A. LEE DELLON, M.D. **ERIC H. WILLIAMS, M.D.**

Patient Questionnaire

Please fill this form out completely and mail it back before your appointment on:

Name:	Age:	DOB:
Address:	City:	
State:	Zip:	
Home#:	SSN:	
Occupation:	Work#:	
Spouse(or parent if minor):		
Spouse Employer:	Work#:	

Insurance Information

Primary Insurance:	
Claims Address(on back of card):	
Policy#:	Group#:
Policy Holder & Employer:	

Out of Network Benefits: Doctor-YES NO Hospital - YES NO Out Patient- YES NO

Secondary Insurance:	
Claims Address(on back of card):	
Policy#:	Group #:
Policy Holder & Employer:	

Third Insurance (if applicable):

Is this a litigation case? YES NO If yes – give name/address of Attorney

Physician Information-

Referring Physician:	Phone#:
Complete Address:	Fax #:

Primary Physician:	Phone#:
Complete Address:	Fax #:

Please list any other Doctors & addresses you want to receive a copy of your consultation.

Thank You.

DO YOU HAVE MEDICARE PART A OR B? ____ YES ____ NO

PATIENT SIGNATURE DATE

Worker's Compensation Carrier

You must bring in complete information below before you will be able to be seen:

Worker Comp. Carrier:	
Carrier Address:	
Carrier Phone#:	Auth verified by:
Adjuster's Name & Phone#:	
Claim Number:	

Injury Information

Date of Injury:	Time of Injury:
Place of Injury:	
Accident reported to employer? YES NO	
Name of person reported to:	
Give a full description of the accident:	
Have you lost time from work?	
If yes, how much time was lost?	
List other doctors you've seen for this condition:	
Were X-rays taken? YES NO	
Any other tests?	
If yes, by which doctor and what were the results?	
Any previous Workers Compensation injuries? YES NO	
Dates & description of previous injuries:	

Authorization

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for the payment in the event that my claim for Worker's Compensation benefits is denied.

Patient's Signature: Date:

DELLON INSTITUTES FOR PERIPHERAL NERVE SURGERY

WELCOME TO THE DELLON INSTITUTE FOR PERIPHERAL NERVE SURGERY. PLEASE TAKE A FEW MINUTES TO COMPLETE THIS FORM TO THE BEST OF YOUR ABILITY. YOUR ANSWERS WILL HELP YOUR DOCTOR BETTER UNDERSTAND YOU MEDICAL CONCERNS.

Problem you wish to discuss with your surgeon:

____

____

Age: _____ Gender: _____ Height: _____ Weight: _____

Circle: I am Right/Left Handed

Do you have any health problems, which required treatment? If so please indicate yes or no below.

____ Diabetes
____ Anemia
____ Bleeding problems
____ Blood clots
____ High blood pressure
____ Heart trouble or heart attacks
____ Stroke
____ Paralysis
____ Sleep Apnea
____ Lung problems
____ Asthma
____ Emphysema
____ Thyroid problems
____ Hepatitis

____ Kidney trouble
____ HIV AIDS
____ Depression
____ Seizures
____ Rectal trouble
____ Arthritis
____ Female problems
____ Reflux
____ Gallblader problems
____ Cancer
____ Radiation & last treatment__________
____ Chemotherapy & last treatment_____
Other ____________

Please list any prior surgeries

Surgery	Date	Physician	Hospital

Medications (please list all Rx meds, diet pills, over the counter meds & vitamins
**Attach a typed list if necessary

Medicine	Dose	Frequency	Medicine	Dose	Frequency

Do you have any <u>latex</u> or <u>medication</u> allergies? Yes / No

I am allergic to : ____

Diseases that run in your family: ________________________________

Social History:
Do you smoke cigarettes/cigars/pipe?
[ ] Never [ ] Previous Smoker - Quit Date_______ [ ] Current Smoker

If you currently smoke: #packs/day_____ # of years you have smoked_____
Are you exposed to second hand smoke? [ ] Yes [ ] No

Do you drink alcohol? [ ] Yes [ ] No:
Drinks per Week_____ For how long?________

Do you use recreational drugs? [ ] Yes [ ] No
Have you used needles? [ ] Yes [ ] No

Occupation:______________________________ Marital Status:______
Name of Spouse_____________________ # of children_____

Review of Systems: Please check any current problems you have on the list below:

Constitutional
__Fever/chills/sweats
__Unexplained weight changes
__Change in energy/weakness
__Excessive thirst or urination

Eyes
__Dry Eyes
__Changes in vision
__Glaucoma
__Cataracts
__Retinal Detachment
__Laser eye surgery

Cardiovascular
__Chest pain/discomfort
__Palpitations
__Mitral Valve Prolapse
__Need antibiotics @ dental visits

Respiratory
__Cough/wheeze
__Difficulty breathing

Gastrointestinal
__Abdominal pain
__Blood in bowel movement
__Nausea/vomiting/diarrhea
__Ulcers

Genitourinary
__Discharge: penis or vagina
__Nighttime urination
__Leaking urine

Musculo-Skeletal
__Muscle/joint pain

Skin
__Rash
__Mole change

Psychiatric
__Problems with sleep
__Anxiety/stress
__Depression

Blood/Lymphatic
__Easy bruising/bleeding
__Blood clots

Neurological
__Headaches
__Dizziness
__Numb sensation in feet
__Burning sensation in feet
__Tingling in fingers waking you up at night
__Increased clumsiness and dropping things

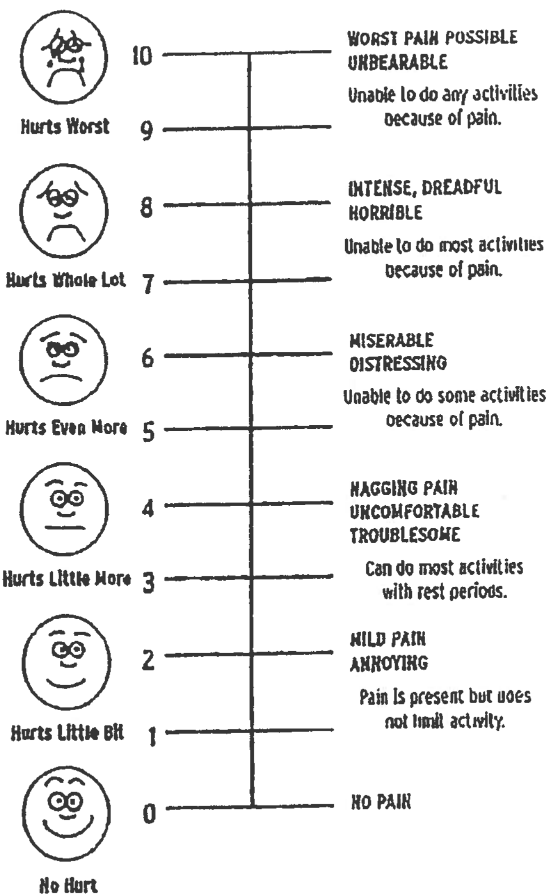
__Pain in forearms
__Feeling like your hands/feet are falling asleep

I CERTIFY THAT THE ABOVE REPRESENTS MY COMPLETE AND ACCURATE MEDICAL AND PSYCHIATRIC HISTORY.

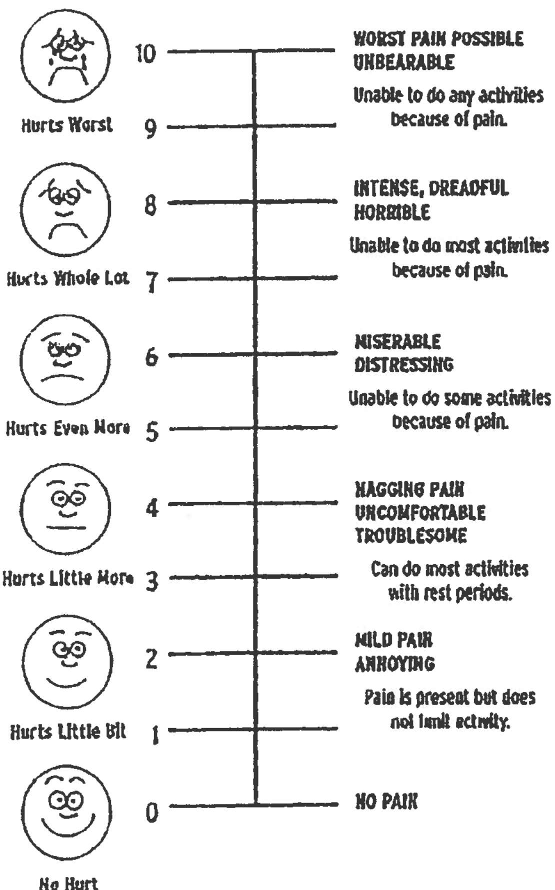
SIGNATURE OF PATIENT : ________________________________

DATE : ______________

Current
Worst Pain



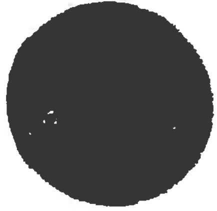
Current
Average Pain



Patient Name and Date:________________________________

Current Activity Levels:________________________________

Additional Comments:________________________________



PATIENT WAIVER

Dear Patient:

Please ensure your full understanding of the following pre-payment policy for A. Lee Dellon, MD. Patients are responsible for obtaining any potential reimbursements from insurance carriers, as A. Lee Dellon, MD does not accept assignment of benefits.

Please be advised of the following:

Medicare Part B participants are required to enter into a private contract with A. Lee Dellon, MD prior to treatment. ***A. Lee Dellon, MD has opted out of Medicare; therefore, you will be unable to file a claim for reimbursement.***

BlueCross BlueShield and other commercial insurance participants will be responsible for the remittance of all fees payable to A. Lee Dellon, MD prior to treatment. Upon request, procedure codes and fees will be provided to the patient for their use in obtaining reimbursement information from the insurance carrier prior to treatment. A HCFA 1500 form will be provided to the patient within ten business days for their use in filing a claim for reimbursement.

Surgery patients are advised to inquire in advance, of their insurance carrier's intent to apply the ***MULTIPLE SURGICAL RULE*** to their procedure.

Fees charged by A. Lee Dellon, MD may exceed the insurance carrier's allowable charges; therefore, patients may not receive full reimbursement of the amount paid to the physician.

Please confirm your understanding of the above information by signing below in the space provided.

______________________________ __________

Patient Signature Date

A. LEE DELLON, M.D. FACS
ERIC H. WILLIAMS, M.D.
GEDGE D. ROSSON, M.D.
SHAR HASHEMI, M.D.
"The Exchange"
1122 Kenilworth Dr., Ste#18
Towson, MD 21204

SIGNATURE ON FILE

I authorize use of this form on all my insurance submissions.
I authorize release of information to all my Insurance Companies.
I understand that I am responsible for my bill.
I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.
I authorize payment direct to my doctor.
I permit a copy of this authorization to be used in place of the original.

Name____

Signature____

Dellon Institute for
Peripheral Nerve Surgery
1122 Kenilworth Drive
Suite 18
Towson, Maryland 21204
410 337 5400 tel
410 337 5520 fax
www.dellon.com

A Lee Dellon, MD, PhD
Plastic Surgery
Peripheral Nerve Surgery
Hand Surgery

Eric H Williams, MD
Plastic Surgery
Peripheral Nerve Surgery
Reconstructive Surgery

Gedge D Rosson, MD
Plastic Surgery
Peripheral Nerve Surgery
Reconstructive Surgery

NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Created a s Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually Identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms and the notice of privacy practices that we in effect at this time.

We realize that these laws are complicated, but we must provide you with the following important information:

- **How we may use and disclose your IIHI**
- **Your privacy rights and your IIHI**
- **Our obligations concerning the use and disclosure of your IIHI**

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time

B. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

THE DELLON INSTITUTE
"THE EXCHANGE"
1122 KENILWORTH DR. , SUITE 18
TOWSON, MD 21204
410-337-5400

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may us the results to us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and staff – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as a spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.**

2. **Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We may also use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may us for your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.**

3. **Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.**

4. **Disclosures Required by Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state and local law.**

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:**

- **Maintaining vital records, such as births and deaths**
- **Reporting child abuse or neglect**
- **Preventing or controlling disease, injury or disability**
- **Notifying a person regarding potential exposure to a communicable disease**
- **Notifiying a person regarding a potential risk for spreading or contracting a disease or condition.**
- **Reporting reactions to drugs or problems with products or devices**
- **Notifying individuals if a product or device they may be using has been recalled**
- **Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.**
- **Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.**

2. **Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights law and the health care systems in general.**

3. **Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceedings. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made and effort to inform you of the request or to obtain an order protecting the information the party has required.**

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- **Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement**
- **Concerning a death we believe has resulted from criminal conduct**
- **Regarding criminal conduct at our office**
- **In response to a warrant, summons, court order, subpoena or similar legal process**
- **To identity/locate a suspect, material witness, fugitive or missing person**
- **In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)**

5. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosure to a person or organization able to help prevent the threat.

6. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

7. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

8. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if your are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

9. Worker's Compensation. Our practice may release your IIHI for worker's compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

Your have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to The Dellon Institutes, "The Exchange" 1122 Kenilworth Dr. Suite 18 Towson, MD 21204, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use of disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment of your care, such as family members or friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to The Dellon Institutes "The Exchange" 1122 Kenilworth Dr. Suite 18 Towson, MD 21204. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to The Dellon Institutes "The Exchange" 1122 Kenilworth Dr. Suite 18 Towson, MD 21204 in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request and amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to The Dellon Institutes "The Exchange" 1122 Kenilworth Dr., Suite 18 Towson,

MD 21204. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse: or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to The Dellon Institute for Peripheral Nerve Surgery, "The Exchange", 1122 Kenilworth Dr. Suite 18 Towson, MD 21204. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12 month period is free of charge, but our practice may charge you for additional lists within the same 12 month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. Your are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact The Dellon Institute for Peripheral Nerve Surgery "The Exchange" 1122 Kenilworth Dr. Suite 18 Towson, MD 21204.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of Department of Health and Human Services. To file a complaint with our practice contact The Dellon Institute for Peripheral Nerve Surgery "The Exchange 1122 Kenilworth Dr. Suite 18 Towson, MD 21204. All Complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Autorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your

authorization, we will no longer us or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice of our health information privacy policies, please contact The Dellon Institute for Peripheral Nerve Surgery "The Exchange" 1122 Kenilworth Dr. Suite 18 Towson, MD 21204.

Dellon Institute for Peripheral Nerve Surgery

A. Lee Dellon, M.D., PhD, F.A.C.S. Eric H. Williams, M.D.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

I, ______________________________; have received a copy of The Institute for
Patient Name
Peripheral Nerve Surgery's Notice of Privacy Practices.

________________________________ ______________
Signature of Patient Date

** Check either of the options below as it pertains to your care and handling of your private information.

___ I have reviewed and understand my rights, pertaining to the Privacy Act presented to me by The Institute or Peripheral Nerve Surgery. I am giving authorization for my spouse ______________________________ to obtain any of my records or medical
Spouse's Name
information in reference to testing, office visits or surgeries I may have through this office.

___ I have reviewed and understand my rights, pertaining the Privacy Act presented to me by The Institute for Peripheral Nerve Surgery. I am giving authorization for my parent's ______________________________________ to obtain any of my records
Parents Name(s)
or medical information in reference to testing, office visits or surgeries I may have through this office.

THE DELLON INSTITUTE

The Exchange Suite 18 1122 Kenilworth Drive Towson, MD 21204 Phone 410.337.5400 Fax 410.337.5520

Authorization for Use and Disclosure of Identifiable Health Information for Plastic or Peripheral Surgery Procedures/Treatment

PATIENT:_______________________DATE:________________TIME:_______

I am having the following plastic/peripheral surgery procedure or treatment:

___

Medical education is an important mission of IPNS. Often this education takes place outside of our office as the faculty share their knowledge with other physicians, institutions and the educational community. I have been asked to allow my identifiable health information (such as a picture or video that can identify me) to be used for these outside educational purposes. I agree with this request and, in connection with this procedure or treatment, I authorize Drs. A. Lee Dellon, Gedge Rosson, Eric Williams and Shar Hashemi to use and disclose my identifiable health information in educational activities outside of IPNS. These may include seminars, motion pictures, video-conferencing, and publication in textbooks or electronic publications such as a website. My identifiable health information includes my actual photograph, a manipulated photograph to show possible outcomes, a drawing or similar illustrative graphic material, a motion picture image or digital image and other representations helpful in the educational process.

I hereby grant permission for the use of any of my medical records including illustrations, photographs and other imaging records created in my case, for use in examination, testing credentialing and/or certifying purposed by the American Board of Plastic Surgery, Inc.

The American Board of Plastic Surgery requires that all identifiable characteristics, with the exception of a full face photograph or photograph of a uniquely identifiable characteristic, be blanked out for submission of materials for the Oral Board Examination of The American Board of Plastic Surgery to protect patient privacy.

Even if my health information is used for the above activities and purposes, I understand that every effort will be made to use only those identifiers necessary for the activity. I also understand that IPNS will make every effort to assure that my information is used only as I authorize. However, once my information is disclosed, it may no longer be protected by federal and state privacy laws.

This authorization has no end date, unless I cancel this authorization. I may cancel this authorization at any time in writing. I understand that if I cancel this authorization, the cancellation would affect only future disclosure of my information, photographs and images. However, if IPNS has already taken action based on my authorization at the time of my cancellation, my cancellation will not affect that disclosure.

I hereby grant permission for the use of any of my medical records including illustrations, photographs. and other imaging records created in my case, for use in examination, testing, credentialing, and/or certifying purposed by the American Board of Plastic Surgery, Inc.
The Board requires that all identifiable characteristics, with the exception of a full face photograph or photograph of a uniquely identifiable characteristic, be blanked out for submission of materials for the Oral Examination of The American Board of Plastic Surgery to protect patient privacy.

Patient Name : ____

Patient Signature:____
For health care agent/guardian/parent/Personal Representative of the patient (circle one)

Representative's Signature:__________________________________

Address:_________________________________**Phone:**____________
If you are the healthcare agent or guardian or court appointed Personal Representative of the patient, please attach proof of your authority to act on behalf of the patient.
I may revoke this authorization by mailing or faxing my written request along with a copy of the original authorization to the dept. or clinic in which I signed this authorization. If I am unable to provide a copy of the original authorization with my request to revoke, I will provide the following information Date of the authorization, Name, Address, Phone Number, Medical Record Number, Social Security Number, Date of birth, Purposes of authorization. A description of the health information covered by the authorization, and the person or entity authorized to use the data. If the form was signed by the Patient's representative, the request will also include The representative's name, relationship, address and phone number.
I understand that if I am unable to provide all of the above information, IPNS may not be able to honor my revocation request

Private Contract

• I A. Lee Dellon, MD (physician's name), have not been excluded from Medicare under [1128] §§1128, [1156] 1156 or [1892] 1892 of the Social Security Act.

• I the Medicare beneficiary or my legal representative accept full responsibility for payment of charges for all services furnished by Dr. A. Lee Dellon.

• I the Medicare beneficiary or my legal representative understand that Medicare limits do not apply to what Dr. A. Lee Dellon may charge for items or services furnished.

• I the Medicare beneficiary or my legal representative agree not to submit a claim to Medicare or to ask Dr. A. Lee Dellon to submit a claim to Medicare.

• I the Medicare beneficiary or my legal representative understand that Medicare payment will not be made for any items or services furnished by Dr. A. Lee Dellon that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

• I the Medicare beneficiary or my legal representative enter into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted-out of Medicare, and that the I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

• The expected or known effective date and expected or known expiration date of the opt-out period is 10/01/04 (effective date) and 9/30/15 ________ (expiration date).

• I the Medicare beneficiary or my legal representative understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

• This contract cannot be entered into by myself, the Medicare beneficiary, or by my legal representative during a time when I, the Medicare beneficiary, require emergency care services or urgent care services. (However, a physician/practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with §3044.28 of the Medicare Carriers Manual)

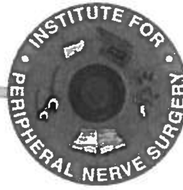
• I the Medicare beneficiary or my legal representative will receive or have received a copy (a photocopy is permissible) of this contract, before items or services are furnished to me under the terms of this contract.

- I A. Lee Dellon, MD (physician's name) will retain the original contract (original signatures of both parties required) for the duration of the opt-out period.

- I A. Lee Dellon, MD (physician's name) will supply CMS with a copy of this contract upon request.

- I A. Lee Dellon, MD (physician's name) understand that the current private contract remains in effect for two years. If I again opt-out of Medicare, I will expediently complete a new contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

(Physician's Signature)	(Date)
(Patient's Signature)	(Date)
(Patient's Legal Representative Signature)	(Date)
(Witness)	(Date)



Dellon Institute for Peripheral Nerve Surgery

A. Lee Dellon, M.D., PhD, F.A.C.S. Eric H. Williams, M.D. Gedge D. Rosson, M.D.

DIRECTIONS

Office Location

1122 Kenilworth Drive, Suite 18, The Exchange
Towson, Maryland 21204 Phone 410.337.5400 In House Medical Fax 410-337-6040

Free Parking is available in the parking lot directly in front of our office building, The Exchange.
Our handicap accessible offices are conveniently located on the first floor. *(No steps or elevator)*

Driving Directions

FROM I-95 SOUTH

Merge onto I-695 W/Baltimore Beltway Outer Loop toward Towson *(9 miles)*
Take Exit 25 toward MD-139/Charles Street *(0.2 miles)*
Turn Left onto Bellona Avenue *(0.1 miles)*
Enter next roundabout and take 3rd exit onto N. Charles Street/MD-139 S *(0.3 miles)*
Turn Left onto Kenilworth Drive *(0.1 miles)*
Take first Left into The Exchange *(150 feet)*
Continue straight past The Exchange building and Park in the bottom lot on the Left.
Our offices are located on the ground floor in Suite 18.

FROM I-95 NORTH

Merge onto I-695 N/Baltimore Beltway Inner Loop via Exit 49B on the Left toward I-70/I-83/Towson *(17.5 miles)*
Merge onto N Charles Street/MD-139 S via Exit 25 toward Baltimore *(0.7 miles)*
Turn Left onto Kenilworth Drive *(0.1 miles)*
Take first Left into The Exchange *(150 feet)*
Continue straight past The Exchange building and park in the bottom lot on the Left.
Our offices are located on the ground floor in Suite 18.

FROM BWI AIRPORT *(Travel time approx. 35 minutes)*

Head Northeast on Friendship Road (0.7 miles)
Slight Left at I-95W (signs for MD-170/I-95/Washington/Baltimore/I-295/Annapolis *(3.8 miles)*
Take Exit 4 A to merge onto I-95 North toward I-695/Baltimore *(2.2 miles)*
Take Exit 49 B on the left, to merge onto I/695W toward Towson *(17.5 miles)*
Take Exit 25 to merge onto N. Charles Street/MD 139 *(0.7 miles)*
Turn Left at Kenilworth Drive *(335 feet)*
Take first Left into The Exchange *(150 feet)*
Continue straight PAST The Exchange building to the Left, and park in the lower lot on the Left.
Our offices are located on the ground floor in Suite 18.

The Dellon Institute

Director; A Lee Dellon,M.D., PhD
1122 Kenilworth Drive, Suite 18
Towson, Maryland 21204

Phone: 410-337-5400 Fax: 410-337-0040

RE: Transportation recommendations:

Closest airport to our office is BWI, (Baltimore Thurgood Marshall)

Our office is located about 30 minutes by cab from the BWI airport.

Unless you prefer renting a car, we recommend you contact Executive Dispatch.

Executive Dispatch will provide you with transportation to and from our office for a cost of approx. $ 65 each way. They are reliable, professional, and their cost is equal to, or less than cab service.

Please contact Executive Dispatch and advise you are a patient of the Dellon Institute to make a reservation. Email is: lorensotrans@yahoo.com.
**They accept credit cards.

With best regards,

Luiann Greer
The Dellon Institute

CELL: (410) 299-6926

DELLON INSTITUTE

Lee Dellon, MD PhD Eric H. Williams, MD

"THE Exchange", 1122 Kenilworth Dr., Suite 18, TOWSON, MARYLAND, 21204

Phone: 410. 337. 5400, Fax: 410. 337. 0040

HOTEL RECOMMENDATIONS

**Sheraton Baltimore North: Tele: 410-321-7400

903 Dulaney Valley Road, Towson, MD 21204
Contact: Reservations and request the "Dellon Institute" rate.

Standard Room: Single/Double $ 115.

Club Level: Single/Double $ 145.

- Located 4 miles from the Timonium Surgery Center, 7 miles from Union Memorial Hospital, and 2 miles from our offices, also, connected to the Towson Town Center Mall, with many Restaurants, and shops. They have a free shuttle to and from our office and to and from the surgery center.
- Club level offers complimentary breakfast, all day beverages and snacks, evening appetizers, beer and wine.

Crowne Plaza, Baltimore: Tele: 410.252.7373

2004 Greenspring Drive, Timonium, Maryland 21093
Contact: Reservations and ask for "Dellon Institute" rate. *Guaranteed rate

Standard Room: Single/Double $ 95.

- Located across the parking lot from the Timonium Surgery Center, and 4 miles from our offices

***For Patients being operated on at Union Memorial:

Inn at the Colonnade, (a Hilton Honors Hotel) Tele: 410-235-5400

4 West University Parkway, Baltimore, MD 21218
Contact: Chastity Michailov for Reservations for "Dellon Institute" rate.
**Ask to please be connected to Chasity in- house reservations, and not to " World wide reservations.

Standard Room: Single/Double $ 109. - $ 109.