INOVA KELLAR CENTER

Practice Policies

Medication Management Clinic

HOURS

An administrative staff member is generally present from 7:30am – 8:00pm Monday – Thursday and 7:30am – 4:00pm on Fridays. If the office is closed, you must back during regular business hours.

EMERGENCIES

Please note Inova Kellar Center is not an emergency facility. If you have an immediate life threatening emergency, call 911 or go immediately to the nearest emergency room. During office hours a staff member will return calls as possible between patients. Every effort to return all patient calls within 24-hours.

APPOINTMENTS

New patient appointments will be scheduled by the Practice Manager. Follow-up appointments may be scheduled by the front desk administrative staff. New patients are generally seen in the mornings or early afternoons. The first session is usually one and one-half hour in length. Should you have a need to re-schedule your initial appointment we will make every effort to accommodate your need, however please note in order to re-schedule we will need to collect a valid credit card number. This number will be held until you appear for the appointment. If you fail to appear for the appointment your card will be charged the full $250 fee for the appointment. Availability for follow-up appointments varies with many late afternoon and early evening appointments generally available on a weekly basis. We do not over-book or double-book appointments; the time you schedule is yours.

CANCELED OR MISSED APPOINTMENTS

When you schedule an appointment at Inova Kellar Center, you are asking a physician to hold a specific block of time for you. In order to efficiently serve the community we have instituted a 24-hour cancellation policy. If you cannot or do not plan to keep your appointment, please let us know 24 working hours in advance to avoid a charge. The charge for missed appointments, cancelled, or changed with less than 24 working hours of notice is $75. This fee will not be billed to your insurance. You will be directly responsible for the remittance of this fee. Improperly canceling or missing an appointment more than twice will result in your child being discharged as a patient and you will need to seek services elsewhere. In addition to the above; should you call to reschedule a previously scheduled appointment twice within a two month period, your child may be discharged as a patient and you will need to seek services elsewhere. We do not over-book or double-book appointments. Please notify us promptly if you cannot make your appointment so that we can offer the time to someone else.

PRESCRIPTION REFILLS

It is the practice of the physicians to write a prescription(s) to cover your needs until your next appointment. There should be no need for additional refills, if you keep scheduled appointments. If an exception occurs, please call the pharmacy (during business office hours, at least three working days before you will run out) and ask them to call the office to approve a refill.* The physicians will approve these refills during office hours, for active patients with scheduled follow-up appointments. Depending upon the exact type of medication prescribed, patients are generally seen at least monthly at first, and then up to every two months and when well established up to every three months. Patients not seen in over three months are not considered active or current patients, and will be discharged as a patient from the clinic.

Medication changes generally require appointments so they can be adequately considered, explained and discussed. Refills will only be approved for current patients who have scheduled follow-up appointments. Please note controlled substances (Ritalin, Adderall, Concerta etc.) cannot be refilled by phone and will not be rewritten except during an appointment. If your child is prescribed one of these medications you will need to schedule monthly follow up appointments.

*In the event an exception does occur a $25 fee will be collected for each prescription written when it is not associated with an actual appointment.

DOCTOR-PATIENT RELATIONSHIP

Following an initial evaluation, our physicians may become your child's psychiatrist if and when a mutual agreement is made to work together toward agreed upon goals (usually one to three appointments). This relationship is a professional, cooperative partnership in which we both have responsibilities to work toward the agreed upon goals. Because of the nature of psychiatric treatment and the practice of our physicians, a person or family must be seen at least every three months to be considered an active or current patient.

RECORDS

There is generally no fee for copying and mailing records of fewer than five pages. Beyond this there is a charge of $.50 per page plus postage, to cover costs and staff time. Upon each occasion a completed and signed release of protected healthcare information form must be completed.

EMAIL

Our physicians do not use or respond to email because of internet privacy concerns, email communication problems and time limitations.

PAYMENT

All relevant payments/co-payments are due at the time of service. Personal checks, exact cash (no change is maintained) and most credit cards will be accepted. There will be a $25 fee for any returned check.

INSURANCE

If applicable (physician is in network) we will bill your insurance for services. We can provide a super bill to assist you in your own filing if necessary. Your insurance policy is a contract between your insurer and you. Please be aware you are ultimately responsible for all charges incurred, as well as for any services not covered by your policy.

LETTERS/FORMS

Due to the additional time required by the physician to complete requested letters and forms an associated fee will be incurred. The fee schedule is as follows:

Letters	$25
Forms (e.g. school forms, FMLA, Disability)	$25

Practice Manager

The Practice Manager is the person you will speak to when setting up initial appointments, making special requests and requesting prescription refill exceptions. *The Practice Manager is not a physician or clinician, but an administrative manager facilitating the procedures of the practice.* In as much, please realize telephone time will be limited. We thank you for your understanding.

I have read and accept the Medication Management Practice Policies:

_____

Patient Name

_____ _____

Parent or Guardian Date

PATIENT IDENTIFICATION

INOVA KELLAR CENTER

PRACTICE POLICIES/MEDICATION MANAGEMENT CLINIC

EFFECTIVE DATE: 11/2012

Inova Kellar Center
Registration Form

Date: _____

Patient Information

Name: _____ Date of Birth: _____

Age: _____ Sex: _____ Race/Ethnic Origin: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Grade: _____

Parent/Legal Guardian Information

Mother/Stepmother (Circle One): _____ Date of Birth: _____

Address (if different from patient): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Father/Stepfather (Circle One): _____ Date of Birth: _____

Address (if different from patient): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Legal Guardian (if different from parent): _____

Relationship to patient: _____ Date of Birth: _____

Address (if different from patient): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Other Information

How did you hear about Inova Kellar Center? _____

For Staff Use Only
TS SIQ: _____ TS %: _____
TS SIQ Jr: _____ SS %: _____

Revised 20 Oct 2011

EMERGENCY CARE FORM

Patient's Name:_____Date of Birth:_____

Mother's Name: _____

Address: _____

Home Number: _____Work: _____ Cell:_____

Father's Name: _____

Address: _____

Home Number: _____Work: _____ Cell:_____

Legal Guardians' Name (if different from parent): _____

Address:_____

Home Number: _____Work: _____ Cell:_____

Child lives with: ☐Parents ☐Father ☐Mother ☐Legal Guardian

List 2 persons we should call in an emergency if parent(s)/guardian cannot be reached

Name of person: _____Phone Number:_____

Relationship to Patient: _____

Name of person: _____Phone Number:_____

Relationship to Patient:_____

MEDICAL INFORMATION:

Name of Primary Doctor: _____

Office Phone: _____

List any allergies patient has: _____

Date of last Tetanus shot: _____

I give permission for my child to receive Tylenol (650 mg) and/or Advil (400mg) every four hours as needed for pain. Yes_____ No_____

CONSENT TO EMERGENCY TREATMENT

The Inova Kellar Center has my permission to transport my child to the nearest emergency facility in an emergency for any medical treatment deemed necessary. The hospital and its medical staff have my authorization to provide treatment, which a physician deems necessary for the well-being of my child.

_____ _____

Parent/ Legal Guardian Signature Date

Patient Name:________________________________ **Page** ___

Allergies:________________________________

Medication	Dose	Route/ Frequency	Last Dose (if known)	Prescribed By	Review Dates & Initials									
Rx ☐ OTC ☐ Herbal ☐														
Rx ☐ OTC ☐ Herbal ☐														
Rx ☐ OTC ☐ Herbal ☐														
Rx ☐ OTC ☐ Herbal ☐														
Rx ☐ OTC ☐ Herbal ☐														
Rx ☐ OTC ☐ Herbal ☐														
Rx ☐ OTC ☐ Herbal ☐														
Rx ☐ OTC ☐ Herbal ☐														

☐ Copy given/sent on transfer Date ____________

PATIENT IDENTIFICATION

Inova Kellar Center

Medication Reconcillation Form

Effective Date: 06/01/10

DEVELOPMENTAL AND SOCIAL HISTORY

Child's Name:_____ DOB:_____

Prenatal History

1. How was mother's health during pregnancy? _____Good _____Fair _____Poor

2. Did mother smoke, consume any alcohol, or use prescription or nonprescription drugs during your pregnancy? _____Yes _____No If yes, please describe_____

_____

_____

Birth History

3. Were there any difficulties with labor or delivery? _____Yes _____No If yes, please describe_____

_____

_____

4. Was your child born on schedule? _____Yes _____No If no, when was he/she born_____

5. What was the child's birth weight and length?_____

6. Were there any health complications following birth? _____Yes _____No If yes, please explain_____

_____

_____

Developmental Milestones and Early Temperament

7. Were there any difficulties with motor development, language development, or toilet training?

_____Yes _____No If yes, please describe_____

_____

_____

8. Would you describe your child's early temperament as _____Easy (regular sleeping and eating patterns, adaptable to change, average activity level, average mood) OR _____Difficult (irregular sleeping and eating patterns, poor adaptability, highly active, wide range in mood) OR _____Other_____

_____

DEVELOPMENTAL AND SOCIAL HISTORY

School History

9. Has there been any concern expressed by either teachers or yourself regarding your child's academic progress or behavior in school? _____Yes _____No If yes, please describe_____

10. What school does your child currently attend?_____

11. What is your child's current grade placement?_____

12. Has your child ever received special education services? _____Yes _____No If yes, please describe_____

Family Composition

13. Please provide the following information in regard to everyone living at home:

Name	age	relationship	occupation	education

14. Please provide the following information in regard to significant family members not living at home:

Name	age	relationship	occupation	education

DEVELOPMENTAL AND SOCIAL HISTORY

15. Are parents presently married? _____Yes _____No If not married, please comment on the relationship each parent has with the child._____

_____

_____

_____

Stressful Events in the Child and/or Families Life

16. Please list any stressful events which have occurred in the past. Also include when these events took place and your child's reaction to them._____

_____

_____

_____

17. Does your child have any known history of physical or sexual abuse? _____Yes _____No

If yes, please describe: _____

18. Do you or does your child have any concerns about his/her sexual history and orientation? _____Yes_____No

If yes, please describe: _____

19. Has any family member had prior contact with the court system, protective services or any other legal/social service agency? _____Yes _____No If yes, please explain_____

_____

_____

20. Are there weapons in the house _____ Yes _____No

If yes describe method of storage_____

_____

_____

Family History

21. Please indicate any family history of behavioral, emotional, substance abuse or academic difficulties:

Mother and/or maternal relatives

_____

Father and/or paternal relatives

Siblings

Support System

22. Please list resources which you find helpful in coping with your child/family's difficulties (e.g. church, extended family, friends, etc.)

Spirituality in Family

23. Affiliated with religious organization, church or synagogue? _____Yes _____No

Name: _____

Level of involvement: _____Minimal _____Sporadic _____Regular _____Very Active

Belief in a Spiritual Being or Higher Power? _____Yes _____No

Social History

24. Does your child have any difficulty making or keeping friends? _____Yes _____No

If yes, please describe

25. Do you have any concerns about the type of friend(s) your child has? _____Yes _____No

If yes, please describe

DEVELOPMENTAL AND SOCIAL HISTORY

26. What are your child's favorite play activities, hobbies or pastimes?_____

Strengths

27. What are the best things about your child?_____

Medical History

Height:_____ Weight: _____ lb/kg List allergies to medication or food: _____

28. How would you describe your child's current general health? _____Good _____ Fair _____Poor

29. Does your child have any current medical problems _____Yes _____No

If yes, please describe: _____

30. Has your child had any recent major accidents or illnesses? _____Yes _____No

If yes, please describe: _____

31. Has your child had any recent surgeries or hospitalizations? _____Yes _____No

If yes, please describe: _____

32. Does your child have any past history of seizures or other medical problems? _____Yes _____No

If yes, please describe: _____

33. Please list your child's primary care physician's name and phone #: _____

34. When was your child's last physical exam? _____

35. Do you see any reason to have your child undergo a physical examination at this time? (yes/no) _____

36. Is your child's immunization status current? _____Yes _____No

Nutritional Assessment:

37. Without reason, has your child gained or lost more than 10 lbs. in the last 3 months? _____Yes _____No

DEVELOPMENTAL AND SOCIAL HISTORY

38. Does your child take laxatives or vomit after eating? _____ Yes _____No

39. Does your child frequently have diarrahea or constipation? _____Yes _____No

Pain Assessment:

40. Is your child experiencing any significant physical pain? _____Yes _____No

If yes, please describe: _____

On a scale of 1 to 10, (1 being the least amount of pain and 10 being the most) what is the pain level?
1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Functional Assessment:

41. Does your child have any significant difficulty moving about or problems with coordination? ____Yes ____ No

If yes, please describe: _____

42. Does your child have any significant difficulty playing sports? _____Yes _____No

If yes, please describe: _____

Other Assessments:

43. Does your child have any significant difficulties with vision or hearing? _____Yes _____No

If yes, please describe: _____

44. Do you have any concerns regarding your child's oral health or hygiene? _____Yes _____No

If yes, please describe: _____

_____

If you answered yes to any of the above questions or indicated your child's health is fair or poor, is he/she under the care of a physician or other healthcare provider? _____ Yes _____No

Condition for which he/she is being treated: _____

Name of physician/healthcare provider and phone #: _____

Mental Health Treatment History

45. Has your child had any prior treatment for emotional/behavioral difficulties? _____Y _____N

If yes, please list the name of the provider(s), date(s) seen and outcome: _____

_____

_____

Was medication prescribed? _____Y _____N If yes, please list: _____

Other Concerns

46. Are any destructive, self destructive or risky behaviors present (examples: threats to hurt oneself or others; killing or harming animals; fire setting; use of illicit substances; participation in gangs; sexual activity or other actions) which may put the child in harm's way? If yes, please describe:

47. Please list any other concerns or ideas you have regarding your child's current behavioral, emotional or academic functioning

48. What do you hope will be different at the end of this treatment?

Completed by: Date

THERAPIST: A yes to any question numbered 37 to 39 indicates that a referral is to be made to the appropriate healthcare provider unless the patient is currently being treated for that condition.

Referral needed: _____Yes _____ No

If yes, for: Pain _____ Nutrition _____ Physical out of date _____ Substance Abuse _____

Referred to:

Follow up:

Reviewed by: Date

INOVA KELLAR CENTER

STATEMENT OF RIGHTS and RESPONSIBILITIES for INDIVIDUALS RECEIVING BEHAVIORAL SERVICES

Each individual who is receiving services in a facility operated, funded or licensed by the Department of Mental Health and Mental Retardation and Substance Abuse Services shall be assured his legal rights and care consistent with basic human dignity insofar as it is within the reasonable capabilities and limitations of the Department of Licensure and is consistent with sound therapeutic treatment.

A. Individual Receiving Services Rights

Except as may be limited on the basis of legal incompetence as adjudicated by a court of competent jurisdiction, each person admitted to a hospital or other facility operated, funded or licensed by the Department shall have the following rights:

1. To be accorded impartial access to appropriate mental health and/or substance use treatment without discrimination on the basis of any factor as to which discrimination is prohibited by applicable law.
2. To be assessed, in the case of a disability, for capability of self preservation in the event of an internal disaster and must be able to benefit from the group nature of treatment.
3. To receive care in a safe, courteous and respectful setting, free of all forms of abuse or harassment, including, but not limited to, mental, physical, sexual or verbal abuse, neglect and exploitation.
4. To be called by his or her preferred name.
5. To expect that the facility will protect the confidentiality of the individual's information and to have access, request amendment to, and receive an accounting of disclosures regarding his or her own health information as permitted under applicable law.
6. To be informed and involved in making decisions regarding his or her individualized care, treatment and services, including the possible anticipated and unanticipated outcomes.
7. To know the names and professional roles of his/her healthcare providers.
8. To refuse care, treatment and services in accordance with law and regulation.
9. To receive effective communication about the rules and regulations, applicable to the individual's conduct, in a language or manner that he or she understands. This includes the right to interpreter services at no cost to the individual.
10. To have the opportunity to communicate in private at times that do not interfere with guidelines or scheduled activities. Any further restriction on an individual's ability to communicate would require authorization from a licensed independent practitioner based on potential harm to the individual or his or her treatment, be documented in the medical record. The regional human rights advocate is to be notified prior to the restriction.
11. To file a complaint with the facility Senior Director, or with the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services or The Joint Commission and not be subject to coercion, discrimination, reprisal or unreasonable interruption of care, treatment and services.
12. To appropriate assessment and management of pain.
13. To access protective and advocacy services.
14. To consent to the recording or filming made for purposes other than the identification, diagnosis, or treatment of the individual and to rescind the consent for use at any time.

15. To consent or decline to participate in research studies. Inova Health System protects research subjects and respects their rights during research, investigation and clinical trials.
16. To be free from restraint and seclusion.
17. To be informed of charges and receive information about financial resources to assist in payment for services rendered.

B. Inova Kellar Center Responsibilities

Inova Kellar Center will use all reasonable efforts to ensure that patients are aware of their rights and can exercise their rights effectively.

The Center will:

1. Provide to each individual receiving services a copy of his or her rights.
2. Post the rights in a public area(s)
3. Establish a complaint and grievance process available to the individual receiving services.
4. Identify, by name and role, the people involved in an individual's care.
5. Protect the integrity of clinical decision-making and ensure that clinical decisions are based on identified individual needs and that financial issues are not used to reduce medically necessary care.
6. Inform individuals receiving services of the rules and regulations of Inova Kellar Center applicable to the patient's conduct, including any restrictions that may be clinically indicated.
7. Provide information on applicable charges upon request as well as the availability of financial assistance information.
8. Inform individuals receiving services of available means to resolve any issues or questions about a facility stay or the treatment provided.

C. Individuals Receiving Services Responsibilities

The individual receiving services is responsible for:

1. Providing complete and accurate information about his/her health, including past treatment, hospital stays, use of medications and other matters relating to the patient's health.
2. Individuals receiving services are responsible for participating effectively in decision making. Individuals are encouraged to take responsibility for requesting additional information or clarification about their health status or treatment when they do not fully understand what is presented, instructions and/or recommendations.
3. Individuals receiving services and their families are responsible for respecting the guidelines of the Inova Kellar Center programs and services regarding the maintenance of a safe and respectful environment at all times for other individuals receiving services, families and staff.
4. Individuals receiving services are responsible for the scheduling and keeping of appointments and providing necessary information for insurance claims and for working with Inova Kellar Center to make payment arrangements, assuring that the financial obligations of his/her health care are fulfilled as promptly as possible.

If you believe your rights have been violated, you may:

- Call or write Inova Kellar Center Senior Director at (703) 218-8500, or
- Call the Regional Human Rights Advocate, Kevin Paluszak, at (703) 323-2098 or
- Contact the Department of Mental Health, Mental Retardation and Substance Abuse Services Office of Human Rights, P.O. Box 1797, Richmond, VA 23218-1797 or
- Contact The Joint Commission at 1-(800) 994-6610 or www.jointcommission.org

ACKNOWLEDGEMENT

A. I have received a copy of the Statement of Rights of Individuals receiving services
B. I have read the Statement of Rights of Individuals receiving Services.
C. I have had an opportunity to ask questions regarding these rights.
D. These questions have been answered to my satisfaction.
E. I understand my rights as a patient at Inova Kellar Center as delineated herein.

_____ _____
Signature of Individual Receiving Services Date

_____ _____
Signature of Parent/Guardian Date

FOR PROGRAMS USE ONLY

Off Grounds Activities

I hereby grant permission for Inova Kellar Center staff to escort my child to local parks for recreation and/or local venues within walking distance of the Center.

Parent/Guardian Signature _____ Date: _____

Agreement to Search

I hereby agree to a daily search of my child and/or my child's belongings and in the event that it is deemed administratively necessary to maintain a safe and therapeutic environment at Inova Kellar Center.

_____ _____
Parent/Guardian Signature Date:

If you believe your rights have been violated, you may:

- Call or write Inova Kellar Center Senior Director at (703) 218-8500, or
- Call the Regional Human Rights Advocate, Kevin Paluszak, at (703) 323-2098 or
- Contact the Department of Mental Health, Mental Retardation and Substance Abuse Services Office of Human Rights, P.O. Box 1797, Richmond, VA 23218-1797 or
- Contact The Joint Commission at 1-(800) 994-6610 or www.jointcommission.org

1HIPAA

I certify that I have been made aware of Inova Health System's **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Inova Health System's health care operations. The Notice also describes my rights and Inova Health System's duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Inova Health System's web site at www.inova.org. I may request that a copy be mailed to me by calling **703-204-3342.**

Inova Health System reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**. I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing Inova Health System's web site listed above to view the most current version.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

NAME OF PATIENT OR PERSONAL REPRESENTATIVE

DATE

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

PATIENT IDENTIFICATION

INOVA HEALTH SYSTEM

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

CAT #84498 / R020609
PKGS OF 100

MR 32-06

INOVA HEALTH SYSTEM

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

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.

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

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 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 Health System'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 protected health information 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.

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 hospital personnel who are involved in taking care of you at the hospital. For example, we may provide a physician at the 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.

In addition, we may disclose your protected 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 may also 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 this hospital.

Payment: Your protected health information 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 protected health information in order to support the business activities of Inova Health System. 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 protected health information 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 protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for Inova Health System. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, 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 protected health information 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.

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 fund raising materials not be sent to you.

We may use certain information (name, address, telephone number, dates of service, age, and gender) to contact you in the future to raise money for Inova Health System. 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.

If you do not wish to be contacted for fund-raising efforts, please notify Inova Health System Foundation, 8110 Gatehouse Road, Falls Church, VA 22042, in writing.

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 and bill you or your third-party payer for services rendered. 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.

Directory: We may include certain limited information about you in the hospital directory while you are a patient at the hospital. The information may include your name, location in the hospital, 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: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

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 Health System'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. These are all part of Inova's Organized Health Care Arrangement (OHCA) 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 treatment at the time.

Single Covered Entity: For purposes of HIPAA only, all covered entities that are owned or controlled by Inova Health System shall be considered to be a Single Covered Entity. Protected health information 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 protected health information 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 as required by law or in response to a valid subpoena.

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 the laws under Virginia Law are more stringent than Federal privacy laws, Virginia law preempts the Federal law.

Your Health Information Rights

Although your health record is the physical property of the healthcare 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.

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 the Inova Health System to review your request and the denial. We will comply with the outcome of the review.

- **Amend**: 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 Health System 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.

- **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.

- **Request Restrictions**: 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 use or disclose information about your surgical procedure.

We are not required to agree to your request. All 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 Health System 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.

- **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, please obtain the required forms from the Chief Privacy Officer and submit your request in writing.

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 the hospital 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 be mailed to you.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the hospital by contacting the Compliance Department and asking for the Chief Privacy Officer or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

We are required to retain our records of the care that we provided to you. Inova Health System 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

1HEAR

Inova Staff: At the first opportunity, provide this Special Needs Form to ALL patients and companions. Use completed form to initiate appropriate action and place form in patient's chart.

Patient or companions: It is important to us to communicate thoroughly with all of our patients and companions. To ensure that we provide effective communication during your stay, please complete the information below.

If you or anyone accompanying you have a special communication need, please indicate below:

In what language would you prefer to communicate with your providers?	☐ English	☐ Spanish	☐ Other (Specify) _____
Are you hard of hearing?	☐ No	☐ Yes	If your response is "No" to both questions, then sign the form below. If your response is "Yes" to one or both of the questions, then sign the form below AND complete the information on the **Deaf or Hard of Hearing Communication Request Form.**
Are you deaf?	☐ No	☐ Yes	

☐ Patient's condition does not allow and/or the companion is not available to complete the Special Needs Form.

Spoken language interpreters are available on site or by phone. If you prefer to communicate in a non English language, trained interpreters will be provided to you.

If your communication needs or those of your companion change during your stay/visit, or you need further assistance, please let your caregiver know and we will make accommodations to assist you.

_____ _____

Signature of Patient/Patient Representative/Companion Date

Print: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Family Member ☐ Friend ☐ Other _____

_____ _____

Signature of Employee Witness Date

Print: _____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name _____

DOB: _____ MR#_____

INOVA HEALTH SYSTEM

SPECIAL NEEDS FORM

CAT # 87498/R102411 • PKGS OF 100

1PMTREV

Patient Name: _____ Medical Record #: _____

Date of Service: _____ Location: _____ Account #: _____

1. **Physicians Who Are Not Employees or Agents of Hospital – I understand that most of the physicians and surgeons furnishing services to me, either individually or through professional corporations including, but not limited to emergency department physicians, radiologists, anesthesiologists, neonatologists, physiatrists, pathologists, and others are independent contractors and are not employees or agents of Inova Health System or this Hospital.** I understand that they are independent in the exercise of decisions requiring professional medical judgement, including decisions about my care. **I understand that I may receive separate bills for such independent contractor services.**

2. **Assignment and Coordination of Insurance Benefits –** I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits to which I/the patient may be entitled. I hereby assign payment(s), if any, from my insurance carrier(s)/health benefit plan(s) to Inova Health System (or its affiliate) and each of the independent contractor physicians and/or professional corporations for services rendered to me. The direct payment hereby assigned and authorized includes any hospital and/or medical insurance benefits to which I am otherwise entitled, including any Major Medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to the Inova Health System (or its affiliate), the independent contractor physicians and/or professional corporations for services rendered to me during the applicable periods of medical care.

3. **Unauthorized, Non-Covered, or Out of Plan Services –** I understand that if my insurance company or health maintenance organization does not consider this admission or any service rendered during this admission a covered service or has not authorized this service, they will not pay for this admission or the service rendered during this admission or outpatient visit. I agree to be fully responsible for payment to the Hospital and any independent contractors providing services to me/the patient for this admission or any service if determined by my insurance company or health maintenance organization to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance or other charge. I also understand that certain physicians and surgeons, such as radiologists, anesthesiologists, neonatologist, physiatrists, pathologists and others may not be participating physician members of my managed care health plan. In the event that my managed health care plan does not reimburse these services provided to me, I acknowledge that I will be responsible for any balance that it declines to pay for such services. ____

4. **Authorization to Release Information and Process Claims –** I authorize release of information, including financial information and confidential health information and medical records regarding services rendered during this episode of care or any related services, which may include records relating to treatment for substance abuse, to my insurance carrier(s), managed care plan or other payor, including past and/or present employer(s), Medicare, Medicaid, or Tricare, authorized private review entities, and/or utilization review entities acting on their behalf, authorized chart reviewers and market surveyors of the Hospital, the billing agents and collection agents or attorneys of Inova Health System (or its affiliates) and/or independent contractor physicians and/or professional corporations, my employer's Workers' Compensation carrier, and, as applicable, the Social Security Administration, the Centers for Medicare & Medicaid Services, the Peer Review Organization acting on the behalf of the federal government, and/or any other federal or state agency for the purpose(s) of satisfying billed charges and/or facilitating utilization review and/or conducting chart review and market surveys and/or otherwise complying with the obligations of state or federal law. A photocopy of this authorization may be honored.

5. **Non Responsibility for Personal Property –** I understand and agree that the Hospital and Inova Health System (or its affiliates) cannot be responsible or liable for any theft of, loss of, or damage to any personal property or other possessions which are not placed in the Hospital's vault for safekeeping. I further understand and agree and authorize that any such money and/or belongings not claimed within sixty (60) days of my discharge from the Hospital may be destroyed or disposed of at the Hospital's discretion, and that any interest or right I may have had in such money or other valuables shall cease. ____

6. **For Medicare Recipients Only –** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to the Hospital and/or independent contractors for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment. My signature below acknowledges receipt of "An Important Message from Medicare" on the date listed below.

7. **Patient Rights and Advance Directives –** Hospital patients have specific rights and a list is provided in the Patient Information Handbook and brochure that are provided to you by the Hospital. Federal and State laws also give you the right to complete a living will or select a durable power of attorney for health care. The Hospital's policy on Advance Directives and a brochure on Advance Directives will be made available to you upon request.

8. **Responsibility for Payment –** In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered services. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorneys' fees and other collection costs.

9. Residents, interns, medical students and other health care professional students may participate, under the supervision of an attending physician or other health care professional, in patient care as part of the Hospital's education programs.

By signing below, I certify that I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms. I further certify that I am the patient listed above or am the guardian, duly authorized representative, parent or other family member of the patient.

_____ _____

PATIENT (GUARDIAN, ETC.) DATE

_____

RELATIONSHIP TO PATIENT (IF NOT SIGNED BY PATIENT)

_____ _____

WITNESS DATE

PATIENT IDENTIFICATION

INOVA HEALTH SYSTEM

AUTHORIZATION FOR CLAIMS, PAYMENT, AND REVIEWS

White: Medical Records • *Yellow:* Patient Copy

CAT #96275 / R040409 • PKGS OF 100