INOVA™

1PAND

Patient Information:

Name (last, first, middle initial): _____ Phone Number (home): _____

Email Address: _____ Alternate Phone Number: _____ ☐ cell ☐ work

Address: _____ Apt # _____ City _____ State ____ Zip Code _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female Social Security Number: _____

Employer: _____ Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Student ☐ Other _____

Emergency Contact: _____ Relationship to Patient: _____

Address: _____ Phone Number: _____

Demographics:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐ More than one race ☐ Declined ☐ Hispanic ☐ Other _____

Ethnicity: ☐ American ☐ Asian Indian ☐ Caribbean Islander ☐ Chinese ☐ Eastern European ☐ Filipino ☐ Japanese ☐ Korean ☐ Middle Eastern ☐ North African ☐ Pakistani ☐ Vietnamese ☐ West African ☐ Declined ☐ Other _____

Insurance Information:

Primary Insurance: _____ Patient is Subscriber/Policy Holder: ☐ Yes ☐ No

Secondary Insurance: _____ Patient is Subscriber/Policy Holder: ☐ Yes ☐ No

Insured Information (if other than patient): We will request to scan your ID and insurance card.

Subscriber/Policy Holder: _____ Relationship to Patient: _____

Address: _____

Social Security Number: _____ Date of Birth: _____ Subscriber Employer: _____

Inova Medical Group reserves the right to charge a fee for any scheduled visits that are:

1. Cancelled with less than 24 hours notice
2. Are missed without calling to cancel (no show)

Cancellation Fee Schedule: New Patient - $50.00; Established Patient - $35.00

Patient/Parent/Guardian Signature: _____ Date: _____ Time: _____

Specialty Care Only: Please indicate your referring doctor as well as other doctors who will need information about your treatment.

Referring MD Name: _____ Specialty: _____

Address: _____ Phone number: _____ Fax Number: _____

Referring MD Name: _____ Specialty: _____

Address: _____ Phone number: _____ Fax Number: _____

Referring MD Name: _____ Specialty: _____

Address: _____ Phone number: _____ Fax Number: _____

Referring MD Name: _____ Specialty: _____

Address: _____ Phone number: _____ Fax Number: _____

PATIENT IDENTIFICATION

Inova Medical Group

Patient Registration Form

CAT # 20288DT / R050514 • PKGS OF 100

Inova Behavioral Health Services

It is your **RIGHT**	Es su **DERECHO**
• TO BE TREATED WITH DIGNITY AND RESPECT • TO BE TOLD ABOUT YOUR TREATMENT • TO HAVE A SAY IN YOUR TREATMENT • TO SPEAK TO OTHERS IN PRIVATE • TO HAVE YOUR COMPLAINTS RESOLVED • TO SAY WHAT YOU PREFER • TO ASK QUESTIONS AND BE TOLD ABOUT YOUR RIGHTS • TO GET HELP WITH YOUR RIGHTS	• SER TRATADO CON DIGNIDAD Y RESPECTO • ESTAR INFORMADO SOBRE SU TRATAMEENTO • OPINAR SOBRE SU TRATAMIENTO • HABLAR CON OTRAS PERSONAS EN PRIVADO • QUE SUS QUEJAS SEAN ATENDIDAS • EXPRESAR SUS PREFERENCIAS • PREGUNTAR Y CONOCER SUS DERECHOS • RECIBIR AYUDA EN LAS EJECUCION DES SUS DERECHOS
If you have questions or need help, see the program contact person or the Human Rights Advocate:	Si tiene pregutas o necesita ayuda, llane a su representante:

Program contact person for

Maria C. Hadjiyane, MA, LPC, CSAC
Director Behavioral Health Adult Ambulatory Services
703.289.4989
Maria.hadjiyane@inova.org

Human Rights Regional Advocate:

For all programs in Fairfax and Arlington counties:
Kevin Paluszak
DBHDS Office of Human Rights
9901 Braddock Road, Fairfax Va. 22032
703-323-2098 (phone) 703-323-2110 (fax)
kevin.paluszak@dbhds.virginia.gov

For all programs in Loudoun counties:
Mark Seymour
Loudoun County Regional Advocate
Phone: (540) 569-3193

PATIENT RIGHTS

1. Retain his/her legal rights as provided by state and federal law.
2. Receive prompt evaluation and treatment or training about which he/she is informed insofar as he/she is capable of understanding.
3. Be treated with dignity as a human being and be free from abuse or neglect.
4. Not be the subject of experimental or investigational research without his/her prior written and informed consent or that of his/her legally authorized representative
5. Be afforded an opportunity to have access to consultation with a private physician at his/her own expense, and in the case of hazardous treatment or irreversible surgical procedures have, upon request, an impartial review prior to implementation, except in case of emergency procedures require for the preservation of his/her health.
6. Be treated under the least restrictive conditions consistent with his/her condition and not be subjected to unnecessary physical restraint or isolation.
7. Be allowed to send and received sealed letter mail.
8. Have access to his/her medical records and be assured of their confidentiality; but notwithstanding other provisions of law, such right shall be limited to access consistent with his/her condition and sound therapeutic treatment.
9. Have the right to an impartial review of alleged, or possible violations of the rights assured under his/her section and the right to access to legal counsel.
10. Have the opportunity to participate in treatment plan.

INOVA™

1ADA

Inova Staff: At the first opportunity, please complete this form with the patient or companion and have it scanned into the patient's electronic medical record. **Complete one form per person requesting accommodation.**

Patient or Companion: If you or any companion assisting in your care has a special need, please indicate below:

☐ Patient's medical condition does not allow completion at this time.

	Patient	Companion/Legal Guardian
Are you deaf or do you have serious difficulty hearing?	☐ Yes ☐ No	☐ Yes ☐ No
Are you blind or do you have serious difficulty seeing, even when wearing glasses?	☐ Yes ☐ No	☐ Yes ☐ No
Do you have serious difficulty walking or climbing stairs? (5 years old or older)	☐ Yes ☐ No	☐ Yes ☐ No
Do you have any other special needs or disability that require services or accommodations during your visit today?	☐ Yes ☐ No	☐ Yes ☐ No
If you have indicated a need above, do you or your companion need services or accommodations related to your identified need(s)?	☐ Yes ☐ No	☐ Yes ☐ No

Please describe type of accommodation requested:

_____

_____

Do you have any special instructions for care providers? If so, please describe below:

_____

_____

Staff Notes regarding accommodations given: (**Inova Staff:** Please document in detail accommodation(s) requested and services given.)

_____

_____

By my signature below, I hereby certify that: (i) I have been given the opportunity to communicate whether I and/or my companion has a disability or special need requiring accommodation; (ii) I have had the opportunity to communicate my needs to staff as reflected above and that the above selections are true, accurate and complete; (iii) I understand that Inova Health System will use its best efforts to accommodate my requests and that any accommodations provided will be given free of charge; (iv) I have been offered/given a copy of the Patient Rights brochure which contains information for filing a complaint if I am unsatisfied with my requested accommodations during my visit today.

_____ _____

Signature of Patient/Patient Representative/Companion Date Time

Print: _____

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

_____ _____

Signature of Employee Witness Date Time

Print: _____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name _____

DOB: _____ MR# _____

Inova Ambulatory Services

Americans with Disabilities Act (ADA)/ Special Needs Assessment

CAT # 20328DT-1P / R052714 • PKGS OF 100

1PSYOUT

Patient's Name: _____ Date: _____

This form is an opportunity for you to share any concerns you may have with your provider. Please fill this out completely. If you have concerns not included here, please be sure to bring those up with your provider.

Reason for today's visit _____

(Females only) Is there any possibility of pregnancy? ☐ No ☐ Yes

Any changes in allergies or medical problems? ☐ No ☐ Yes _____

_____

Any changes in or concerns with medications? ☐ No ☐ Yes _____

_____

_____

_____

Do you take your medicine every day? ☐ Yes ☐ No ☐ Sometimes I forget

0 1 2 3 4 5 6 7 8 9 10

Are you experiencing any physical pain? ☐ No ☐ Yes, rate your pain 0 to 10 using faces above _____

Using the faces above, rate how you are feeling today _____

What symptoms are you experiencing? _____

_____

_____

_____

_____

_____

Patient Signature: _____ Date: _____ Time: _____

Staff Signature/Title: _____ Date: _____ Time: _____

PATIENT IDENTIFICATION

INOVA HEALTH SYSTEM

FOLLOW-UP VISIT SELF-REPORT

CAT # 87275/R041511 • PKGS OF 100

1PTRCR

Acknowledgement of Patient Rights

Each person who is a patient or resident in a hospital or other facility operated, funded or licensed by the **Virginia Department of Behavioral Health and Developmental 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 or Licensee and is consistent with sound therapeutic treatment.

I acknowledge that I have received my statement of **Patient Rights, and the contact information for my local human rights representative.**

Patient Initials: _____ Date/Time:_____

Acknowledgement of Community/Group Rules

Each person admitted to one of the Inova Behavioral Health programs is given a copy of the program's community/group rules.

I acknowledge that I have received the Community/Group rules for the following program: (please check one)

- ☐ Inpatient (psychiatry)
- ☐ Partial Hospitalization (psychiatry)
- ☐ Intensive Outpatient Program
- ☐ Relapse Prevention
- ☐ Sober Living
- ☐ Inpatient (substance abuse)
- ☐ Day Treatment (substance abuse)
- ☐ Early Recovery
- ☐ After Care Group
- ☐ Other: _____

Patient Initials: _____ Date/Time:_____

_____ _____

Patient Signature Date/Time

_____ _____

Witness Signature Date/Time

PATIENT IDENTIFICATION

INOVA HEALTH SYSTEM
INOVA BEHAVIORAL HEALTH

ACKNOWLEDGEMENT OF PATIENT RIGHTS & GROUP RULES

CAT # 20090DT/R121913 • PKGS OF 25

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

INOVA NOTICE OF PRIVACY PRACTICES

Effective Date: September 15, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND SHARED 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 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 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 information may be used or shared and your rights concerning that information. This notice applies to records of your care in an Inova facility or through an Inova service, whether given by Inova personnel, individuals or organizations working with Inova, or by your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of information about you created in the doctor's office or clinic.

Inova's Responsibilities

We are required to follow 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 information about you that we maintain at that time. If any major change is made to this Notice, we will provide a copy to you the next time you visit an Inova facility. You may ask us for a copy of any revised Notice of Privacy Practices by going to our web site at www.inova.org, by calling 703-204-3342, or you may ask for one at the time of your next appointment.

Uses and Disclosures

How we may use and share medical information about you.

The following categories describe examples of the way we use and share medical information about you:

For Treatment: We may use medical information about you to provide you treatment or services. We may share your information with 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 past treatment at an Inova facility. Inova departments also may share information about you in order to provide the care you need, such as prescriptions, lab work, meals, and x-rays.

We may share information about you with people outside of Inova who provide or are involved in your care. We may also provide your physician or a future healthcare provider with copies of various reports to assist in your care.

Payment: Your information will be used to obtain payment for your health care services. This may include certain activities that your health insurance plan may perform before it approves or pays for the health care services such as; making a decision about your coverage for insurance benefits, reviewing services provided to you to determine medical necessity, and performing utilization review activities. For example, we may share certain information about your care with your health plan to obtain approval for a procedure or a hospital stay.

Healthcare Operations: We may use or share your information in order to support the business activities of Inova. These activities include, but are not limited to, quality review activities, employee review activities, training of medical students, licensing, marketing and fundraising, and other business activities.

For example, we may share your health information with medical school students that see patients at our facilities. In addition, we may use a sign-in sheet at the registration desk where we ask you to sign your name and list your physician. We may also call you by name in the waiting room when we are ready to assist you. We may use or share your information to contact you to remind you of your appointment.

Law Enforcement/Legal Proceedings: We may share 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 protective than Federal privacy laws, Virginia law is followed.

Your Information Rights:

Although your health record belongs to Inova, you have the **Right to**:

- **Review or Receive a Copy**: You have the right to review or receive a copy of medical information in our possession. This includes medical and billing records, but does not include psychotherapy notes. You may request a paper or electronic copy of your Inova medical record. Copies must be provided within 15 days of your request. In very limited circumstances, we may deny your request to inspect and copy your records. If this occurs, you may request that the denial be reviewed. A licensed health care professional not involved in the original denial will be chosen by Inova to review your request. We will comply with the outcome of the review.

- **Request an Amendment of Information in your Record**: If you feel that the medical information we have on file is incorrect or incomplete, you may ask us to make changes. You have the right to ask for an amendment for as long as Inova keeps your record. We may deny your request under certain circumstances. If this occurs, you will be given the reason for the denial and we will explain your options for responding to the denial.

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

- **Right to Restrict Release of PHI For Certain Services**

    - If you pay for a service or procedure in full out of pocket, you have the right to ask us not to share information about that treatment with your insurance company. This restriction applies only if the disclosure to the health plan is for the purposes of payment or health care operations. You should let us know your wishes prior to receiving the service or procedure. You should complete the *Request for Restriction of Disclosure to Health Plan* when you register.

    - You also have the right to request a limit on the medical information we share about you with 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 share information about your surgical procedure.

    - You have the right to ask us to limit the medical information we use or share about you for treatment, payment or health care operations. **We are not required to agree to your request**. Your request will be forwarded to the Chief Privacy Officer or his/her designee for consideration. 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 has the right to contact you by other means and at other locations if you do not respond to any communication from us that requires a response. If you wish to request confidential communications, please complete the *Request for Confidential Communication and/or Disclosure Restriction* form when you register.

- **Breach Notification**: You have a right to be notified if there is 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.

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.

INOVA™

1AKPMP

The Virginia Prescription Drug Monitoring Program (PDMP) is a statewide electronic database which collects designated data on substances dispensed in the state. The PDMP is housed by a specified statewide regulatory, administrative or law enforcement agency. The housing agency distributes data from the database to individuals who are authorized under state law to receive the information for purposes of their profession. Prescribers and dispensers may query the database to assist in determining treatment history and determine patient compliance with prescribed medications.

I, _____, agree and understand that the Physician and his/her staff at Inova Behavioral Health and Inova CATS Program use the Virginia Prescription Drug Monitoring Program as needed to verify and rule out any non-compliance of prescription drugs.

_____	_____	_____
Patient Signature	Date	Time
_____	_____	_____
Staff Signature	Date	Time

PATIENT IDENTIFICATION

Inova Behavioral Health Services

Virginia Prescription Monitoring System Agreement

CAT # 20107DT/R091014 • PKGS OF 25

INOVA
Join the future of health

Authorization for Claims Payment and Reviews

1. **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 ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance 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 Insurance Plan(s) 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.

2. **Unauthorized, Non-Covered, or Out of Plan Services** - I understand if my Insurance Plan(s) 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 Inova Health System for this admission or any service if determined by my Insurance Plan(s) 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 In the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.

3. **For Medicare Recipients Only** - I certify 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.

4. **Residents, Interns or Medical Students**- I understand 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 my care as part of the Inova Health System's education programs.

By signing below, I certify 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 and 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. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Inova Health System. *I understand and agree this document will remain in effect for all future outpatient or physician office visits to Inova Health System, unless specifically rescinded in writing by me.*

Patient Signature: _____ Date: _____

Relationship to Patient: _____

Inova CATS Program
3300 Gallows Road, Falls Church, Virginia 22042
Central Access (703) 289-7560 Fax (703) 776-7799

1BROI

Patient Full Name _____ Medical Record # _____

Street _____ City _____ State _____ Zip _____

Telephone Numbers: (home) _____ (cell) _____

Patient's Date of Birth _____ Dates of Service _____

I, _____ authorize the Inova CATS Program to release / disclose the following information to:

Name or Person or Entity to receive information _____ Relationship to Patient _____

Street _____ City _____ State _____ Zip _____

Telephone Number _____ Fax Number _____

Information to be released / disclosed:

- ☐ Admission to the program
- ☐ Assessment and Diagnosis (Axis 1-5)
- ☐ Compliance with treatment recommendations and referrals
- ☐ Results of drug screens and breathalyzer tests
- ☐ Progress towards accomplishing treatment plan goals and objectives
- ☐ Other _____
- ☐ Diagnostic lab work
- ☐ Program participation
- ☐ Financial documentation
- ☐ Treatment plan goals and objectives

For the purpose of:

- ☐ Service coordination
- ☐ Participation in family program
- ☐ Reports to probation officer or attorney
- ☐ Emergency Contact
- ☐ Completion of family interview
- ☐ Other _____

I understand that my records are protected under Federal confidentiality regulations (42 CFR Part 2). Any person or entity receiving my information will be informed that re-disclosure is not permitted without my consent or otherwise permitted by the regulations. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance upon it. I understand that written notification is preferred, but not required to revoke this consent and should be forwarded to the address at the top of this form. I understand that in any event this consent automatically **expires 90 days from the date of signature.** This consent includes information placed in my record after the date of the signature below.

I understand that the Inova CATS Program may not condition my treatment on my decision to sign this authorization.

Signature of Patient or Authorized Representative _____ Date **(Authorization expires 90 days after signature)** _____

Printed Name of Authorized Representative (as applicable) _____ Relationship to Patient _____

PATIENT IDENTIFICATION

INOVA HEALTH SYSTEM
INOVA CATS PROGRAM

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

CAT # 20115DT/R102612 • PKGS OF 25