapy (LLLT)
- Ionic Foot Bath
- Sauna therapy
- Colonic Hydrotherapy

By signing below, you acknowledge that Hopkins Medical Group has informed you in writing that the above tests or recommended interventions may be outside the scope of common medical practice, may carry additional risk for which you will be given additional information and the opportunity to ask questions in the relevant clinical circumstances and are not under any obligation to pursue the above testing or treatments for you or your dependents for whom we may recommend the above in the context of a patient and medical provider relationship.

Signature _____ Date _____

Printed Name _____