Hopkins Medical Group

A Membership Practice

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, 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, podcasts and blog posts to keep you informed and educated. 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 discounts on services such as laser therapy, nutritional counseling as well as the price of supplements and skin care products. We also provide emergency care for dehydration, pneumonia, asthma, COPD, infections, wound care etc. You will save on ER copays by taking advantage of the many services at HMG.

1. $480/year- set up a recurring monthly payment of $40 (cancel anytime with 90 days notice) . Prepayment option is not refundable after 90 days in the practice.

Your membership takes effect on the day of your first appointment. You can either enroll in the office that day or you can sign up and pay for your membership 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 `on the day of my first appointment my membership fee is due. I understand I must become a member of the practice in order to receive care at Hopkins Medical Group.

_____ _____

Patient Signature Date

OUR MISSION

To serve our communities with compassion and respect as we promote their health and well-being.

OUR VALUES

Compassion, accountability, respect, and responsibility.

Patient Acknowledgement

Appointment Cancellation Policy

Dear Patient,

HOPKINS MEDICAL has instituted an Appointment Cancellation Policy. A cancellation made with less than a 48 hour notice significantly limits our ability to make the appointment available for another patient in need. To remain consistent with our mission, we have instituted the following policy:

1. Please provide our office a 48-hour notice if you need to reschedule your appointment. This will allow us the opportunity to provide care to another patient. A message can always be left with the answering service to avoid a cancellation fee being charged. All Monday cancellations must be received by Thursday end of day.
2. A “No-Show”, “No-Call” or missed appointment, without proper 48-hour notification, may be assessed a $50 fee. If you are scheduled for an hour appointment with WAVI, Laser or Lens the
3. cancellation fee is $100.
4. This fee is not billable to your insurance.
5. As a courtesy, we make reminder calls, for appointments, one to two days in advance. Please note, if a reminder call or message is not received, the cancellation policy remains in effect.
6. Repeated missed appointments may result in termination of the physician/patient relationship.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. A copy of this policy will be provided to you. Please sign and date below your acknowledgement.

I have read and understand the Appointment Cancellation Policy and I acknowledge its terms. I also understand and agree that such terms may be amended from time-to-time by the clinic.

Name_____. Signature_____. Date_____

Registration Forms

Patient Name: _____ DOB: _____

Sex: Male/Female Social Security: _____ Email: _____

Address: _____ City/State/Zip: _____

Home # _____ Work: _____ Cell: _____

Pharmacy: _____ Phone #: _____

Primacy Care: _____ Phone #: _____

Emergency Contact: _____ Relationship: _____

Phone #:

_____

Insurance Information:

Primary Insurance: _____ ID: _____

Group #: _____ Phone #: _____

Secondary Insurance: _____ ID: _____

Group #: _____ Phone #: _____

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED INCLUDING MEDICARE, MEDIGAP, PREIVATE INSURANCE AND OTHER HEALTH INSURANCE PLANTS TO DR. PATRICIA T. HOPKINS.

THE ASSIGNENT WILL REMAIN IN EFFECT UNTIL REVOKED IN WRITING. A PHOTOCOPY OF THIS STATEMENT IS TO BE CONSIDERED AS VALID AS AN 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 THE PAYMENT.

SIGNATURE: _____ DATE: _____

PRINTED: _____

Patient: _____ **DOB:** _____ **Date:** _____

Reason for visit:

_____
_____
_____

Signs/Symptoms you are experiencing:

_____
_____

Current Medications/Doses and Supplements:

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

Allergies:

_____
_____

Are you having pain today? No Yes

If so Scale 0-10 _____ Location _____ Description _____

List any physician names, radiology/laboratory testing or recent hospitalization that you feel would be important to review for this appointment.

_____
_____
_____

Please write any questions you might have for the provider today

_____
_____
_____

Past Medical History:

Migraines/Headaches	Asthma	Seizures	Fibromyalgia	Hernia
High Blood Pressure	Diabetes	Glaucoma	Muscle Disorder	Liver Disease
Dentures/Capped Teeth	Bipolar	Cataracts	Pneumonia	Gout
Bladder Problems	Anemia	Stroke	Gallstones	Kidney Stones
Bleeding Problems	Angina	Emphysema	Thyroid Disease	Depression
Neurological Disorders	Fevers	Heart Attack	Stomach Ulcers	Cancer
Irregular Heart Beat	TB	Blood Clots	Kidney Disease	

Other Health Problems: _____

Please list any operations you have had in the past:

1. 4.

2. 5.

3. 6.

Social History:

Tobacco:	No	Yes	**Lives Alone:**	No	Yes
Alcohol:	No	Yes	**Seat Belt Use:**	No	Yes
Drugs:	No	Yes	**Employed:**	No	Yes
Exercise:	No	Yes	**Sexually Active:**	No	Yes
Children:	No	Yes	**Pets:**	No	Yes
Caffeine:	No	Yes	**Motility Devices:**	No	Yes

Family History (Please list all known health issues):

Grandfather: _____
Grandmother: _____
Father: _____
Mother: _____
Sibling: _____
Sibling: _____

MASSACHUSETTS (HIPAA) MEDICAL RECORDS RELEASE FORM
Permission to Share Information

If you want the _____to share information about you with another person or
(Fill in name of person or organization)
organization, please make sure that you fill out all of the sections below (Sections I-VI). This will tell us what information you want us to share and who to share it with. If you leave any sections blank, with the exception of Section II (B), your permission will not be valid, and we will not be able to share your information with the person(s) or organization you listed on this form.

SECTION I

I, _____, give my permission for _____
(print your name) (Fill in name of person or organization)

to share the information about me that I list in Section II with the person(s) or organization that I list in Section V.

SECTION II

A. Health and Personal Information

Please describe the information you want the _____ to share about you.
(Fill in name of person or organization)
Please include any dates and details you want to share.

_____

_____

_____

_____

B. Permission about Specific Health Information. Only if you choose to share any of the following information, please write your initials on the line:

_____I specifically give permission, as required by M.G.L. c. 111, § 70F, to share information in my record about HIV antibody and antigen testing, and HIV/AIDS diagnosis or HIV/AIDS treatment.

____I specifically give permission, as required by M.G.L. c. 111, §70G, to share information in my record about my genetic information.

_____I specifically give permission to share information in my record about alcohol or drug treatment. If this information is shared, I understand that a specific notice required by 42 CFR, Part 2 shall be included prohibiting the redisclosure of this confidential information.

SECTION III – Reason for Sharing this Information

Please describe the reason(s) for sharing this information. If you do not want to list reasons, you may simply write: "at my request," if you are initiating the request.

_____

_____

_____

SECTION IV – Who May Share This Information

I give permission to the person or organization listed below to share the information I listed in Section II:

_____
Name

_____
Organization

_____
Address

_____

Massachusetts Department of Public Health
Authorization for Release of Information

SECTION V – Who May Receive My Information
The person or organization listed in Section IV may share the information I listed in Section II with this person(s) or organization:

_____
Name

_____
Organization

_____
Address

_____

I understand that the person(s) or organization listed in this section may not be covered by federal or state privacy laws, and that they may be able to further share the information that is given to them.

SECTION VI – How Long This Permission Lasts
This permission to share my information is good until _____.
Indicate date or event
If I do not list a date or event, this permission will last for one year from the date it is signed.

- I understand that I can change my mind and cancel this permission at any time. To do this, I need to write a letter to _____, and send it or bring it to the place where I am now giving
(Fill in name of person or organization)
this permission (or fill in specific location) If the information has already been given out by, I understand that it is too late for me to change my mind and cancel the permission.

- I understand that I do not have to give permission to share my information with the person(s) or organization I listed in Section V.

- I understand that if I choose not to give this permission or if I cancel my permission, I will still be able to receive any treatment or benefits that I am entitled to, as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive.

SECTION V – Signature
Please sign and date this form, and print your name.

_____ _____
Your Signature Date

_____
Print Your Name

If this form is being filled out by someone who has the legal authority to act for you (such as the parent of a minor child, a court appointed guardian or executor, a custodial parent, or a health care agent), please:

Print the name of the person filling out this form: _____

Signature of the person filling out this form: _____

Describe how this person has legal authority for this individual: _____

_____

Hopkins Medical Group

NOTICE OF PRIVACY PRACTICES

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

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. Uses And Disclosures We May Make Without Written Authorization. We may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain payment for treatment.

Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.
- To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. Disclosures We May Make Unless You Object. Unless you instruct us otherwise, we may disclose your information as described below.

- To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.

3. Uses and Disclosures With Your Written Authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. Your Rights Concerning Your Protected Health Information. You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.

- We normally contact you by telephone, mail at your home address and possibly by e-mail if you have given your e-mail address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.

- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.

- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete.

- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.

- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. Changes To This Notice. We reserve the right to change the terms of this Notice at anytime, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. Contact Information. If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

Privacy Officer:	Pat Hopkins
Phone:	617-773-9198
Address:	571 Main Street Weymouth, MA 02190

8. Effective Date. This Notice is effective February 1, 2019.

MASSACHUSETTS (HIPAA) MEDICAL RECORDS RELEASE FORM
Permission to Share Information

If you want the _____to share information about you with another person or
(Fill in name of person or organization)
organization, please make sure that you fill out all of the sections below (Sections I-VI). This will tell us what information you want us to share and who to share it with. If you leave any sections blank, with the exception of Section II (B), your permission will not be valid, and we will not be able to share your information with the person(s) or organization you listed on this form.

SECTION I

I, _____, give my permission for _____
(print your name) (Fill in name of person or organization)

to share the information about me that I list in Section II with the person(s) or organization that I list in Section V.

SECTION II

A. Health and Personal Information

Please describe the information you want the _____ to share about you.
(Fill in name of person or organization)
Please include any dates and details you want to share.

_____

_____

_____

_____

B. Permission about Specific Health Information. Only if you choose to share any of the following information, please write your initials on the line:

____I specifically give permission, as required by M.G.L. c. 111, § 70F, to share information in my record about HIV antibody and antigen testing, and HIV/AIDS diagnosis or HIV/AIDS treatment.

____I specifically give permission, as required by M.G.L. c. 111, §70G, to share information in my record about my genetic information.

____I specifically give permission to share information in my record about alcohol or drug treatment. If this information is shared, I understand that a specific notice required by 42 CFR, Part 2 shall be included prohibiting the redisclosure of this confidential information.

SECTION III – Reason for Sharing this Information

Please describe the reason(s) for sharing this information. If you do not want to list reasons, you may simply write: "at my request," if you are initiating the request.

_____

_____

_____

SECTION IV – Who May Share This Information

I give permission to the person or organization listed below to share the information I listed in Section II:

_____
Name

_____
Organization

_____
Address

_____

Massachusetts Department of Public Health
Authorization for Release of Information

SECTION V – Who May Receive My Information
The person or organization listed in Section IV may share the information I listed in Section II with this person(s) or organization:

_____
Name

_____
Organization

_____
Address

_____

I understand that the person(s) or organization listed in this section may not be covered by federal or state privacy laws, and that they may be able to further share the information that is given to them.

SECTION VI – How Long This Permission Lasts
This permission to share my information is good until _____.
Indicate date or event
If I do not list a date or event, this permission will last for one year from the date it is signed.

- I understand that I can change my mind and cancel this permission at any time. To do this, I need to write a letter to _____, and send it or bring it to the place where I am now giving
(Fill in name of person or organization)
this permission (or fill in specific location) If the information has already been given out by, I understand that it is too late for me to change my mind and cancel the permission.

- I understand that I do not have to give permission to share my information with the person(s) or organization I listed in Section V.

- I understand that if I choose not to give this permission or if I cancel my permission, I will still be able to receive any treatment or benefits that I am entitled to, as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive.

SECTION V – Signature
Please sign and date this form, and print your name.

_____ _____
Your Signature Date

_____
Print Your Name

If this form is being filled out by someone who has the legal authority to act for you (such as the parent of a minor child, a court appointed guardian or executor, a custodial parent, or a health care agent), please:

Print the name of the person filling out this form: _____

Signature of the person filling out this form: _____

Describe how this person has legal authority for this individual: _____

_____

TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

- I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.
- I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.
- I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.
- I understand that telehealth services can only be provided to patients, including myself, who are residents of or physically located in the state of Massachusetts at the time of this service.
- I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.
- I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:
    - *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
    - *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*
    - *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*
- I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.
- I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).
- I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.
- The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.
- I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.
- I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.

- I understand that electronic communication cannot be used for emergencies or time-sensitive matters.
- I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.
- I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).
- I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.
- By beginning the visit, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.
- I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.
- To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.
- I certify that I have read and understand this agreement and that I have had the opportunity to have questions answered to my satisfaction.

PATRICIA HOPKINS, MD.
571 MAIN STREET
SO. WEYMOUTH, MA 02190

PATIENT CONTROLLED SUBSTANCE AGREEMENT

The purpose of this agreement is to set out the rules that this office follows in order to prescribe medications that are controlled by the Drug Enforcement Agency (DEA). We are committed to making sure we address your needs while providing you with alternatives designed to minimize the addictive potential of the controlled substance treatments we use. In this regard, we may refer you to a Pain Management program to ensure you have access to the best, safest treatments available. If your controlled substance medication (pain, stimulant, sedative) requires ongoing prescriptions that have significant addiction potential we will be requesting you to see a specialist as applicable. To clarify our expectations in giving you this medication and to emphasize the risk of taking these substances we are requesting you to read and sign this agreement.

I,_____, understand that I am being prescribed_____, which is a controlled substance; therefore I must adhere to the following restrictions. **Failure to conform to any of the below listed restrictions may result in being dismissed as a patient and being reported to the police.**

1. I will not use alcohol/illegal drugs while being prescribed medication(s).
2. I will not take any other prescribed medications without first notifying my doctor.
3. I will notify my doctor immediately of any other physician(s) currently prescribing me a controlled substance(s) or that have been prescribed to me in the past thirty days (including emergency rooms and immediate care center). Legally, failure to do so is a crime (obtaining or attempting to obtain drugs by fraud and/or deceit) and may be reported to the Police.
4. I will submit to random urine and/or serum drug screens as ordered.
5. I will only fill prescriptions for controlled substance at the pharmacy listed below. I will inform my doctor of any plans to change pharmacy. I will not obtain controlled substances from more than one pharmacy at a time. The only exception will be for acute need outside of the local area. I will authorize my doctor to communicate with my pharmacist.

   Pharmacy:_____Phone:_____

   Address/Location: _____
6. I authorize my doctor to communicate with all physicians I have seen.
7. I understand it is illegal to share this medication.
8. I agree to keep my medication safe and secure in order to prevent loss or theft.
9. I understand that I will be taken off this medication if there is evidence of addiction and/or abuse.
10. I understand that some of these medications may cause drowsiness and slower reflexes, interfering with the ability to drive and operate machinery, and short term memory impairment. I understand that overdose of this medication may cause death.
11. I agree to keep all scheduled appointments with my physician/therapist. My medication may be weaned and discontinued if I fail to attend my scheduled appointments.
12. I also understand that part of my treatment may involve reduction and discontinuation of any addictive medications. I understand and accept the risk of addiction that can occur with this medication.
13. I authorize this office to release a copy (or original) of this controlled substance agreement to the Police if I violate any of the listed terms or at their request.
14. (Y or N) Have you received ***any*** prescription medications from ***any*** other physician in the past thirty days? If yes, please list physician and medication below.

    Physician:_____Medication(s): _____
15. I understand I may be called at any time to the office for a count of all my remaining medications. I agree to arrive on the day notified and will be **responsible for any costs this may incur.**
16. I waive my right of privacy and authorize my doctor to contact any health care provider, legal authority, friend and/or relative in order to obtain or provide information about my care (including abuse of controlled substances).

No refills will be authorized on weekends, holidays or after office hours.

Only the person for whom the *official* (previously known as triplicate) is written may retrieve the prescription, In the event that the patient is unavailable please list designee below. ***Designee will be required to show picture identification.***

I read the above, asked questions and understand this agreement. If I violate this agreement, I know the physician may discontinue my treatment.

Patient Name (PRINTED) **Date of Birth**

Patient / Legal Guardian Signature **Date**

Physician Signature **Date**

PATRICIA HOPKINS, MD.
571 MAIN STREET
SO. WEYMOUTH, MA 02190