PREMIER HEALTH CONSULTANTS OF NORTHERN VIRGINIA
Premium Care. Personal touch.

**PREMIER HEALTH CONSULTANTS OF NORTHERN VIRGINIA**
**Dr. Kavita Namjoshi M.D.**
**Ph: 703-662-3359** **Fax: 703-956-1307**

1860 Town Center Dr, Suite 260
Reston, VA 20190

24430 Stone Springs Blvd, Suite 500
Dulles, VA 20166

## COVID-19 Pandemic Treatment Consent Form

Name: _____ DOB: ____/____/_____

Office: ☐ Reston ☐ Dulles Provider: Dr. Namjoshi

You have elected to receive care during the events of the COVID-19 National Emergency. We are providing this special consent, in addition to any procedure-specific consent that you may receive, because of the unique circumstances of the current COVID-19 pandemic. Some considerations to keep in mind as you seek medical treatment under these unique circumstances:

- Traditionally office visits have a relatively small risk of infection. However, the COVID 19 pandemic and the ongoing community transmission of the COVID-19 virus creates additional risks from being in the proximity of Healthcare providers, patients, or staff.
- Social distancing of 6 feet or more is not always possible during in person office visits, which may increase the chances of COVID-19 transmission.
- We are following infection control protocols diligently, which may limit the spread of the disease, but there is a still a possibility of transmission to you (and to others you come into contact with after leaving this office) of the COVID-19 virus which can cause serious health problems, including but not limited to, severe respiratory problems, high fevers and death.
- Here is what we are doing to protect you the patient, team members and ourselves:
    - We are following safety directives from the state and CDC as a way to limit patient and staff exposure to this virus.
    - We engage in a daily office preparation safety routine.
    - We conduct patient and staff COVID-19 screening.
    - We utilize personal protective equipment for office staff and patients and provide training to our staff on the proper methods of putting on and removing this equipment.
    - We implement cleaning and disinfecting protocols before the office opens and between patients.
    - All team members follow applicable guidelines for sterilization and surface disinfection procedures.
    - We implement protocols to minimize crowding in the office including online/over the phone check in, expedited exam room assignments etc.

My Initials by each statement indicate my understanding and acceptance:

Initial

☐ I understand that the COVID-19 Virus has a long incubation period during which carriers of the virus may not show symptoms but may still be highly contagious. It is impossible to determine who has it and who does not, given the current limits in the virus testing.

☐ I understand that there is still much we do not know about the COVID-19 Virus and, therefore, there may be risks that are yet unknown.

☐ I confirm that I am NOT presenting with any of the following symptoms of COVID-19 listed below:

- Fever > 100.4
- Shortness of breath or difficulty breathing
- Dry Cough
- Chills
- Reseated shaking with chills
- Muscle pain
- Headache
- Sore throat
- New loss of taste and/or smell

☐ I understand that travel by air, bus or train significantly increases my risk of contracting and transmitting the COVID-19 virus, and I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days.

☐ I verify that I have not traveled outside of the United States in the past 14 days to countries that have been affected by the COVID-19 virus.

☐ I understand that the CDC currently recommends social distancing of at least 6 feet or more under many circumstances and that social distancing of 6 feet or more is not always possible during office visits.

The safety and well-being of our patients continues to be our primary concern. We will continue to monitor the status of COVID-19 nationally and within our community and update office policy as needed to continue to provide services to our community.

Initial

☐ I confirm that I have read this entire document, and I knowingly and willingly consent to have medical treatment during the COVID-19 pandemic.

Signature of patient/surrogate: _____

Name of patient/surrogate: _____ DOB: _____

Date: _____

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# Consent for Financial/Office Policies of PREMIER HEALTH CONSULTANTS OF NORTHERN VIRGINIA

We are pleased that you have chosen PREMIER HEALTH CONSULTANTS OF NORTHERN VIRGINIA (PHCNVA) as your healthcare provider. The following is a statement of our Financial Policy, which you must read, agree to and sign, prior to treatment. The policy applies to ALL services rendered by our staff whether inpatient or outpatient.

**Insurance Information**

Your health insurance is a contract between you and your insurance company. It is *your* responsibility to know your health plan benefits, including co-payment amounts, deductibles, co-insurance, and lab contracts. We will submit a claim to your insurance company for all visit charges, as a service to you. However, we do not share in the contract between you and your insurance company. You are responsible for any charges not covered by your insurance plan.

A photocopy of your ID and insurance card is needed by our billing department to assist you in filing your claim. It is the patient's responsibility to inform this office if your insurance requires pre-certification or pre-authorization of services prior to scheduling of such services. The patient will be responsible for services denied by insurance due to "No Eligibility", "Non-Covered Service", "Pre-authorization/Certification Not Obtained". Statements are released after your insurance pays, denies, or non-payment by your insurance.

**Patient Payment Policy and Guidelines:**

Patients and their guardians are financially responsible for ALL charges, regardless of third-party involvement. Full payment is due at the time of service unless prior insurance billing arrangements have been made. Patients with insurance will be required to pay ALL "out of pocket" expenses at the time of service.

**1. PATIENT RESPONSIBILITIES:**

**Provide Accurate Information:** You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes, YOU must inform PHCNVA immediately. Insurance denials or billing errors due to patient supplied information will result in the transfer of the account balance to the patient's immediate financial responsibility.

**Know Your Insurance Coverage, Benefits, and Referral Requirements:** Your health insurance is a contract between you and your health insurance plan(s). Patients are responsible for understanding their health insurance coverage benefits and referral requirements to receive diagnostic and therapeutic services in our office. Please present your insurance ID card to our staff upon arrival for each appointment.

**In Network Coverage:** For insurance companies that we are contracted with, we will determine your copay due at the time of the visit. Co-payments and co-insurance amounts, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are DUE AT THE TIME OF SERVICE.

**Out of Network Coverage:** For these plans, your copay is due at the time of the visit. You are responsible for the charges of the provided services, which may be higher than the similar services for an in-network provider. Co-payments and co-insurance amounts, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are DUE AT THE TIME OF SERVICE. You can choose to be a Self-Pay patient and submit your bill for reimbursement to your insurance company.

**Remember to bring:**

- Your insurance card (s)
- Valid photo ID
- Office co-pay and "Credit card on file" information

**2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS**

I hereby authorize and direct payment of my medical benefits to Premier Health Consultants of Northern Virginia on my behalf for any services furnished to me by the providers. PHCNVA is only responsible for filing claims to contracted insurance companies. We file claims as a courtesy to our patients, any deductibles, co-insurance and non-covered services are your responsibility.

**3. AUTHORIZATION TO RELEASE RECORDS**

I hereby authorize PHCNVA to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

**4. MEDICARE REQUEST FOR PAYMENT**

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in to Premier Health Consultants of Northern Virginia. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

**5. DEDUCTIBLES AND CO-PAY**

Full payment is due at the time services are rendered. This includes co-payments, deductibles, and services not covered by your insurance*. If you are on a high deductible plan, we collect a deposit of $150 for new patients and $100 for established patients until the deductible has been met. If you are not able to pay your co-pay or deductible you may be asked to reschedule your appointment.

*If you have an Annual Wellness Visit or Physical/Preventative Exam, but need or request additional services, we may bill you for those additional services.

All services for patients who are minors will be billed to the custodial parent or legal guardian. If you are uninsured and demonstrate financial need or if you have a large balance, a payment plan may be available.

6. **SELF-PAY PATIENTS:**

Self-pay or uninsured patients are responsible for payment at the time of service. The fee schedule is based upon established norms for our specialty and geographical area.

**7. CREDIT CARD ON FILE POLICY:**

PHCNVA requires a credit card on file. A consent for this is included separately and is also on our website at www.phcnva.com. It is your responsibility to ensure that the Credit card information provided is accurate.

**8. RETURNED CHECKS**

There will be a $35 fee assessment for returned checks for non-sufficient funds, stop payments, and account closures. Your account will be flagged for failure to pay and checks will no longer be accepted as a form of payment for your account.

**9. APPOINTMENT CANCELLATION AND NO SHOWS**

We will attempt to contact you for appointment reminders; however, it is the responsibility of the patient to arrive for his/her appointment on time. We ask that you notify us 24 hours in advance to cancel and /or reschedule your appointment. Please be aware that failure to do so will result in a missed appointment or late cancellation fee of $75.00 and no additional appointments will be scheduled until the fee is paid.

**10. DISABILITY AND FMLA PAPERWORK**

There will be a charge of $25.00 for the completion of medical forms. FMLA forms require that you come in for an appointment. Payment is due at the time that you pick-up these forms. Please allow 10 to 14 days for the completion of these forms. If you would like the forms mailed or faxed to you or the insurance, payment will be due prior to mailing or faxing. Copies of your medical records can be obtained with advanced notice in accordance with 8.01-413 of the Code of Virginia, with charges to not exceed $0.50 per page for the first 50 pages and $0.25 for the remaining pages thereafter, in addition to the $15.00 handling fee plus postage expense.

**11. OUTSTANDING BALANCES/COLLECTIONS**

Prior to providing additional services to you, payment in full of total outstanding balances will be required. We will send you 2 statements one month apart and any unpaid balances after 60 days will be assessed a $10 fee per month. If you have an outstanding balance for 90 days your account will be sent to an outside collection agency and you will be charged an additional surcharge of $50. Failure to pay bills may result in dismissal from the practice.

If you are uninsured and demonstrate financial need and complete the required paperwork or if you have a large balance, a payment plan may be available.

**12. DISMISSAL**

If you are “dismissed” from the practice it means you can no longer schedule appointments, get medication refills, or consider us to be your doctor. You have to find a doctor in another practice. Common Reasons for Dismissal:

- Failure to keep appointments, frequent no-shows
- Chronic Non-compliance - you won’t follow physician instructions repeatedly about critical health issues
- Abusive to staff
- Failure to pay your bill

**Dismissal Process**: We will send a letter to your last known address, via certified mail, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on this letter, we will see you. After that, you must find another doctor. We will forward a copy of your medical record to your new doctor after you let us know who it is and sign a release form.

In consideration for medical services rendered, I acknowledge receiving notice of the financial policy and agree to pay for said medical services according to the above terms. My signature below indicated that I have read and agree to the above policy.

DOB: _____

Patient/Guarantor Name (please print)

_____ _____

Signature of Patient/Guarantor Date

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# No-Show/Late Cancellation Policy

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That is why it is very important that you keep your scheduled appointment with us and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, Premier Health Consultants of Northern Virginia sends text message/email reminders 3 days and 1 day in advance of the appointment time.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24-hour notice. Cancellations with less than 24-hour notice will be considered "Late Cancellations". If you do not keep your appointment without a 24-hour cancellation/reschedule (or Late Cancellation), you will be considered a "No-Show".

"No-Show" will be assessed a $75.00 No-Show service charge to your account. "Late Cancellations" may be assessed a $50.00 late cancellation charge. The No-Show and Late-Cancellation service charges are not reimbursable by your insurance company. You will be billed directly for it.

After three consecutive "No-Show"s to your appointment, our practice may decide to terminate its relationship with you.

I understand the "No-Show" and "Late-Cancellation" policy of Premier Health Consultants of Northern Virginia and agree to provide a credit card number, which may be charged $75.00 for any No-Show or $50.00 Late-Cancellation of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a potential No-Show or Late-Cancellation service charge to the credit card provided.

_____ ____/__ _/_____

Patient/Responsible Party Signature Date

DOB:

_____

Patient/Responsible Party Name

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# Credit Card on File Policy

Our office policy requires that we maintain a credit card on file with our office. This will make the checkout process quicker, easier, and also contactless. Your Credit card information will be held securely at an offsite location in compliance with industry standards.

Your Insurance Provider will send you an EOB - Explanation of Benefits, outlining your responsibility for the encounter. Once your insurance provider has paid their portion of your bill and notified us of the amount that is your responsibility, we will notify you of the balance owed via email and charge your credit card for the exact balance indicated on the EOB. We also will email you a copy of the receipt.

This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment. You can dispute the charges directly with the Insurance company. If there is any additional payment from the Insurance company, that amount will be refunded back to you. You can reach out to our office via email, phone or messaging through the portal with any questions you have regarding any charge.

You can also set a limit to the amount that can be charged at one time, though we request that it be set to a minimum of $250.00

Co-pays and known deductibles are still due at the time of service.

If you have an HSA account card, you can keep your HSA card on file with us. However, we may require an additional card to be kept on file should the funds in your HSA account become insufficient.

I authorize Premier Health Consultants of Northern Virginia to charge any outstanding balances on my account, including co-pays, coinsurance, fees for late cancellation of appointments and no-show fees to the credit card on file.

_____ ____/__ _/_____

Patient/Responsible Party Signature Date

DOB:
_____

Patient/Responsible Party Name

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## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment
- Follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received PREMIER HEALTH CONSULTANTS OF NORTHERN VIRGINIA's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that PREMIER HEALTH CONSULTANTS OF NORTHERN VIRGINIA has the right to change its Notice of Privacy Practices from time to time and that I may contact PREMIER HEALTH CONSULTANTS OF NORTHERN VIRGINIA at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____ DOB: DOB: ___/____/_____

Signature _____

Relationship to Patient _____

Date _____/_____/_____

**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: ___/_____/_____

_____

_____

_____

_____

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# NOTICE OF PRIVACY PRACTICES

Effective Date: 12/1/2020
Revised Date: 12/1/2020

**THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU (PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI). PLEASE REVIEW THIS NOTICE CAREFULLY.**

Required of PREMIER HEALTH CONSULTANTS OF NORTHERN VIRGINIA (PHCNVA) by the Privacy Regulations created by Health Insurance Portability and Accountability Act of 1996 (HIPAA)

**A. OUR COMMITMENT TO YOUR PRIVACY**:

Our Practice is dedicated to maintaining the privacy of your Protected Health Information (PHI). Protected Health Information is defined as individually identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We are required by law to provide you with the notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We must provide you with the following information:

- How we may use and disclose your PHI
- Your privacy rights regarding your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future.

The terms of this notice apply to all records containing your PHI that are created or retained by PHCNVA. We reserve the right to revise or amend this Notice of Privacy Practices (Notice), any revision or amendment to this notice will be effective for all of your records that PHCNVA has created or maintained in the past, and for any records that we may create or maintain in the future. There is a copy of this notice at the front desk of each PHCNVA site and it is available on our website at www.phcnva.com. You may obtain a paper copy of this notice by requesting one from the front desk staff or the Practice Manager of any PHCNVA site.

**B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:**

Privacy Officer
Premier Health Consultants of Northern Virginia
1860 Town Center Dr, Suite 260
Reston, VA 20190
Phone: 703-662-3359

**C. WE MAY USE AND DICLOSE YOUR PHI IN THE FOLLOWING WAYS:**

**1. Treatment.** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many who work for our practice, including but not limited to, doctors , clinical assistants, laboratory technicians, radiology technicians, and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. We may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents. We may disclose your PHI to other health care providers for purposes related to your treatment.

**2. Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

**3. Health Care Operations.** Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities who currently have or have had a relationship with you in the past in order to assist in their health care operations. We may use your PHI to obtain accreditation, credentialing or licensing of our doctors or other health care personnel.

**4. Appointment Reminders.** Our practice may use and disclose your PHI to contact you and remind you of an appointment.

**5. Treatment Options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

**6. Health-Related Benefits and Services.** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

**7. Release of Information to Family/Friends.** Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you; provided that such disclosures will be limited to your PHI that is relevant to their involvement in your care or the payment for your care. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information. If you are present, your PHI will be disclosed to a friend or family member: if we obtain your consent, if we provide you with an opportunity to object and you do not object, or if we reasonably assume

that you do not object. If you are not present or you do not have an opportunity to agree or object because of incapacity or emergency, we may make disclosures that, in our professional judgment, are in your best interest.

**8. Disclosures Required By Law.** Our practice will use and disclose your PHI when required by federal, state or local law. We will disclose your health information: a) On request of a law enforcement official if you are or are suspected to be a victim of a crime and we are unable to obtain your authorization. b) To alert a law enforcement official of your death if we suspect your death may have resulted from criminal conduct. c) To a law enforcement official when we believe your health information is evidence of criminal conduct that has occurred on our premises. d) To a law enforcement official, in an emergency, to report a crime, the location or victims of a crime, and the identity of the person who committed the crime. e) To a medical examiner or coroner to identify a deceased person, determine the cause of death, or other duties authorized by law. f) To prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

**9. Health Information Exchanges (HIE).** PHCNVA may use/share information with other health care providers or information exchanges, such as ConnectVirginia. The ConnectVirginia services comprise Virginia's Health Information Exchange and enable the ability to securely share patient information electronically with participating providers. The common goal of the HIE is to support the care received by patients in the Commonwealth by ensuring that providers have access to timely and comprehensive patient information. HIE's help patients as Doctors, hospitals, and health care providers share your medical information via phone, fax, and mail. This provides a better, safer, and faster way for your medical providers to share pertinent information through a secure HIE. When providers join the network, they can quickly access information such as allergies or medications, giving them the ability to coordinate and improve the quality of your care. Under this program, we (i) will disclose your PHI to the ConnectVirginia System through their Clinical Data Repository and (ii) may use PHI pertaining to you that has been submitted to the ConnectVirginia Clinical Data Repository by your other health care providers to assist us in your treatment. Should you become a patient of another participating provider of ConnectVirginia, your PHI disclosed by PHCNVA will be available to your provider there so that he/she can utilize it for your treatment. Sharing your information with ConnectVirginia may mean that physicians or specialist groups will be able to treat you faster or more thoroughly. If you wish to elect to "opt out" or withdraw your information from any of these exchanges, or refuse to grant PHCNVA access to information on one specific or any relevant health information exchanges please contact the privacy officer. Details about ConnectVirginia can be found at: https://connectvirginia.org/ and http://www.vhi.org/connectvirginia/ .

**10. Fundraising.** If PHCNVA or an organization owned/contracted by PHCNVA engages in fundraising we may use a limited portion of your PHI for this purpose; however, you do have the right to "opt out" or request that your PHI not be used for fundraising. We will honor any requests received in writing by the Privacy Officer.

**D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES**

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

**1. Public Health Risks.** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information

• notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

**2. Health Oversight Activities.** Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

**3. Lawsuits and Similar Proceedings.** Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

**4. Law Enforcement.** We may release PHI if asked to do so by a law enforcement official: a) regarding a crime victim in certain situations, if we are unable to obtain the person's agreement. b) concerning a death we believe has resulted from criminal conduct. c) regarding criminal conduct at our offices. d) in response to a warrant, summons, court order, subpoena or similar legal process e) to identify/locate a suspect, material witness, fugitive or missing person f) In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

**5. Deceased Patients.** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

**6. Research.** Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when : (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (1) the information being sought is necessary for the research study; (ii) the use or disclosure of your PHI is being used only for the research and (iii) the researcher will not remove any of your PHI from our practice; or (c) the PHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the PHI of the decedents.

**8. Serious Threats to Health or Safety.** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

**9. Military.** Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

**10. National Security.** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

**11. Inmates.** Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

**12. Workers' Compensation.** Our practice may release your PHI for workers' compensation and similar programs.

**13. Organ and Tissue Donation.** PHCNVA may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

**14. Immunizations.** PHCNVA may release immunization records to schools, educational institutions, and licensed youth camps with your consent.

**E. YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding the PHI that we maintain about you:

**1. Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to The Practice Manager specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

**2. Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to The Practice Manger. Your request must be clear and concise: (a) information you wish restricted; (b) whether you are requesting to limit practice use, disclosure or both; and (c) who you want the limits to apply.

**3. Inspection and Copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Practice Manger in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

**4. Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Practice Manager. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

**5. Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required documentation i.e., the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. To obtain an accounting of disclosures, you must submit your request in writing to the Practice Manager. All

requests for an accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

**6. Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the Practice Manager or our Front Desk personnel.

**7. Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Resources. To file a complaint with our practice, contact the Practice Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

**8. Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, We will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

**9. Right to Notification of Breach of Your Unsecured Health Information.** You have a right to notification of any breach of your unsecured PHI. That means you are entitled to receive notice of any access, use or disclosure of your unsecured PHI that is not permitted under applicable law and which is determined to be subject to the breach reporting rules. Following discovery of a breach of your unsecured PHI, we will notify you of the breach by sending written notice to you by first class mail at your last known address. We will notify you following our investigation of the circumstances surrounding the breach, but in no event later than 60 calendar days after the date we discover the breach. We will notify you by telephone or other expedited means, in addition to written notice, in any situation we believe is urgent because of a possible imminent misuse of your unsecured PHI. When required by applicable law, we will also provide notification of a breach to the media and/or to the Secretary of the U.S. Department of Health & Human Services.

**If you have any questions regarding this notice or our health information privacy policies, please contact our Office Manager.**

PREMIER HEALTH CONSULTANTS OF NORTHERN VIRGINIA
Premium Care. Personal touch.

**PREMIER HEALTH CONSULTANTS OF NORTHERN VIRGINIA**
**Dr. Kavita Namjoshi M.D.**
**Ph: 703-662-3359** **Fax: 703-956-1307**

1860 Town Center Dr, Suite 260
Reston, VA 20190

24430 Stone Springs Blvd, Suite 500
Dulles, VA 20166

## Authorization for Request of Protected Health Information

*****All sections must be completed for request to be processed*****

☐ I authorize the following entities to send my records to PREMIER HEALTH CONSULTANTS OF NORTHERN VIRGINIA:

Hospital: ☐ All Records ☐ H&P ☐ Consults ☐ Lab Tests ☐ Radiology ☐ Discharge Summary

Office: ☐ All Records ☐ Office Progress Notes ☐ Labs/Radiology ☐ Consult Notes ☐ Treatment Records.

| Name of provider/entity | Fax | Phone | Email |
|---|---|---|---|
| Name of provider/entity | Fax | Phone | Email |
| Name of provider/entity | Fax | Phone | Email |
| Name of provider/entity | Fax | Phone | Email |

I understand that I have the right to change this authorization. If I want to change this authorization, I will provide PREMIER HEALTH CONSULTANTS OF NORTHERN VIRGINIA with an updated and signed form.

This existing authorization will be considered valid till an updated and signed authorization is provided to PREMIER HEALTH CONSULTANTS OF NORTHERN VIRGINIA.

DOB: _____ _____

**Print Name** **Date**

_____ _____

**Signature* (Required)** **Relationship to Patient**

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## Authorization for Disclosure of Protected Health Information

*****All sections must be completed for request to be processed*****

**DISCLOSURE AUTHORIZATION** **Name:**_____ DOB: _____ **DOB:** ___/___/_____

**Address:**_____ **Phone:** _____

☐ I authorize PREMIER HEALTH CONSULTANTS OF NORTHERN VIRGINIA (PHCNVA) to disclose my health information to the following provider(s) or entities specified below:

| | | | |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| Name of person, provider, entity | Fax | Phone | Email |
| _____ | _____ | _____ | _____ |
| Name of person, provider, entity | Fax | Phone | Email |
| _____ | _____ | _____ | _____ |
| Name of person, provider, entity | Fax | Phone | Email |
| _____ | _____ | _____ | _____ |
| Name of person, provider, entity | Fax | Phone | Email |

***This information may be disclosed immediately.***

**PURPOSE**: ☐ Patient ☐ Legal ☐ Insurance ☐ Continuing Care ☐ Other _____

**I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. *_____ (Please Initial)**

As the person signing this authorization, I understand that:

- The provision of treatment or payment cannot be conditioned on my signing of this authorization.
- Any health information re-disclosed by a recipient may no longer be protected by this authorization.
- The original or copy of the authorization shall be included in my medical record.
- I have a right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my medical records.

☐ I do not authorize disclosure of my health information to anyone, other than for treatment, payment, and health care operations.

**INFORMATION TO BE RELEASED [required] If you fail to specify, 1 year of records will be provided**

Service Date Range: From: ____/_____/_____ To: ____/_____/_____

☐ All Records ☐ Office Progress Notes ☐ Labs/Radiology ☐ Consult Notes ☐ Treatment Records

☐ Other (specify): _____

DELIVERY METHOD ☐ Paper (mail) ☐ CD (mail) ☐ Fax ☐ Email

***I understand I will be responsible for the charges incurred in the release of my protected health information. Rates are determined by Delivery Method Selected. PAYMENT OPTIONS: Check, Credit Card, or Money Order. <u>No charge for records being released to another healthcare provider</u>***

**PERSONAL CARE REPRESENTATIVE**

❑ I do not authorize anyone to act as my personal representative

❑ I authorize you to discuss my health information with the following individual(s) acting as my personal care representative:

| | |
|---|---|
| **Name of Personal Care Representative:** | |
| **Relationship of Representative:** | |

**METHOD OF CONTACT:**

Our standard method of contact is via the Portal. For appointment reminders and notification of Portal messages chose below:

☐ Text to my personal cell ☐ Email on file ☐ Both

I understand that I have the right to change this authorization. If I want to change this authorization, I will provide PREMIER HEALTH CONSULTANTS OF NORTHERN VIRGINIA with an updated and signed form. If an updated and signed form is not received, the existing authorization will not be updated.

_____ _____

**Print Name** **Date**

_____ _____

**Signature* (Required)** **Relationship to Patient**

*For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.

| Date Reviewed | Staff Initials |
|---|---|
| | |
| | |