16220 FREDERICK RD, SUITE #427, GAITHERSBURG, MD 20877
PHONE: (301) 948-2995 | FAX: (301) 948-6056
EMAIL: CONTACT@SHADYGROVEPODIATRY.COM
WEBSITE: WWW.SHADYGROVEPODIATRY.COM

DR. AMIR ASSILI | DR. DAVID BAEK | DR. HOAN DANG | DR. JON DILLARD | DR. SVETLANA MALINSKY

NEW PATIENT PACKET

BASIC PATIENT INFORMATION		
PATIENT ACCOUNT NUMBER (OFFICE USE ONLY):		**DATE:**
FULL NAME (LAST, FIRST, MIDDLE INITIAL):		
BIRTHDATE:		**AGE:**
SOCIAL SECURITY NUMBER (NOT REQUIRED):		**SEX:**
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
PLEASE PROVIDE YOUR PHONE NUMBERS BELOW AND CHECK OFF WHICH NUMBER IS PRIMARY:		
☐ HOME:	☐ CELL:	☐ WORK:
PLEASE INDICATE YOUR PREFERRED METHODS OF RECEIVING APPOINTMENT REMINDERS:		
☐ PHONE CALL AT CHECKED # ABOVE	☐ TEXT MESSAGE AT CELL # ABOVE	☐ EMAIL ADDRESS (INDICATE BELOW)

OTHER PATIENT INFORMATION			
PCP (PRIMARY CARE PHYSICIAN):			
PHARMACY (NAME, LOCATION):			
EMPLOYER:			
IF PATIENT IS A MINOR, INDICATE GUARDIAN AND RELATION:			
EMAIL:	**WEB ENABLE FOR PATIENT PORTAL?**	☐ YES	☐ NO
PRIMARY LANGUAGE:	**DO YOU NEED AN INTERPRETER?**	☐ YES	☐ NO
DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL)?	☐ YES	☐ NO	
DO YOU GIVE PERMISSION TO ACCESS YOUR PRESCRIPTION HISTORY TO BEST PROVIDE TREATMENT?	☐ YES	☐ NO	
ARE YOU HISPANIC OR LATINO?	☐ YES	☐ NO	☐ DECLINED TO SPECIFY
WHICH CATEGORY BEST DESCRIBES YOU? (ONE OR MORE CATEGORIES MAY BE MARKED. THIS IS NOT BY ANY MEANS TO DISCRIMINATE AGAINST ANY SINGLE PERSON AND WILL NOT DETER THE TREATMENT YOU RECEIVE IN OUR OFFICE. THIS INFORMATION IS COLLECTED TO ENSURE THAT WE ARE ABLE TO PROVIDE THE HIGHEST QUALITY OF CARE FOR ALL PATIENTS).	☐ ASIAN ☐ ASIAN INDIAN ☐ BLACK OR AFRICAN AMERICAN ☐ MIDDLE EASTERN OR NORTH AFRICAN ☐ OTHER PACIFIC ISLANDER ☐ WHITE ☐ DECLINED TO SPECIFY		

EMERGENCY CONTACT INFORMATION	
NAME OF EMERGENCY CONTACT:	
RELATIONSHIP OF EMERGENCY CONTACT:	
PHONE NUMBER OF 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 START?	
WHO REFERRED YOU TO THIS PRACTICE?	

PLEASE CHECK OFF ALL APPLICABLE CONDITIONS FROM THE LIST BELOW:

☐ DIABETES / A1C: ___________________	☐ DIALYSIS	☐ INTESTINAL PROBLEM	☐ SEIZURES
☐ ARTHRITIS	☐ HEART DISEASE	☐ KIDNEY DISORDER	☐ STOMACH PROBLEM
☐ ANEMIA	☐ HEPATITIS	☐ LIVER DISORDER	☐ SLEEP APNEA
☐ CANCER: _________________________	☐ HIGH BLOOD PRESSURE	☐ NEUROLIGICAL ISSUE	☐ STROKE
☐ CARDIAC: ________________________	☐ HIGH CHOLESTEROL	☐ RESPIRATORY	☐ THYROID PROBLEM
☐ DERMATOLOGIC ISSUE: _____________	☐ HIV/AIDS	☐ **OTHER (SPECIFY):** ____	

PLEASE PROVIDE ANY ALLERGIES TO MEDICATIONS:	
ARE YOU ALLERGIC TO LATEX? ☐ YES ☐ NO	**ARE YOU ALLERGIC TO ADHESIVES?** ☐ YES ☐ NO
PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: (LET US KNOW IF YOU HAVE A LIST TO COPY)	
PLEASE PROVIDE YOUR SURGICAL HISTORY (BLANK BOX TO RIGHT): (INCLUDE DATES IF POSSIBLE) IE: 2007 – RIGHT ACL SURGERY	
PLEASE LIST PAST HOSPITALIZATIONS (BLANK BOX TO RIGHT): (INCLUDE DATES, REASON IF POSSIBLE) IE: 2009 – INFECTION	

SOCIAL HISTORY	
ARE YOU A SMOKER? ☐ YES ☐ NO	IF SO, HOW MUCH DO YOU SMOKE?
WERE YOU EVER A SMOKER? ☐ YES ☐ NO	WHEN DID YOU QUIT?
DO YOU DRINK ALCOHOL? ☐ YES ☐ NO	HOW OFTEN DO YOU DRINK?

FAMILY HISTORY

PLEASE CHECK OFF AND INDICATE WHO IN YOUR IMMEDIATE FAMILY (PARENTS, SIBLINGS, ETC) HAS OR HAD ANY OF THE FOLLOWING:

☐ ARTHRITIS	☐ DIABETES	☐ HEART DISEASE	☐ CANCER (INDICATE)	**√** *EXAMPLE*
				FAMILY MEMBER
				FAMILY MEMBER

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, AND MALINSKY 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 (ONLY IF APPLICABLE)

MEDICARE WILL ONLY PAY FOR SERVICES THAT IT DETERMINES TO BE "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. I AUTHORIZE THE RELEASE OF ANY MEDICAL AND OTHER INFORMATION NECESSARY TO PROCESS THE CLAIM. 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 WITH REGARD TO 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 THE COURSE OF TREATMENT, DURABLE MEDICAL EQUIPMENT MAY BE RECOMMENDED. I AUTHORIZE MY INSURANCE COMPANY TO PAY SHADY GROVE PODIATRY, LLC DIRECTLY. I UNDERSTAND THAT MY INSURANCE WILL COVER THIS ITEM IF IT IS MEDICALLY NECESSARY, BUT THAT I AM RESPONSIBLE FOR ANY NON-COVERED SERVICES, DEDUCTIBLES AND COINSURANCE.

X ____

SIGNATURE OF PATIENT/ PARENT GUARDIAN **DATE**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND/OR HAVE REVIEWED 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 OF AND DISCLOSURE OF MY HEALTHCARE INFORMATION, AND RIGHTS I MAY HAVE REGARDING MY PROTECTED HEALTH INFORMATION. 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. BY MY SIGNATURE 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 NAME: ____________________________________RELATION: ______________________

AUTHORIZED INDIVIDUAL NAME: ____________________________________RELATION: ______________________

X ____

SIGNATURE OF PATIENT/ PARENT GUARDIAN **DATE**

CANCELLATION POLICY

IN AN EFFORT TO EFFICIENTLY SCHEDULE APPOINTMENTS AND IN CONSIDERATION OF OUR OTHER PATIENTS, WE REQUIRE 24-HOURS' NOTICE IF YOU HAVE TO CANCEL OR CHANGE AN APPOINTMENT. A $50.00 CHARGE WILL OCCUR FOR THE FIRST MISSED APPOINTMENT AND AN ADDITIONAL $25.00 CHARGE WILL OCCUR FOR SUBSEQUENT MISSED APPOINTMENTS. FOR LATE ARRIVALS, WE OFFER A 15 MINUTE GRACE PERIOD FROM THE SCHEDULED TIME. IF YOU ARRIVE LATER THAN THE GRACE PERIOD, YOU WILL BE CHARGED THE FEE. IF THERE IS AN EMERGENCY, WE UNDERSTAND AND WOULD APPRECIATE A CALL / NOTIFICATION TO THE OFFICE. THANK YOU. BY SIGNING BELOW, I AGREE WITH THE ABOVE.

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 BEING PROVIDED TO ANOTHER PHYSICIAN'S OFFICE. READ THE FOLLOWING CAREFULLY FOR THE APPLICABLE FEE(S):

- **HANDICAPPED PARKING PLACARD FORM -** $5.00
- **DISABILITY PAPERWORK** - $10 - $65 (BASED ON LENGTH AND REQUIRED DETAIL)
- **FMLA (FAMILY MEDICAL LEAVE ACT) FORMS**: $40 - $65 (BASED ON LENGTH AND REQUIRED DETAIL)
- **PERSONAL MEDICAL RECORDS:** $0.76 PER PAGE (PAGES 1-20), $0.38 / PAGE (PAGES 21-50) – PATIENT MUST SIGN AN AUTHORIZATION TO RELEASE FORM, X-RAY DISCS ARE NOT CHARGED AND MUST BE PICKED UP BY THE PATIENT ONLY.

- PRE-PAYMENT IS REQUIRED FOR OUR OFFICE TO MAIL THE FORMS. THERE WILL BE AN ADDITIONAL $.58 CHARGE FOR POSTAGE AND HANDLING.
- 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. IF THIS IS THE CASE, THE OFFICE WILL DIRECTLY CONTACT YOU TO SET THIS UP.
- SHADY GROVE PODIATRY, LLC REQUIRES AT LEAST FIVE (5) BUSINESS DAYS FOR THE COMPLETION OF ANY FORM(S). AFTER THIS TIME, YOUR FORM WILL BE AVAILABLE FOR PICK-UP AT THE FRONT DESK—CALL OUR OFFICE TO CONFIRM IT IS COMPLETED AND READ FOR PICKUP. IF IT IS COMPLETED SOONER, WE WILL CONTACT YOU.
- IF OFFICIAL COPIES OF YOUR MEDICAL RECORDS ARE REQUIRED TO COMPLETE ANY FORM(S), THE RELEASE OF INFORMATION FORM MUST BE COMPLETED—SPEAK TO A FRONT DESK ASSOCIATE IF YOU NEED AN ROI FORM.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I UNDERSTAND THE FEE SCHEDULES AND GUIDELINES STATED ABOVE AND THAT I WILL BE RESPONSIBLE FOR THE FORMS AND/OR RELEASE OF RECORDS AS REQUESTED BY MYSELF.

X ____

SIGNATURE OF PATIENT/ PARENT GUARDIAN **DATE**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW DRS. ASSILI, BAEK, DANG, DILLARD, AND MALINSKY MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Drs. Assili, Baek, Dang, Dillard, and Malinsky 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, and Malinsky or received by Drs. Assili, Baek, Dang, Dillard, and Malinsky 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, and Malinsky 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.[1]

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

Payment Activities may include:

- Activities undertaken by Drs. Assili, Baek, Dang, Dillard, and Malinsky 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, and Malinsky 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, and Malinsky 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, and Malinsky 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, and Malinsky 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 as a result 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 public health activities.
  We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, open receipt of written request 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,

[1] This notice is prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. 164.520.

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.

- 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.

- 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 a 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, and Malinsky 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, and Malinsky have taken action 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, and Malinsky 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, with the exception of 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, and Malinsky may 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, and Malinsky 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, and Malinsky 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 request by you.

You have the right to request that Drs. Assili, Baek, Dang, Dillard, and Malinsky amend portions of your healthcare records, as long as 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, and Malinsky 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, and Malinsky 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, and Malinsky, please contact the Privacy Officer at the following:

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

It is the policy of Drs. Assili, Baek, Dang, Dillard, and Malinsky that no retaliatory action will be made 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 January 1, 2023.

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