Inova Geriatrics & Advanced Illness
Medical House Calls
Admission Consent & Assignment of Benefits

Patient Name (First, Middle, Last)	Date of Birth (00/00/0000)
Patient Address	
Phone Number (Including Area Code)	Alt. Phone Number (Including Area Code)

Consent for Services

I consent and authorize Inova's Geriatric & Advanced Illness program, its agents and associates, to care for and treat me in my home and at Inova Health System. A representative of Inova Health System has explained my plan of care and has answered all of my questions in a satisfactory manner. I understand that my treatment plan may change, and if so, these changes will be discussed with me and the final decision will be mine. Unless I object, my family/caregiver will receive instructions to assist with my care. I agree to notify my health care team of any changes in my condition, any side effects of medications, or any other significant events related to my health and well-being._____(Initials)

Use and Disclosure of Medical Information

I understand that practices about the use and disclosure of medical information are described in the current Notice of Privacy Practices (enclosed)._____(Initials)

Virginia Health Care Proxy

I have received written information about having a health care proxy (enclosed). A proxy allows me to name someone to make health care decisions if I become unable to make or communicate those decisions. If I choose to complete this form, I will give a copy to a member of my home health care team. This copy will become part of my medical record.
_____(Initials)

Patient Rights and Responsibilities

I have received a copy of Inova Health System's Patient Rights and Responsibilities (enclosed)._____(Initials)

I have reviewed the Inova Medical House Calls Guidelines document (enclosed). _____(Initials)

INOVA
Join the future of health.

Assignment of Benefits

I request that payment of authorized Medicare, Medicaid, or other insurance benefits be made on my behalf for any services furnished to me by !nova's Geriatric and Advanced Illness program. I authorize any holder of medical information about me to release to the Center of Medicare & Medicaid Services and its agents and to my medical insurers any information needed to determine or secure eligibility information for these benefits._____ (Initials)

Liability for Payment

I certify that all information given on my behalf is correct to the best of my knowledge. I understand that services provided to me by (nova Geriatrics and Advanced Illness will be billed to my insurance plan(s), if any. I also understand that no patient is denied services due to an inability to pay for medical care. However, I may complete an application to determine if I am eligible for payment assistance through the Virginia Health Safety Net Program._____(Initials)

*By signing this form, you are stating you understand the information given above and that any questions have been answered to your satisfaction.

Patient (or Patients Representative) Signature	Date (00/00/0000)
Check here if only Patient's Oral Consent Given ☐	Witness Signature (only if Patient's Oral Consent Given)
Check here if above Signature is a Patient's Representative ☐ Patient Representative's Name, Address, Phone Number:	Patient Representative's Relationship to Patient (e.g. spouse/child): Patient Representative's Authority (e.g. guardian, medical power of attorney):

Patient's Name: _____ History #: _____

Patient's Date of Birth: _____ Date(s) of Service: _____

Patient's phone number: (_____) _____ (_____) _____
DAYTIME EVENING

I authorize: _____

to release or disclose the following information to:

_____ _____
NAME OF PERSON, PHYSICIAN OR AGENCY TO RECEIVE INFORMATION (FAX NUMBER FOR PHYSICIAN OFFICE ONLY)

_____
STREET ADDRESS CITY STATE ZIP CODE

Information to be Released / Disclosed:

- ❑ Emergency Record
- ❑ Face Sheet
- ❑ Discharge Summary
- ❑ Psychiatric Admit Note
- ❑ Psychiatric Evaluation
- ❑ Consultation
- ❑ X-ray Report
- ❑ Progress Notes
- ❑ Lab / EKG
- ❑ Operative Report
- ❑ Physicians Orders
- ❑ Other _____
- ❑ Billing Information
- ❑ Substance Abuse Records
- ❑ Plan of Care (HH)
- ❑ Complete Health Record
- ❑ Medical Abstract
- ❑ X-ray Films/CD

Purpose:

- ❑ Medical Follow-Up
- ❑ Attorney
- ❑ Individual use
- ❑ Disability
- ❑ Insurance
- ❑ Other _____

Patient advised of charges: ❑ Yes ❑ No ❑ N/A

❑ I prefer to pick up records **❑ I wish to review records (by appointment only)**

I understand that if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.

I understand written notification is necessary to cancel this authorization and can be addressed to the department listed at the top of this form. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

I understand that I am under no obligation to sign this form. Inova Health System may, however, condition the provision of research-related treatment on my signature of this authorization for the use or disclosure of protected health information for such research, in accordance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, §164.508(b)(4). Inova Health System may also condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on my signature of this authorization.

I understand that this disclosure may include information regarding drug abuse, alcoholism, or alcohol abuse, psychiatric or mental illness, Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV regulated by Federal Statute (42 CFR Part 2).

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE DATE (This authorization will expire 6 months after date signed)

_____ _____
NAME OF PERSONAL REPRESENTATIVE (IF APPLICABLE) RELATIONSHIP TO PATIENT

PATIENT IDENTIFICATION

INOVA HEALTH SYSTEM

INOVA INITIATED AUTHORIZATION TO RELEASE / DISCLOSE PROTECTED HEALTH INFORMATION

CAT #64515 / R032403 • PKGS OF 100

The following pages are for your information only.

They do not require any signature and they do not need to be returned to Inova.

MAKING ROUTINE AND URGENT APPOINTMENT REQUESTS:

- Your medical provider might already have made plans with you for regular medical house call appointments on a recurring schedule. The below guidelines do not refer to those plans but instead address needs that arise unexpectedly.

- Call for a routine appointment the same way you would call any primary care office seeking an appointment. You may plan for a routine visit **1-2 weeks** in advance or you may ask for an expedited appointment within a few days.

- Call for an urgent visit when you have symptoms that would have forced you to go to an Urgent Care facility or to the Emergency Room. For urgent medical needs during business hours, clinical office staff can usually respond, via telephone, to a phone call immediately or within **30 minutes**. A doctor or nurse practitioner can usually respond with a visit to the home within **24-48 hours.** Please note that you need to **dial 911 for a true emergency.**

- If you call with an urgent request, it is possible that you may be advised to go to the Emergency Room.

CALLING AFTER HOURS, DURING WEEKEND AND ON HOLIDAYS:

- Please observe hour-of-day/night courtesy. The on-call provider will respond to calls within **20 minutes**. Please do not call at night or during weekends to request refills of prescriptions or to schedule routine visits for the week following.

- No controlled substances will be prescribed during on-call hours.

ADDITIONAL GUIDELINES:

- Call for prescription refills **at least 7 business days** before you're out of any medication.

- Call if you need forms completed by your provider and allow **7 business days (plus any time for testing** needed in order for provider to complete the forms) for completion of these forms.

- Call to coordinate for other physician needs whenever you need. Be aware that *elective* procedures scheduled by other providers do not prioritize our appointment schedule.

- If you have a non-urgent question or request that cannot be addressed by the clinical office staff, you may leave a message and a physician or nurse practitioner will return the call as soon as is feasible, generally within **24-48 hours.**

- Your provider might need to obtain lab work and imaging as part of your medical care. If your provider determines there is a need for this, the services may be provided by an outside company. **There may be costs associated** with this billable to you and/or your insurance company.

Effective Date: November 15, 2014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AT INOVA AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Inova's Chief Privacy Officer by calling the Compliance Department at 703-205-2337.

Each time you visit a hospital, physician, or other health care 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 information is considered protected health information (PHI). The Health Insurance Portability and Accountability Act (HIPAA) requires that we provide you with a notice regarding how your PHI may be used or disclosed and your rights concerning that information. This notice applies to all of the records of your care generated by and as part of the care furnished to you in an Inova facility or through an Inova service, whether made by Inova personnel, agents of Inova and its affiliated facilities, or by your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

Inova's Responsibilities

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised copy by accessing our web site www.inova.org, calling 703-204-3342 and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. If any major change is made to this Notice, it will automatically be provided to you at the time of your next visit to an Inova facility. It will also be posted on our website at the time of the change.

Uses and Disclosures

How we may use and disclose Medical Information about you.

The following categories describe examples of the way we use and disclose medical information:

For Treatment: We may use medical information about you to provide you treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at Inova. For example, we may provide a physician at an Inova hospital with information regarding your prior treatment at an Inova facility if it might have bearing on the current condition for which you are being treated. Different Inova departments also may share medical information about you in order to coordinate the different things you may need, such as prescriptions, lab work, meals, and x-rays.

We may disclose medical information about you to people outside of Inova who provide services that are related to your care. We may also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you are discharged from an Inova facility.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose your PHI in order to support the business activities of Inova. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fund raising activities, and conducting or arranging for other business activities.

For example, we may disclose your PHI to medical school students that see patients at our facilities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when we are ready to assist you. We may use or disclose your PHI as necessary to contact you to remind you of your appointment.

We may use or disclose your PHI as necessary to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your PHI for other marketing activities. For example, your name and address may be used to send you a newsletter about the services we offer or to send you information about products or services that we believe may be beneficial to you. These activities are not considered to be marketing under the HIPAA Privacy Rule.

Use of your PHI for activities that would be considered marketing or disclosures that would constitute the sale of PHI may not be made without a signed authorization from you.

If you do not want to receive the materials described above, please contact our Chief Privacy Officer by calling our Compliance Department at 703-205-2337 and request that these marketing materials not be sent to you.

We may use certain information to contact you in the future to raise money for Inova. We may also provide this information to our institutionally related foundation for the same purpose. The money raised will be used to expand and improve services and programs we provide the community.

Information that may be used about you for fundraising purposes includes your name, address, telephone number, dates of service, age, gender, general information about the department in which you received care, the identity of your treating physician and general outcome of your treatment.

If you do not wish to be contacted for fund-raising efforts, please notify the Inova Health System Foundation, at 8110 Gatehouse Road, Falls Church, VA 22042, or by calling 703-289-2072.

Business Associates: Some of the services provided by Inova are provided through contracts with business associates. Examples may include transcription services or outside billing services with which we contract. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information. Inova's requirements for safeguarding your information are included in Business Associate Agreements with each such entity. In addition, all business associates are subject to oversight by the Secretary of Health and Human Services (HHS) and must adhere to all requirements of the HIPAA Privacy and Security Rules.

Directory: We may include certain limited information about you in a facility directory while you are a patient at the facility. The information may include your name, location in the facility, your general condition (*e.g.*, good, fair, etc.) and your religious affiliation. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. If you would prefer not to be included in the facility directory please request the *Request to be Excluded* Form from the Registration staff or from the Chief Privacy Officer.

Individuals Involved in Your Care or Payment for Your Care: We may release medical information about you to a friend or family member who is involved in your medical care or who helps pay for your care. In addition, we may disclose medical 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. If you desire to limit disclosure of such information to friends or family members, we will ask that you designate one individual to whom we may make such disclosures. It will then be up to you to instruct that individual as to how they may disseminate information about you to other interested parties.

Research: Your medical information may be used or disclosed for research purposes without your permission if an Institutional Review Board (IRB) approves such use or disclosure. We may disclose medical information about you to researchers preparing to conduct a research project. In addition, researchers may contact you directly about participation in a study. The researcher will inform you about the study and give you an opportunity to ask questions. You will be enrolled in a study only after you agreed and signed a consent form indicating your willingness to participate in the study.

Future Communications: We may communicate to you via newsletters, mailings or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our facilities are participating.

Organized Health Care Arrangement: Inova's facilities, including but not limited to its hospitals, deliver care in clinically integrated settings in which individuals typically receive care from more than one health care provider including Inova's workforce; physicians and allied health practitioners who are in private practice and have clinical privileges at Inova facilities; hospital-based physician groups such as anesthesia; radiology, pathology and emergency medicine; department chairs and medical directors; and other health care entities affiliated with Inova. These are all part of Inova's Organized Health Care Arrangement (OHCA) and may utilize a shared electronic health record database. We are presenting you this document as a joint notice for these purposes. Information will be shared as necessary to carry out treatment, payment and health care operations. Physicians and caregivers may have access to PHI in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Health Information Exchange: We may make your protected health information available electronically through an information exchange service to other health care providers that request your information. Participation in information

exchange services also lets us see health care information about you from other health care providers who participate in the exchange.

Single Covered Entity: For purposes of HIPAA only, all covered entities that are owned or controlled by Inova shall be considered to be a Single Covered Entity. PHI will be made available to personnel at other facilities included in this Single Covered Entity, as necessary to carry out treatment, payment and health care operations. Caregivers at other facilities may have access to PHI at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the Chief Privacy Officer for further information on the specific sites included in this affiliated covered entity.

As required by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or legal authorities charged with preventing or controlling disease, injury or disability
- Correctional institutions
- Workers Compensation agents
- Organ and tissue donation organizations
- Military command authorities
- Health oversight agencies
- Funeral directors, coroners and medical directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes:

- in response to a court order, subpoena, warrant, summons or similar process;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at an Inova facility; and
- about wounds made by certain weapons.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements. If Virginia Law is more stringent than Federal privacy laws, Virginia law preempts the Federal law.

Uses or disclosures of your PHI not described in this notice will be made solely upon written authorization from you or your personal representative. Written authorizations may be revoked by contacting the department originally authorized to use/disclose the information.

Your Health Information Rights:

Although your health record is the physical property of the health care practitioner or facility that compiled it, you have the **Right to:**

- **Inspect and Copy:** You have the right to inspect and copy medical information in our possession that may be used to make decisions about your care. As a rule, this includes medical and billing records, but does not include psychotherapy notes. You may request an electronic copy of your PHI maintained in Inova's electronic health record (EHR). Access to your records must be provided within 15 days of the receipt of your request. We may deny your request to inspect and copy your records in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. A licensed health care professional not involved in the original denial of your request will be chosen by Inova to review your request and the denial. We will comply with the outcome of the review.

- **Request an Amendment of Your Information:** If you feel that your medical information we have on file is incorrect or incomplete, you may ask us to amend that information. You have the right to request an amendment for as long as Inova retains the information. We may deny your request for an amendment and, if this occurs, you will be notified of the reason for the denial and will be provided with your options as defined in the HIPAA Privacy Rule.

- **Request an Accounting of Disclosures:** You have the right to request an accounting of any disclosures we make of your medical information for purposes other than treatment, payment or health care operations.

- **Right to Restrict Release of Information For Certain Services**
    - You have the right to request a restriction on disclosure of health information about services you paid for out of pocket in full. This request should be made prior to the service being provided and applies only if the disclosure is to a health plan for purposes of payment or health care operations.
    - You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member

or friend. For example, you could ask that we not disclose information about your surgical procedure. Restrictions should be requested in writing by completing a **Request for Confidential Communication and/or Disclosure Restriction.** You may obtain a copy of this form at the time you register for your service or you may obtain one on our Web site www.inova.org.

- **With the exception of restrictions regarding services or procedures that you pay for out of pocket, we are not required to agree to your request.** Requests for restrictions or limitations on the medical information we use or disclose about you for treatment, payment or health care operations must be forwarded to the Chief Privacy Officer. Only the Privacy Officer or his/her designee can agree to such restrictions or limitations. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

- **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. For example, you may ask that we contact you at a location other than your home or by U.S. Mail. Such requests must be made in writing and must include a mailing address where bills for services and related correspondence regarding payment for services will be received. It is important that you note that Inova reserves the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.
- **Breach Notification:** You have a right to be notified following a breach of your unsecured PHI.
- **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 may obtain a copy of this notice at our web site http://www.inova.org.

To exercise any of your rights under this notice, please obtain the required forms from the Registration Department in the facility where you received your services and submit your request in writing. You may also access these forms at our web site http://www.inova.org.

CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. The revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in Inova's facilities and will include the effective date. In addition, each time you register at or are admitted to Inova for treatment or health care services as an inpatient or outpatient, we will provide access to the most recent version. You may always access the most recent version at our web site http://www.inova.org or may call 703-204-3342 and request that a copy of the most recent version is mailed to you.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Inova by contacting the Compliance Department at 8110 Gatehouse Road, Falls Church, VA 22042 Attention: Chief Privacy Officer. You may file a complaint with the Secretary of the Department of Health and Human Services. Instructions for filing a complaint with the Secretary are found at: www.hhs.gov/ocr/privacy.

All complaints must be submitted in writing. You will not be penalized for filing a complaint about Inova's Privacy practices.

OTHER USES OF MEDICAL INFORMATION

We are required to retain our records of the care that we provided to you. Inova will make other uses and disclosures of medical information not covered by this notice or the laws that apply to us only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If we receive written revocation of your permission, we will cease the use or disclose medical information you originally authorized. We would not be able to take back any disclosures we had already made with your permission.

CHIEF PRIVACY OFFICER

Telephone Number: 703-205-2337

VIRGINIA ADVANCE DIRECTIVE FOR HEALTH CARE

I, _____, willingly and voluntarily make known
Printed Name of Individual Making This Advance Directive for Health Care (Declarant)
my wishes in the event that I am incapable of making an informed decision about my health care, as follows:

(YOU MAY INCLUDE ANY OR ALL OF THE PROVISIONS IN SECTIONS I, II AND III BELOW.)

SECTION I: APPOINTMENT AND POWERS OF MY AGENT

(CROSS THROUGH THIS SECTION IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.)

A. Appointment of My Agent

I hereby appoint _____ _____
Name of Primary Agent E-mail Address

_____ _____
Home Address Telephone Number

as my agent to make health care decisions on my behalf as authorized in this document.

If the primary agent named above is not reasonably available or is unable or unwilling to act as my agent, then I appoint as successor agent to serve in that capacity:

_____ _____
Name of Successor Agent E-mail Address

_____ _____
Home Address Telephone Number

I grant to my agent full authority to make health care decisions on my behalf as described below. My agent shall have this authority whenever and for as long as I have been determined to be incapable of making an informed decision.

In making health care decisions on my behalf, I want my agent to follow my desires and preferences as stated in this document or as otherwise known to him or her. If my agent cannot determine what health care choice I would have made on my own behalf, then I want my agent to make a choice for me based upon what he or she believes to be in my best interests.

B. Powers of My Agent

(IF YOU APPOINTED AN AGENT ABOVE, YOU MAY GIVE HIM/HER THE POWERS SUGGESTED BELOW. YOU MAY CROSS THROUGH ANY POWERS LISTED BELOW THAT YOU DO NOT WANT TO GIVE YOUR AGENT AND ADD ANY ADDITIONAL POWERS YOU DO WANT TO GIVE YOUR AGENT.)

The powers of my agent shall include the following:

1. To consent to or refuse or withdraw consent to any type of health care, including, but not limited to, artificial respiration (breathing machine), artificially administered nutrition (tube feeding) and hydration (IV fluids), and cardiopulmonary resuscitation (CPR). This authorization specifically includes the power to consent to dosages of pain-relieving medication in excess of recommended dosages in an amount sufficient to relieve pain, This applies even if this medication carries the risk of addiction or of inadvertently hastening my death.
2. To request, receive and review any oral or written information regarding my physical or mental health, including but not limited to medical and hospital records, and to consent to the disclosure of this information as necessary to carry out my directions as stated in this advance directive.
3. To employ and discharge my health care providers.
4. To authorize my admission, transfer, or discharge to or from a hospital, hospice, nursing home, assisted living facility or other medical care facility.
5. To authorize my admission to a health care facility for treatment of mental illness as permitted by law. (If I have other instructions for my agent regarding treatment for mental illness, they are stated in a supplemental document.)
6. To continue to serve as my agent if I object to the agent's authority after I have been determined to be incapable of making an informed decision.
7. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law if the study offers the prospect of direct therapeutic benefit to me.
8. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law that aims to increase scientific understanding of any condition that I may have or otherwise to promote human well-being, even though it offers no prospect of direct benefit to me.

9. To make decisions regarding visitation during any time that I am admitted to any health care facility, consistent with the following directions:

_____

10. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

ADDITIONAL POWERS OR LIMITATIONS, IF ANY:

_____

_____

_____

SECTION II: MY HEALTH CARE INSTRUCTIONS

[YOU MAY USE ANY OR ALL OF PARTS 1, 2 OR 3 IN THIS SECTION TO DIRECT YOUR HEALTH CARE EVEN IF YOU DO NOT HAVE AN AGENT. IF YOU CHOOSE NOT TO PROVIDE WRITTEN INSTRUCTIONS, DECISIONS WILL BE BASED ON YOUR VALUES AND WISHES, IF KNOWN, AND OTHERWISE ON YOUR BEST INTERESTS. IF YOU ARE AN EYE, ORGAN OR TISSUE DONOR, YOUR INSTRUCTIONS WILL BE APPLIED SO AS TO ENSURE THE MEDICAL SUITABILITY OF YOUR ORGANS, EYES AND TISSUE FOR DONATION.]

1. I provide the following instructions in the event my attending physician determines that my death is imminent (very close) and medical treatment will not help me recover:

[CHECK ONLY 1 BOX IN THIS PART 1.]

☐ I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis or antibiotics. I understand that I still will receive treatment to relieve pain and make me comfortable. (OR)

☐ I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable. (OR)

☐ *[YOU MAY WRITE HERE YOUR OWN INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE DYING, INCLUDING SPECIFIC INSTRUCTIONS ABOUT TREATMENTS THAT YOU DO WANT, IF MEDICALLY APPROPRIATE, OR DON'T WANT. IT IS IMPORTANT THAT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]:*

_____

_____

_____

_____

2. I provide the following instructions if my condition makes me unaware of myself or my surroundings or unable to interact with others, and it is reasonably certain that I will never recover this awareness or ability even with medical treatment:

[CHECK ONLY 1 BOX IN THIS PART 2.]

☐ I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis or antibiotics. I understand that I still will receive treatment to relieve pain and make me comfortable. (OR)

☐ I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable. (OR)

☐ I want to try treatments for a period of time in the hope of some improvement of my condition. I suggest _____ as the period of time after which such treatment should be stopped if my condition has not improved. The exact time period is at the discretion of my agent or surrogate in consultation with my physician. I understand that I still will receive treatment to relieve pain and make me comfortable. (OR)

☐ *[YOU MAY WRITE HERE YOUR INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE UNABLE TO INTERACT WITH OTHERS AND ARE NOT EXPECTED TO RECOVER THIS ABILITY. THIS INCLUDES SPECIFIC INSTRUCTIONS ABOUT TREATMENTS YOU DO WANT, IF MEDICALLY APPROPRIATE, OR DON'T WANT. IT IS IMPORTANT THAT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]*

_____

_____

_____

_____

3. I provide the following other instructions concerning my health care:

[YOU MAY WRITE HERE STATEMENTS AND INSTRUCTIONS ABOUT TREATMENTS THAT YOU DO WANT, IF MEDICALLY APPROPRIATE, OR ABOUT TREATMENTS YOU DO NOT WANT UNDER SPECIFIC CIRCUMSTANCES OR ANY CIRCUMSTANCES. IT IS IMPORTANT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]

SECTION III: ANATOMICAL GIFTS

(YOU MAY USE THIS DOCUMENT TO RECORD YOUR DECISION TO DONATE YOUR ORGANS, EYES AND TISSUES OR YOUR WHOLE BODY AFTER YOUR DEATH. IF YOU DO NOT MAKE THIS DECISION HERE OR IN ANY OTHER DOCUMENT, YOUR AGENT CAN MAKE THE DECISION FOR YOU UNLESS YOU SPECIFICALLY PROHIBIT HIM/HER FROM DOING SO, WHICH YOU MAY DO IN THIS OR SOME OTHER DOCUMENT. CHECK ONE OF THE BOXES BELOW IF YOU WISH TO USE THIS SECTION TO MAKE YOUR DONATION DECISION.)

☐ I donate my organs, eyes and tissues for use in transplantation, therapy, research and education. I direct that all necessary measures be taken to ensure the medical suitability of my organs, eyes or tissues for donation. I understand that I may register my directions at the Department of Motor Vehicles or directly on the donor registry, www.DonateLifeVirginia.org, and that I may use the donor registry to amend or revoke my directions; OR

☐ I donate my whole body for research and education.

[Write here any specific instructions you wish to give about anatomical gifts.]

AFFIRMATION AND RIGHT TO REVOKE:

By signing below, I indicate that I understand this document and that I am willingly and voluntarily executing it. I also understand that I may revoke all or any part of it at any time as provided by law.

Date Signature of Declarant

The declarant signed the foregoing advance directive in my presence. *[TWO ADULT WITNESSES NEEDED]*

Witness Signature Witness Printed

Witness Signature Witness Printed

This form satisfies the requirements of Virginia's Health Care Decisions Act. If you have legal questions about this form or would like to develop a different form to meet your particular needs, you should talk with an attorney. It is your responsibility to provide a copy of your advance directive to your treating physician. You also should provide copies to your agent, close relatives and/or friends. For information on storing this advance directive in the free Virginia Advance Health Directive Registry, go to http://www.VirginiaRegistry.org. This form is provided by the Virginia Hospital & Healthcare Association as a service to its members and the public. (June 2012, www.vhha.com) ▲❋✳

If You Have Questions, Concerns or Comments

At Inova, we recognize the importance of effective communication between you and our dedicated healthcare team. We encourage you to ask questions and share concerns while you are in the hospital so that those who are caring for you can provide prompt, courteous solutions to any issues that may arise.

Additionally, the hospital's patient representatives are available to help patients and families with problems, clarify hospital policies, and assist with disability access issues or other special needs. The Patient Relations program has a process to address all complaints and grievances. Patient representatives welcome the opportunity to assist you, and can be reached at the phone numbers listed below.

Patient Representative Contact Numbers

Inova Alexandria Hospital.....703.504.3128

Inova Fairfax Medical Campus.....703.776.3663

- Inova Fairfax Hospital
- Inova Children's Hospital
- Inova Heart and Vascular Institute
- Inova Women's Hospital

Inova Fair Oaks Hospital.....703.391.3607 or 703.391.3885

Inova Loudoun Hospital.....703.858.6795

Inova Mount Vernon Hospital.....703.664.7555

We hope you will allow us the opportunity to assist with any issues that may arise during your hospital stay. If you choose, you may also contact the Virginia Department of Health, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, VA 23233, or call 800.955.1819.

Additionally, you may contact the Office of Quality Monitoring, The Joint Commission, One Renaissance Blvd., Oakbrook Terrace, IL 60181, or call 800.994.6610.

Insurance Concerns

If you have questions or concerns about decisions made by your health insurance plan, contact the Managed Care Ombudsman at 877.310.6560.

Ethics Consultation

Our hospitals' Ethics Committees provide consultation services to help a patient or family deal with questions of life and death, as well as the quality of life. The Ethics Consultation team helps patients, families, physicians and hospital staff talk about appropriate plans of care when an ethical dilemma exists. The role of the team is to advise; it does not judge or make decisions. Its assistance is intended to help clarify issues for the patient and family members involved, and give them the information they need to make decisions.

Anyone directly involved with a patient can seek a consultation on the patient's behalf, including the patient, family members, friends, physicians, nurses, as well as other members of the patient's care team.

To contact a member of our hospital's Ethics Consultation team, call the hospital operator or the hospital's patient representative.

Your Guide to Patient Rights and Responsibilities

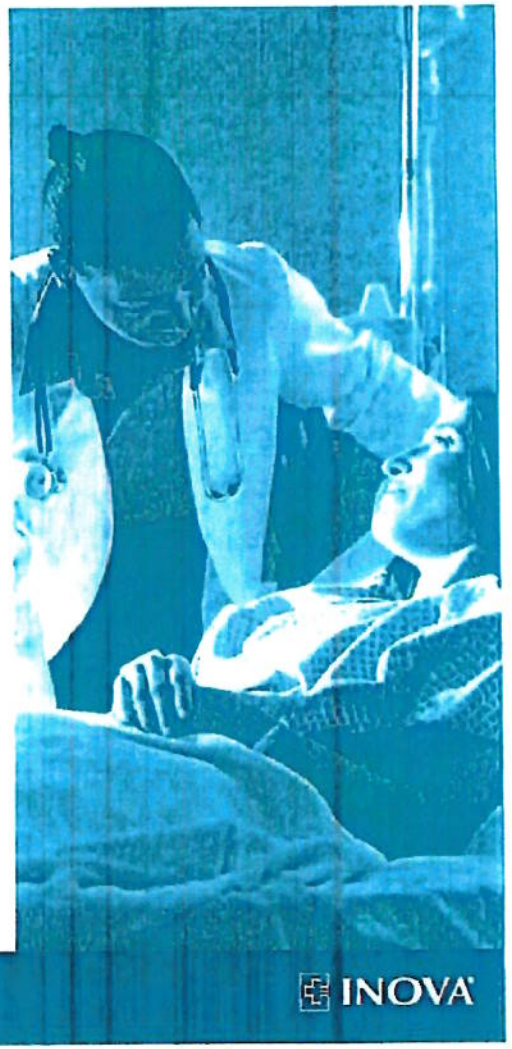
Your Healthcare Decisions

You have the right to complete an Advance Directive which shares your wishes if you are unable to make healthcare decisions for yourself. An Advance Directive can include:

- Designating someone to make healthcare decisions for you and the types of decisions they can make
- Specific healthcare decisions to include end-of-life decisions
- Organ donation decision

It is our policy to respect your wishes in accordance with the law and the hospital's capabilities. If your attending or treating physician has a personal conscience-based objection to the stated wishes in your Advance Directive (for example, reproductive or end-of-life decisions), under Virginia Code 54.1-2987 and Inova policy, the physician must make a reasonable effort to transfer your care to another physician willing to comply with your wishes.

If you have an Advance Directive, please provide us with a copy. If you would like more information on Advance Directives, please ask your nurse or patient representative.



inova.org/patientrights

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Patient Rights and Responsibilities

We can provide better healthcare services when you and your family work together as partners with our staff and physicians. It is our responsibility to advise you of your rights as a patient; you also have responsibilities in your treatment and care. We urge you to ask questions, be proactive and take an active part in your care plan. If you have questions or concerns, please discuss these with your doctor, any staff member or contact the hospital's patient representative.

Overview of Patient Rights

While you are in our hospital, you have certain rights as a patient. You have the right to:

- Receive treatment regardless of your age, gender, race, national origin, language, religion, sexual orientation, disability or any other discrimination prohibited by law
- Know the names and titles of your healthcare team members
- Receive information in a language or manner you understand. This includes the right to interpreter services at no cost to you.
- Be informed about possible results of care, treatment and services, including unexpected results
- Be informed and involved in making healthcare decisions
- Agree to or refuse care, treatment and services
- Appropriate evaluation and management of pain
- Courteous and respectful care
- Be free from restraints of any form that are not medically necessary
- Receive visitors designated by the patient, including but not limited to, a spouse, a domestic partner (including same-sex domestic partner), another family member or a friend. Also included is the right to withdraw or deny such consent at any time.
- Be informed of the hospital's practice that allows for the presence of a support individual unless it interferes with the rights of others, or is not recommended for medical reasons
- Have a family member or representative, and your physician, notified of your admission
- Prepare an advance directive to make certain your healthcare choices are followed if you are unable to communicate those choices to us
- Receive care in a safe setting, free of all forms of abuse or harassment
- A hospital setting that preserves dignity and contributes to a positive self-image
- Respect for your cultural and personal values, beliefs, and preferences, as well as an opportunity to take part in religious and other spiritual services
- Contact protective and advocacy services
- Expect that the hospital will protect your confidentiality and respect your privacy
- See your medical record; request amendments to your medical record; and request a list of persons or organizations to whom your health information was disclosed as determined by federal or state law
- Give permission to the recording or filming made for purposes other than identification, diagnosis or treatment. You also have the right to cancel this agreement.
- Agree or refuse to participate in research studies
- File a complaint and not be subject to discrimination, force, punishment or unreasonable interruption of care, treatment or services
- Have your hospital bill explained and receive information about financial help

Patient Responsibilities

As a patient, you are responsible for the following:

- Providing complete and accurate information about your health, including past illnesses, hospital stays, use of medications and other matters relating to your health
- Asking questions when you do not understand what you have been told about your care or what you are expected to do
- Following the care, service or treatment plan developed for you
- Telling your doctor if you believe you cannot follow through with your treatment plan and understanding the possible results if you decide not to follow the recommended treatment plan
- Providing the hospital with accurate contact and billing information
- Detailed knowledge of your health insurance coverage including deductibles, co-pays and network coverage
- Being considerate of other patients, staff and hospital property and following hospital rules and regulations. This applies to your visitors as well.
- Providing necessary information for insurance claims and to pay your bills or make arrangements for financial obligations in a timely manner
- Recognizing that the hospital cannot accept responsibility for any personal property not deposited in the hospital safe

Rights of the Disabled

When serving the disabled, our hospital continually strives to meet the objectives of the Americans with Disabilities Act (ADA) and the Virginians with Disabilities Act. If you encounter any physical or communication barrier during your time at our hospital, or if you believe you have been denied access to the hospital's full array of services because of your disability, please contact the Compliance Department at **703.205.2337** or the patient representative.

Services for the Deaf and Hard of Hearing

To ensure effective communication with patients, their family members, and companions who are deaf or hard of hearing, we provide auxiliary aids and services free of charge, such as:

- Sign language and oral interpreters
- Telecommunications typewriters for the deaf or hearing impaired (TTY/TDD)
- Video remote interpreting (VRI)
- Written materials
- Telephone handset amplifiers
- Assistive listening devices (marketed as a Pocketalker or Posey sound amplifier)
- Telephones compatible with hearing aids
- Open and closed captioning of most hospital television programs

Please ask your nurse or other hospital personnel for assistance, or contact **703.776.7641**.