VIRGINIA HOSPITAL CENTER
Physician Group

PATIENT INFORMATION

(Please make sure to print clearly and sign at the bottom of this page.)

Patient's Last Name | First | Middle Initial | Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Birth Date | Social Security Number | Gender: ☐ Male ☐ Female ☐ Other

Street Address | Apt# | City | State | Zip Code

Home Phone | Work Phone | Cell Phone

Email Address | Preferred Method of Contact: ☐ Email ☐ Phone (specify number) ☐ Mail

Race: ☐ Decline ☐ Other: _____ | Ethnicity: ☐ Hispanic or ☐ Non-Hispanic

☐ Asian ☐ Black ☐ Hispanic ☐ White | Preferred Language: _____

Referring Provider (Full Name) | Primary Care Provider (Full Name)

Phone Number | Phone Number

Occupation | Employer

Emergency Contact & Number | Relationship

Preferred Pharmacy Name | Preferred Pharmacy Number

How did you hear about us? : ☐ Website _____ ☐ Family/Friend ☐ Physician Referral ☐ Other: _____

INSURANCE INFORMATION *(Please present all insurance cards and a photo ID to the receptionist.)*

Primary Insurance | Member ID# | Group ID#

Subscriber's Name | Relationship | DOB

Subscriber's Social Security #

Secondary Insurance | Member ID# | Group ID#

Subscriber's Name | Relationship | DOB

Subscriber's Social Security #

RESPONSIBLE PARTY (If same as patient, do not complete this portion.)

Name | Address | Relationship

Social Security #

Patient/Guardian Signature | Date

By signing here, I attest that the above information is true and accurate to the best of my knowledge.

Effective Date: February 2016

VIRGINIA HOSPITAL CENTER
Physician Group

HEALTH QUESTIONNAIRE

Patient Name _____ Date _____

DOB _____ Height _____ Weight _____

REASON FOR VISIT

Why are you seeing the doctor today? _____

Have you been treated for this problem in the past? ☐ Yes ☐ No

If yes, please explain _____

Have you had any recent radiology or laboratory studies? ☐ Yes ☐ No

If yes, please indicate **where**, **when**, and **type** of study _____

In an effort to help us keep track of your important vaccinations and health screenings, we collect the following information in order to deliver the best healthcare.

Date of Last Tetanus Shot ____/____/____
Type : ☐ Tdap ☐ TD
Location: ☐ Physician Office ☐ Place of Work ☐ Other

Date of Last Pneumococcal Vaccine ____/____/____
Type : ☐ Prevnar ☐ Pneumovax
Location: ☐ Physician Office ☐ Place of Work ☐ Other

Date of Last Influenza Shot ____/____/____
Location: ☐ Physician Office ☐ Place of Work ☐ Other

Date of Last Mammogram ____/____/____

Date of Last Colonoscopy ____/____/____

Date of Last Pap Smear ____/____/____

MEDICAL HISTORY

Please indicate if you have received treatment for the conditions below, or if you are currently receiving treatment.

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Alzheimer's	☐	☐	Gallbladder Problems	☐	☐	Obesity	☐	☐	Thyroid
☐	☐	Anemia	☐	☐	Gout	☐	☐	Osteoporosis	☐	☐	Ulcer
☐	☐	Arthritis	☐	☐	Heart Disease/Heart Attack	☐	☐	Phlebitis			
☐	☐	Asthma	☐	☐	Hepatitis	☐	☐	Peripheral Vascular Disease			
☐	☐	Attention Deficit Disorder	☐	☐	HIV/AIDS	☐	☐	Polio			
☐	☐	Birth Defects	☐	☐	High Blood Pressure	☐	☐	Psychological Problems			
☐	☐	Bladder Problems	☐	☐	High Cholesterol	☐	☐	Pulmonary Embolism			
☐	☐	Bleeding or Bruising	☐	☐	Intestinal/Bowel Problems	☐	☐	Rheumatoid Arthritis			
☐	☐	Cancer Type _____	☐	☐	Kidney Problems	☐	☐	Sexually Transmitted Disease			
☐	☐	Diabetes	☐	☐	Liver Disease	☐	☐	VRE/MRSA/Staph Infection			
☐	☐	DVT/Blood Clots	☐	☐	Lung Problems	☐	☐	Stroke/TIA			
☐	☐	Epilepsy	☐	☐	Migraine	☐	☐	Tuberculosis			

Are there any other medical problems that we should be aware of? _____

Do you exercise or participate in sports? ☐ Yes ☐ No Type and frequency: _____

Are you currently pregnant or could you possibly be pregnant? ☐ Yes ☐ No **Date of Last Menstrual Period** ____/____/____

MEDICATIONS

Please list the medications that you are currently taking (including herbal supplmenets). Please include those with and without a prescription.

Medication	Dose	Frequency	Reason for taking medication

Effective Date: February 2016

VIRGINIA HOSPITAL CENTER
Physician Group

HEALTH QUESTIONNAIRE

ALLERGY

Please list any present or past allergies (including medication, food, metal, or environmental).

Allergy	Reaction	How reaction was/is treated

SURGERIES AND/OR HOSPITALIZATIONS

Type of Surgery/Reason for Hospitalization	Date	Hospital Name/Surgical Center

☐ I have not had any surgeries or been hospitalized

FAMILY HISTORY

Please indicate if your mother, father, grandparents, brothers, or sisters have been treated or are currently receiving treatment for the conditions listed below and indicate which family member.

Condition	Family Member	Condition	Family Member	Condition	Family Member
☐ Alzheimer's	_____	☐ Heart Disease	_____	☐ Stroke	_____
☐ Cancer	_____	☐ Hypertension	_____	☐ Sudden Death	_____
☐ Diabetes	_____	☐ Osteoporosis	_____	☐ Thyroid	_____
☐ Gout	_____	☐ Rheumatoid Arthritis	_____	☐ Other	_____

SOCIAL HISTORY

Do you use tobacco products? ☐ Yes ☐ No ☐ Former

If Yes/Former: Number _____ Packs per day for _____ years. Type of Tobacco: _____

Do you consume alcoholic beverages? ☐ Yes ☐ No Amount and frequency: _____

Do you use recreational drugs? ☐ Yes ☐ No Type and frequency: _____

Other _____

Patient Name | Date

Signature of Patient / Guardian | Date

Name of Guardian | Date

FOR OFFICE USE

Reviewed By | Date

Effective Date: February 2016

VIRGINIA HOSPITAL CENTER
Physician Group

CONSENT FOR TREATMENT

1. **GENERAL CONSENT FOR TREATMENT.** I hereby authorize employees and agents of Virginia Hospital Center Physician Group and Virginia Hospital Center Urgent Care, including physicians, physician assistants, nurse practitioners, nursing and other staff members to render medical evaluations and care to the patient indicated below.

   I acknowledge that according to Virginia state law, I shall be deemed to have consented to the testing for infection with Human Immunodeficiency virus (HIV), Hepatitis B, Hepatitis C viruses should any healthcare provider, or any person employed by or under the direction and control of a healthcare provider, by directly exposed to my body fluids in connection with rendering care to the patient, in a manner which may, according to the current guidelines of the Center for Disease Control, transmit HIV, Hepatitis B, or Hepatitis C viruses. Test results may be released to the person exposed.

2. **E- PRESCRIBING CONSENT.** The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

   - **Formulary and benefit transactions –** Gives the prescriber information about which drugs are covered by the drug benefit plan.
   - **Medication history transactions –** Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

   By signing this consent form you are agreeing that this office can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

3. **OTHER CONSENTS.** Virginia Hospital Center participates in an affiliated teaching program; physicians may be assisted in patient care by residents and/or medical students. I understand I have the right to refuse residents or medical students' involvement in my care and will notify my care provider(s) of any such decision.

   I agree to receive a survey from a premier polling company. The surveys are used to assess the quality of care delivered to our patients and ensure that we are providing the best care possible.

4. **PATIENT INFORMATION.** I authorize the practice to provide _____(List All Names / Relationships)_____ with information (including both medical and billing information). This release will remain active in your electronic health record, and will not be cancelled unless there is written authorization from the patient to do so on file.

5. **PATIENT PORTAL.** Virginia Hospital Center Physician Group and Virginia Hospital Center Urgent Care utilize a web portal as part of the electronic health record, which communicates information including but not limited to test results and visit summaries. You may activate your patient portal by providing your physician's office with a current email address and completing the user registration process through eClinical Works. I understand that I may decide to opt out of participation at any time either in writing, or by completing the VHC Physician Group Patient Portal opt-out form.

   - The duration of this consent is indefinite and continues until revoked in writing. **I understand that by not signing this consent, the patient will not be provided medical care except in the case of an emergency.**

Patient Name (please print) Date

Signature of Patient, Parent or Legal Guardian Date

Relationship, if Guardian

Contact Information If Minor:

Family Address

_ _ _ _ _ _

Guardian's Telephone: Home Cell Work

In the event we do contact you, is it suitable to leave a message(s) in the following manner? (Check all that apply.)

☐ on answering machine ☐ with an ADULT household member ☐ exclusively with patient

Please check: ☐ Cell ☐ Home ☐ Other

Provider Representative Signature/Witness Date

Effective Date: February 2016

VIRGINIA HOSPITAL CENTER
Physician Group

ACKNOWLEDGEMENT OF RECEIPT OF VIRGINIA HOSPITAL CENTER (VHC) PHYSICIAN GROUP POLICIES

By signing here, I attest to the following Virginia Hospital Center (VHC) Physician Group Policies which I have reviewed in the VHC Physician Group Patient Welcome Packet or online at **www.vhcphysiciangroup.com/policies**:

PATIENT FINANCIAL RESPONSIBILITY FOR SERVICES

I have read and understand the Patient Financial Responsibility for Services and have provided true and correct insurance and demographic information. Per the policy, I will promptly notify the VHC Physician Group practice of any changes to my health insurance carrier, including new ID number(s) with my current carrier.

PRESCRIPTION REFILL POLICY

I have read and understand the Prescription Refill Policy including that the VHC Urgent Care Center does not refill medications.

REFERRAL POLICY

I have read and understand that VHC Physician Group must adhere to guidelines as outlined by the contracts in place with my insurance company. I acknowledge that I have a responsibility to understand my plan's requirements and follow to them.

I attest that all submitted information is true and accurate to the best of my knowledge and that I have read, understand and agree to compliance with the aforementioned VHC Physician Group policies.

Patient Name	Printed Name	Date
Signature of Legal Representative	Printed Name	Date

OFFICE USE ONLY

Reviewed By	Date

VIRGINIA HOSPITAL CENTER

VIRGINIA HOSPITAL CENTER
ARLINGTON HEALTH SYSTEM
NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

The confidentiality of your health information is very important to us. Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by and as part of the care furnished to you in a Virginia Hospital Center Arlington Health System facility or through a Virginia Hospital Center Arlington Health System service, whether made by Virginia Hospital Center Arlington Health System personnel, agents of Virginia Hospital Center Arlington Health System and its affiliated facilities including hospitals, clinics and other health care providers that Virginia Hospital Center Arlington Health System operates, as well as any health care facility or physician practice now or in the future controlled by or under common control by Virginia Hospital Center Arlington Health System, or by your personal physician. Your personal physician may have different policies or notices regarding the physician's use and disclosure of your medical information created in the physician's office or clinic.

Our Responsibilities

This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to:

- Make sure that health information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the notice that is currently in effect.

Contact Information

After reviewing this notice, if you need further information or want to contact us for any reason regarding the handling of your health information, please direct any communications to the following contact person:

Privacy Official
Health Information Department
Virginia Hospital Center
1701 N. George Mason Drive, Arlington, VA 22205
Phone: 703.558.6116; Toll Free: 855.816.2446

Organized Health Care Arrangement

Virginia Hospital Center Arlington Health System's facilities, including but not limited to Virginia Hospital Center, deliver care in clinically integrated settings in which individuals typically receive care from more than one health care provider including Virginia Hospital Center Arlington Health System's workforce, physicians and allied health practitioners who are in private practice and have clinical privileges at Virginia Hospital Center, hospital-based physician groups such as anesthesia, radiology, pathology and emergency medicine, department chairs and medical directors. These are all part of Virginia Hospital Center Arlington Health System's organized health care arrangement and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment, and health care operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect current and future care that we provide to you. Neither this joint notice nor participation in an organized health care arrangement create an employer-employee relationship between Virginia Hospital Center Arlington Health System and a medical staff member where none otherwise exists.

How We May Use and Disclose Health Information About You

The following categories describe different ways that we use and disclose health information.

For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to physicians, nurses, technicians, medical students, or other facility personnel who are involved in taking care of you at the facility. For example: a physician treating you for a broken leg may need to know if you have diabetes, because diabetes may slow the healing process. Different departments of the Virginia Hospital Center Arlington Health System facility also may share health information about you in order to coordinate the different things you may need, such as prescriptions, lab work, and x-rays. In addition, we may disclose your health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician. We also may provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you are discharged from a Virginia Hospital Center Arlington Health System facility.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company, or a third party payer. This may include certain activities that your health insurance plan may undertake before it approves or pays for health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provide to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health information about a surgery you received at the hospital, so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may also provide your physician or other medical personnel involved in taking care of you at Virginia Hospital Center Arlington Health System facility or their billing agents with information so they can send bills to your insurance company or to you.

For Health Care Operations: We may use and disclose health information about you for our health care operations purposes. These uses and disclosures help us run our facilities and to make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide to evaluate the need for new services or treatment. We may also disclose information to physicians, nurses, technicians, medical students, and other Virginia Hospital Center Arlington Health System facility personnel for review and educational purposes. We may also combine the health information we have with that of other hospitals for comparisons that will help us make decisions on improvements. We may remove information that identifies you from this set of health information to protect your privacy.

Business Associates: There are some services provided in our organization through contracts with business associates. For example, certain laboratory tests may be sent out for processing, and a copy service is used to make copies of your health record. When services are contracted, we may disclose your health information to our business associate so that they can perform the job that we have asked them to do for us. To protect your health information, however, we share with our business associates only the minimum amount of information necessary for them to assist us, and require them to safeguard the information we do share according to contractual agreement.

Hospital Directory: We may include certain limited information about you in the Virginia Hospital Center directory while you are a patient at Virginia Hospital Center. This information may include your name, location in Virginia Hospital Center, your general condition (e.g. fair, stable, etc.), and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, even if they don't ask for you by name. This is so your family, friends and clergy can visit you in Virginia Hospital Center and generally know how you are doing. If you do not want to be included in the facility directory, you will need to notify the admission staff at the time of each admission. If emergency circumstances prevent us from asking you about the directory, we will use our professional judgment to determine what is in your best interest until there is a reasonable opportunity for you to object.

For Contacting you about Services: We may use your health information to contact you to:

- Give a reminder that you have an appointment for treatment or medical care at a Virginia Hospital Center Arlington Health System facility.
- Tell you about possible treatment alternatives
- Tell you about health-related benefits or services
- Assess your satisfaction with our services
- As part of our fundraising efforts, we may use, or disclose to a business associate or institutionally-related foundation, certain health information about you, such as your name, address, phone number, e-mail information, dates you received treatment or services, treating physician, outcome information, and department of service (for example cardiology or orthopedics), so that we or they may contact you to raise money on our behalf. The money raised will be used to expand and improve the services and programs we provide the community. You are free to opt out of fundraising solicitation, and your decision will have no impact on your treatment or payment for services. Any fundraising materials that you may receive will tell you how you can opt out of receiving any further fundraising communications from us. Please note that we will promptly process your request to be removed from our fundraising list, and we will honor your request unless we have already sent a communication prior to receiving notice of your election to opt out.

Individuals Involved in Your Care or Payment for Your Care: We may release health information about you to your personal representative or a designated family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. We may require your written permission to release such information, however, if you are incapacitated or otherwise unavailable, we will use our professional judgment to determine whether to make any such disclosure.

Research: Under certain circumstances, we may disclose your health information for research consistent with our legal obligations, for example, when an institutional review board has reviewed the research proposal, established protocols to ensure the privacy of your health information, and approved the research.

As Required or Authorized by Law: We may disclose health information about you when required or authorized by law to do so to the following types of entities, including but not limited to:

- The Food and Drug Administration (FDA), or an entity regulated by the FDA, to report an adverse event or a potential defect related to a drug or medical device.
- Public Health or Legal Authorities (such as Child Protective Services, Human Rights Advocate/Board, Mental Health Advocate/Board) to:
  - Prevent or control disease, injury or disability;
  - Report births and deaths;
  - Report suspected abuse, neglect, or domestic violence;
  - Report reactions to medications or problems with products;
  - Notify people of recalls of products they may be using;
  - Notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Data Registries including Tumor and Trauma Registries
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: We may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process, but only if like notice has been given to you or your attorney in accordance with applicable law.

Law Enforcement: We may release certain health information to law enforcement authorities for law enforcement purposes, such as:

- As required by law, including reporting certain wounds and physical injuries;
- A court order; subpoena, warrant, summons or similar process;
- A need to identify or locate a suspect, fugitive, material witness, or missing person;
- A need for information about the victim of a crime, if, under certain limited circumstances, we are unable to obtain the person's agreement;
- A death we believe may be the result of criminal conduct;
- Investigation of criminal conduct at the facility;
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

To Avert a Serious Threat To Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to the health and safety of the public, to you, or to another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Minors: If you are an unemancipated minor under Virginia law, there may be circumstances in which we disclose health information about you to a parent, guardian, or other person acting in loco parentis, in accordance with our legal responsibilities.

Parents: If you are a parent of an unemancipated minor, and are acting as the minor's personal representative, we may disclose health information about your child to you under certain circumstances. For example, if we are legally required to obtain your consent as your child's personal representative in order for your child to receive care from us, we may disclose health information about your child to you. In some circumstances, we may not disclose health information about an unemancipated minor to you. For example, if your child is legally authorized to consent to treatment (without separate consent from you), consents to such treatment, and does not request that you be treated as his or her personal representative, we may not disclose health information about your child to you without your child's written authorization.

Deceased Individuals. Following your death, we may disclose health information to a coroner or to a medical examiner as necessary for them to carry out their duties and to funeral directors as authorized by law. In addition, following your death, we may disclose health information to a personal representative (for example, the executor of your estate), and unless you have expressed a contrary preference, we may also release your health information to a family member or other person who acted as a personal representative or was involved in your care or payment for care before your death, if the health information is relevant to such person's involvement in your care or payment for care. We are required to apply safeguards to protect your health information for 50 years following your death.

Incidental Uses and Disclosures. There are certain incidental uses or disclosures of your information that occur while we are providing service to you or conducting our business. For example, after surgery the nurse or physician may need to use your name to identify family members that may be waiting for you in a waiting area. Other individuals waiting in the same area may hear your name called. We will make reasonable efforts to limit these incidental uses and disclosures.

Health Information Exchange. We participate in one or more electronic health information exchanges, which permits us to exchange health information about you with other participating providers (for example, physicians and hospitals) and their business associates. For example, we may permit a physician providing care to you to access our records in order to have current information with which to treat you. In all cases, the requesting provider must verify that they have or have had a treatment relationship with you, and, if required by law, we will ask the provider to obtain your consent before accessing your health information through the health information exchange. Participation in a health information exchange also lets us access health information from other participating providers and health plans for our treatment, payment and health care operations purposes. We may in the future allow other parties, for example, public health departments, that participate in the health information exchange, to access your protected health information for their limited uses in compliance with federal and state privacy laws, such as to conduct public health activities.

Your Health Information Rights

Although your health record is the physical property of the Virginia Hospital Center Arlington Health System facility, you have the following rights regarding the health information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy health information we maintain about you that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. If we maintain the information electronically and you ask for an electronic copy, we will provide the information to you in the form and format you requested, assuming it is readily producible. If we cannot readily produce the record in the form and format you request, we will produce it another readable electronic form we agree to. We may charge a cost-based fee for producing copies, including the cost of retrieving, copying, mailing, and use of supplies associated with your request. We may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional, chosen by Virginia Hospital Center Arlington Health System, will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review**.**

Right to Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Virginia Hospital Center Arlington Health System facility. You must provide a reason for your request. We may deny your request for an amendment. If this occurs, you will be notified in writing of the reason for the denial, and of your right to submit a statement (of reasonable length) disagreeing with the decision, which will be added to your records.

Right to An Accounting of Disclosures: You have the right to request an accounting of disclosures of your health information. This is a list of the disclosures we made of health information about you. The accounting will not include certain disclosures, such as those made for treatment, payment, or health care operations and certain other types of disclosures, for example, as part of a facility directory or disclosures in accordance with your authorization. We will provide you the accounting free of charge, however if you request more than one accounting in any 12 month period, we may impose a reasonable, cost-based fee for any subsequent request. Your request should indicate the period of time in which you are interested (for example, "from May 1, 2003 to June 1, 2003"). We will be unable to provide you an accounting for any disclosures made before April 14, 2003, or for a period of longer than 6 years. Requests must be in writing. You may contact the Privacy Official to obtain a form to request an accounting of disclosures.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations or to persons involved in your care or payment for your care. We are not required to agree to your request, with one exception explained in the next paragraph, but we will let you know whether we have agreed to your request.

We are required to agree to your request that we not disclose certain health information to your health plan for payment or health care operations purposes if (1) you pay out-of-pocket in full for all expenses related to that service either at the time of service or within timeframes specified by our written policies and (2) the disclosure is not otherwise required by law. Such a restriction will only apply to records that relate solely to the service for which you have paid in full. If we later receive an authorization from you dated after the date of your requested restriction which authorizes us to disclose all of your records to your health plan, we will assume you have withdrawn your request for restriction.

You must make a separate request to each covered entity from whom you will receive services that are involved in your request for any type of restriction, including physicians and allied health practitioners who are in private practice and have clinical privileges at Virginia Hospital Center, hospital-based physician groups such as anesthesia, radiology, pathology and emergency medicine. Contact the Privacy Official if you have questions regarding which providers will be involved in your care.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you can ask that we use an alternative address for billing purposes.

Notice in the Case of Breach. You have the right to receive notice of an access, acquisition, use or disclosure of your health information that is not permitted by HIPAA, if such access, acquisition, use or disclosure compromises the security or privacy of your Protected Health Information (we refer to this as a breach). We will provide such notice to you without unreasonable delay but in no case later than 60 days after we discover the breach.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to paper copy of this notice.

You may obtain a copy of this notice at our website: www.virginiahospitalcenter.com

To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice on our website at www.virginiahospitalcenter.com. The effective date will be on the first page of the notice. In addition, each time you register or are admitted for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Virginia Hospital Center Arlington Health System Privacy Official (contact information appears on page 1 of this Notice), or with the Secretary of the U.S. Department of Health and Human Services. All complaints to Virginia Hospital Center Arlington Health System must be submitted in writing.
You will not be penalized for filing a complaint.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION.

There are many uses and disclosures we will make only with your written authorization. These include:

Uses and Disclosures Not Described Above. We will obtain your authorization for uses and disclosures of your health information that are not described in the notice above.

Psychotherapy Note. These are notes made by a mental health professional documenting conversations during private counseling sessions or in joint or group therapy. Many uses or disclosures of psychotherapy notes require your authorization.

Marketing. We will not use or disclose your protected health information for marketing purposes without your authorization. Moreover, if we will receive any financial remuneration from a third party in connection with marketing, we will tell you that in the authorization form.

Sale. We will not sell your protected health information to third parties without your authorization. Any such authorization will state that we will receive remuneration in the transaction.

If you provide authorization for the disclosure of your health information, you may revoke it at any time by giving us notice in accordance with our authorization policy and the instructions in our authorization form. Your revocation will not be effective for uses and disclosures made in reliance on your prior authorization.

VIRGINIA HOSPITAL CENTER
Physician Group

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

By signing this form you acknowledge receipt of the Notice of Privacy Practices for Virginia Hospital Center Arlington Health System and its affiliated medical groups. Our Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change.

_____
MRN

_____ | _____
Signature of Patient / Patient Representative | Date

_____ | _____
Name of Patient / Patient Representative (please print) | Relationship to Patient

OFFICE USE ONLY

We attempted to obtain written acknowledgement of patients' receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained from the patient for the following reason:

☐ Patient Refused to Sign

☐ Patient Representative Refused to Sign

☐ Patient/ Patient Representative Refused Copy of Notice of Privacy Practices

☐ Emergency Situation Prevented Signature

☐ Other (please specify) _____

_____ | _____
Provider Representative Signature | Date

Effective Date: February 2016