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Consent for Services

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

Notice of Privacy Practices and Acknowledgement of Receipt

I understand that practices about the use and disclosure of medical information are described in the current Notice of Privacy Practices (enclosed). I certify that I have received Inova's **Notice of Privacy Practices** and that I have a right to receive an additional copy upon request.

Patient Rights and Responsibilities

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

Authorization for Claims, Payment and Reviews

I request that payment of authorized Medicare, Medicaid, or other insurance benefits be made on my behalf for any services furnished to me by Inova's Medical House Calls program. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents and to my medical insurers any information needed to determine or secure eligibility information for these benefits.

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

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova Medical House Calls

Admission Consents & Guidelines

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Guidelines

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

Urgent Needs During Business Hours:

- Business hours are 8:00 am - 4:30 pm Monday-Friday, excluding holidays.
- Clinical office staff can usually respond to phone calls regarding urgent needs via telephone **within one hour**.
- A medical provider can usually respond with a visit to the home **within 24-48 business hours**.
- **You need to dial 911 for an emergency**.

Urgent Needs After Business Hours, During Weekends and on Holidays:

- Observe hour-of-day/night courtesy. The on-call provider can usually respond to calls **within 20 minutes**.
- The following **MAY NOT** be requested at night or during weekends:
  - refills of prescriptions
  - scheduling of routine visits for the coming week
  - prescriptions for controlled substances
  - form completion
- **You need to dial 911 for an emergency**.

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

Additional Guidelines:

- **Routine Appointment -** Call for a routine appointment the same way you would call any primary care office seeking an appointment. You may plan for a routine visit **1-2 weeks** in advance or you may ask for an expedited appointment within a few days.
- **Prescription Refill -** Call for prescription refills **at least 7 business days** before you are out of any medication.
- **Forms Completion -** Call if you need forms completed by your provider and **allow 7-10 business days (plus any time for testing needed)** in order for provider to complete the forms.

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

CAT #30870 / R090623 ● PKGS OF 50

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Additional Guidelines: (continued)

- **Other Requests -** Call to coordinate for other requests as needed. Be aware that **elective** procedures scheduled by other medical providers do not prioritize our appointment schedule.
- If you have a non-urgent question or request that cannot be addressed by the clinical office staff, you may leave a message and a medical provider will return the call, generally **within 24-48 hours**.

Your provider might need to obtain lab work and imaging as part of your medical care. If your provider determines there is a need for these services, they may be provided by an outside company. There may be costs associated.

I understand the information given above, and all my questions have been answered to my satisfaction.

_____ _____ _____

Patient/DDM (signature) Date Time

If DDM:

(print name): _____

(address): _____

(phone number): _____

Relationship: Authority: ☐ Guardian ☐ DDM ☐ Other:

OFFICE USE ONLY

☐ **Oral Consent Obtained** (witness to oral consent must sign below)

_____ _____ _____

Witness to Oral Consent (signature) Date Time

_____

Witness to Oral Consent (print name)

Interpreter Information (To be completed by Inova staff, if applicable)**:**

☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____

☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova Medical House Calls

Admission Consents & Guidelines

CAT #30870 / R090623 ● PKGS OF 50

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Consent to Receive Chronic Care Management Services

As a patient with two or more ongoing health conditions, you may benefit from a care management program that Inova Medical House Calls offers to Medicare patients.

The services available through our Chronic Care Management program include:

- Helping you manage ongoing health conditions, checking in with you on your health care needs, making appointments for preventive care, and helping you understand and take your medications.
- Making sure you can get in touch with your provider or care team 24-hours-a-day, 7-days-a-week, including by telephone, email, and through your electronic health record.
- Ensuring that our providers can come to your home to provide care you need in a timely and efficient manner.
- Working with you to make a plan for how to best care for your health issues.
- Helping you work with and coordinate care across different providers and settings, including specialists or other providers, hospitals, emergency department, diagnostic services home nursing and physical therapy/occupational therapy.

Your Rights

As part of the chronic care management services, you will have access to your care plan. You have the right to stop chronic care management services at any time (effective the end of a calendar month).

Please contact the Medical House Calls office at **(703) 698-2431** to stop your consent.

By signing this consent you understand and agree to the following:

- Inova Medical House Calls will provide chronic care management services to you.
- Inova Medical House Calls will bill Medicare for these services during any month that we provide at least 20 minutes of chronic care management services to you.
- Inova Medical House Calls may share your care information electronically with other providers delivering care to you.

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova Medical House Calls

Chronic Care Management Consent

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By signing this consent you understand and agree to the following (continued)**:**

- You will advise Inova Medical House Calls if you receive these services from any other provider during any month. Only one provider or hospital can provide and bill for chronic care management services for you during a calendar month.
- **Standard co-insurance, copays, and deductibles apply to chronic care management services, so you may be billed for these services up to once a month. These charges are in addition to those incurred for regular home visits and include telephone encounters other than discussion of scheduling and coordination of care. The charges are according to time spent by the clinical staff and co-pays typically run $0-40 per month depending on how much time is spent. <u>If no time is spent by clinical staff on your needs, there will be no charge</u>. There must be at least 20 minutes in a calendar month spent by a clinical staff member before charges can be applied.**

Patient (signature): _____ Date: _____ Time: _____

Patient (print name): _____

Designated Decision Maker (if applicable):

(signature): _____ Date: _____ Time: _____

(print name): _____

Interpreter Information (To be completed by Inova staff, if applicable):

☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____

☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova Medical House Calls

Chronic Care Management Consent

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1ROI

* All items with an asterisk are MANDATORY fields.

Do NOT use for CATS releases

A

* Patient Name _____ Medical Record Number _____

* Patient Date of Birth _____ * Contact Phone Number _____

Contact Email _____

* Patient Address _____

Street Address City State Zip Code

B * **I authorize Inova to** (check one):

☐ **Release** the information indicated to:

☐ **Request** the information indicated from:

_____

Name of person or entity to receive or disclose information

_____

Street Address City State Zip Code

Phone# _____ Fax# _____ Email _____

C * **Information to be Released/Disclosed:**

Facility: _____

☐ All Inova facilities

Dates of Service:

_____

_____

_____

(**check all that apply):**

☐ Billing Information
☐ Complete Medical Record
☐ Consultations
☐ Discharge Summary
☐ EKG/EEGs
☐ Emergency Room Records
☐ History & Physical
☐ Laboratory Reports
☐ Medication List
☐ Operative Reports
☐ Pathology Reports
☐ Physician Orders
☐ Progress Notes
☐ Psychiatric Admit Note
☐ Psychiatric Evaluation
☐ Radiology Images/CD
☐ Radiology Reports
☐ Other (specify):

_____

_____

D * **Purpose** (check all that apply):

☐ Medical Follow-Up
☐ Attorney
☐ Personal Use
☐ Disability
☐ Insurance
☐ Other _____

E * **Provide Record by Means of** (check one):

☐ MyChart
☐ Fax (25 pages or less)
☐ Electronic Media (CD/Thumbdrive)
☐ Mail – Regular
☐ Mail – Expedited. On request, Health Information Management can expedite record delivery. You will be billed for actual charges incurred.
☐ In Person Review. You will need to make an appointment for the review.
☐ Email – Encrypted
☐ Email – Unencrypted
☐ Pick-up

F I understand that:

- If the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.
- Written notification is necessary to cancel this authorization. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.
- This disclosure release may include sensitive information in my records that do not require separate authorization based on federal or state regulations.
- Treatment will still be provided to me if I do not sign this form.
- This authorization will expire six (6) months after the date signed.

_____ _____

* **Patient or Authorized Representative** (signature) * Date/Time (Authorization will expire six months after date signed)

_____ _____ ☐ Self

* **Patient or Authorized Representative** (print name) * Relationship to Patient (specify, or check box if "self")

Interpreter Information (To be completed by Inova staff, if applicable):

☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____

☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

Inova
Authorization to Request/Disclose Protected Health Information

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH

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3PTIDEN

This form will provide us the legal spelling of your first name, middle initial, last name, and your date of birth. Accurate patient information is important for your **safety** while receiving services at any Inova facility.

Please Print Clearly

Legal First Name of Patient: _____

Legal Middle Name of Patient: _____

Legal Last Name of Patient: _____

Date of Birth (month/day/year): _____ Legal Sex: ☐ Male ☐ Female ☐ X Social Security #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Best Contact Phone Number: _____ ☐ Mobile ☐ Work ☐ Home

Email: _____

My signature verifies that the information provided is correct to the best of my knowledge. I understand that this will be used as patient identification at Inova.

Patient or Designated Decision Maker (DDM) (signature): _____ Date: _____ Time: _____

If signed by DDM (print name): _____ Relationship to Patient: _____

Witness (signature): _____ Date: _____ Time: _____

Witness (print name): _____

Interpreter Information (To be completed by Inova staff, if applicable):

☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____

☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Inova

Patient Identification

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH

Outpatient Location: _____

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Please list the names and phone numbers of anyone currently involved in patients care. Please call any non-Inova Providers and request that they send our office the 2 most recent visit notes. They can be faxed to the Medical House Calls office at 571-665-6878.

Current PCP (Primary Care Provider)
1.

Specialists (cardiologist, nephrologist, dermatologist, etc.)
1.
2.
3.
4.
5.

Home Health Company (nursing, physical therapy, occupational therapy, etc.)
1.

Hospice or Palliative Care
1.

Care Manager, Social Worker, APS Worker, etc.
1.
2.

Private Pay Services (caregiver, aide services)
1.

Days and times are caregivers in home.

The following pages are for your information only. They do not require any signature and they do not need to be returned to Inova.

Senior Services
Medical House Calls
(703) 698-2431

Dear Valued Inova Patient,

Beginning April 5, 2021, all patient care information including lab results, pathology and test results will be available to patients in MyChart as soon as posted. This is a mandate of the 21st Century Cures Act designed to place more control of treatment information in the hands of the patient. Inova's goal is to embrace patients and their families as integral members of the care team.

There will be eight types of clinical notes that must be shared:

- Consultation notes
- Discharge summary notes
- History & physician notes
- Imaging notes
- Laboratory notes
- Pathology report notes
- Procedure notes
- Progress notes

Please note that you will have immediate access to laboratory results, pathology, and radiology results. This may mean that you see the results before members of your care team have had a chance to review them. Trust that your Inova care team has a treatment plan to address any concerns that may arise from your testing.

How do I update my notification preferences in MyChart?

Are you getting too many notices from MyChart, or not enough? To update your notification preferences, follow these steps:

1. Login to MyChart
2. Select "Menu" (top left of the page)
3. Select "Account Settings"
4. Select "Communication Preferences" and adjust by selecting or deselecting items

Our team is prepared to answer your questions, so please do not hesitate to reach out for assistance as needed. For additional information, please visit our website at https://www.inova.org/mychart/opennotes

Thank you,

You Inova Care Team

VIRGINIA ADVANCE MEDICAL DIRECTIVE

I, _____, intentionally and voluntarily make known my wishes in the event that I am incapable of making an informed decision, as follows:

I understand that my advance directive may include the selection of an agent in addition to setting forth my choices regarding health care. The term ***"health care"*** means: the furnishing of services to any individual for the purpose of preventing, alleviating, curing or healing human illness, injury or physical disability, including but not limited to medications; surgery; blood transfusions; chemotherapy; radiation therapy; admission to a hospital, nursing home, assisted living facility or other health care facility; psychiatric or other mental health treatment; and life-prolonging procedures and palliative care.

The phrase ***"incapable of making an informed decision"*** means: unable to understand the nature, extent and probable consequences of a proposed health care decision; unable to make a rational evaluation of the risks and benefits of a proposed health care decision as compared with the risks and benefits of alternatives to that decision; or unable to communicate such understanding in any way.

This advance directive shall not terminate in the event of my disability.

(YOU MAY INCLUDE IN THIS ADVANCE DIRECTIVE ANY OR ALL OF SECTIONS I THROUGH V BELOW.)

SECTION I: APPOINTMENT OF AGENT

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

I hereby appoint the following as my primary agent to make health care decisions on my behalf as authorized in this document:

Name of Primary Agent | Telephone | Fax if any

Address | E-mail if any

If the above-named primary agent is not reasonably available or is unable or unwilling to act as my agent, then I appoint the following as successor agent:

Name of Successor Agent | Telephone | Fax if any

Address | E-mail if any

I hereby grant to my agent named above full power and authority to make health care decisions on my behalf as described below whenever I have been determined to be incapable of making an informed decision. My agent's authority is effective as long as I am incapable of making an informed decision.

In exercising the power to make health care decisions on my behalf, my agent shall follow my desires and preferences as stated in this document or as otherwise known to my agent. My agent shall be guided by my medical diagnosis and prognosis and any information provided by my physicians as to the intrusiveness, pain, risks and side effects associated with treatment or nontreatment. My agent shall not make any decision regarding my health care which he or she knows, or upon reasonable inquiry ought to know, is contrary to my religious beliefs or my basic values, whether expressed orally or in writing. If my agent cannot determine what health care choice I would have made on my own behalf, then my agent shall make a choice for me based upon what he or she believes to be in my best interests.

My agent shall not be liable for the costs of health care that he or she authorizes, based solely on that authorization.

SECTION II: POWERS OF MY AGENT

(CROSS THROUGH ANY POWERS IN THIS SECTION II THAT YOU DO NOT WANT TO GIVE YOUR AGENT AND ADD ANY POWERS OR INSTRUCTIONS THAT YOU DO WANT TO GIVE YOUR AGENT.)

The powers of my agent shall include the following:

A. To consent to or refuse or withdraw consent to any type of health care, treatment, surgical procedure, diagnostic procedure, medication and the use of mechanical or other procedures that affect any bodily function, including, but not limited to, artificial respiration, artificially administered nutrition and hydration, and cardiopulmonary resuscitation. This authorization specifically includes the power to consent to the administration of dosages of pain-relieving medication in excess of recommended dosages in an amount sufficient to relieve pain, even if such medication carries the risk of addiction or of inadvertently hastening my death.

My agent's authority under this Subsection A shall be limited by any specific instructions I give in Section IV below regarding my health care if I have a terminal condition.

B. To request, receive and review any oral or written information regarding my physical or mental health, including but not limited to medical and hospital records, and to consent to the disclosure of this information.

C. To employ and discharge my health care providers.

D. To authorize my admission to or discharge (including transfer to another facility) from any hospital, hospice, nursing home, assisted living facility or other medical care facility. If I have authorized admission to a health care facility for treatment of mental illness, that authority is stated in Subsections E and/or F below.

E. To authorize my admission to a health care facility for the treatment of mental illness for no more than 10 calendar days provided that I do not protest the admission and provided that a physician on the staff of or designated by the proposed admitting facility examines me and states in writing that I have a mental illness, that I am incapable of making an informed decision about my admission, and that I need treatment in the facility; and to authorize my discharge (including transfer to another facility) from the facility.

F. To authorize my admission to a health care facility for the treatment of mental illness for no more than 10 calendar days, **even if I protest**, if a physician on the staff of or designated by the proposed admitting facility examines me and states in writing that I have a mental illness, that I am incapable of making an informed decision about my admission, and that I need treatment in the facility; and to authorize my discharge (including transfer to another facility) from the facility.

(If you give your agent the powers described in this Subsection F, your physician must complete the following attestation.)

Physician attestation: I am the physician or licensed clinical psychologist of the declarant of this advance directive. I hereby attest that I believe the declarant to be presently capable of making an informed decision and that the declarant understands the consequences of this provision of this advance directive.

_____
Physician Signature Date

_____
Physician Name Printed

G. To authorize the following specific types of health care identified in this advance directive **even if I protest.**
(Specifically cross-reference any applicable sections of this advance directive.)

_____

_____

(If you give your agent the powers described in this Subsection G, your physician must complete the following attestation.)

Physician attestation: I am the physician or licensed clinical psychologist of the declarant of this advance directive. I hereby attest that I believe the declarant to be presently capable of making an informed decision and that the declarant understands the consequences of this provision of this advance directive.

_____
Physician Signature Date

_____
Physician Name Printed

H. To continue to serve as my agent even if I protest the agent's authority after I have been determined to be incapable of making an informed decision.

I. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law if the study offers the prospect of direct therapeutic benefit to me.

J. To authorize my participation in any health care study approved by an institutional review board or research review committee pursuant to applicable federal or state law that aims to increase scientific understanding of any condition that I may have or otherwise to promote human well-being, even though the study offers no prospect of direct benefit to me.

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

_____

_____

_____

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

(Add below any additional powers you give your agent, limits you impose on your agent or other information to guide your agent.)

I further instruct my agent as follows:

_____

_____

_____

SECTION III: HEALTH CARE INSTRUCTIONS

(CROSS THROUGH SUBSECTIONS A AND/OR B BELOW IF YOU DO NOT WANT TO GIVE ADDITIONAL SPECIFIC INSTRUCTIONS ABOUT YOUR HEALTH CARE.)

A. I specifically direct that I receive the following health care if it is medically appropriate under the circumstances as determined by my attending physician:

_____

_____

B. I specifically direct that the following health care not be provided to me under the following circumstances:
(You also may specify that certain health care not be provided under any circumstances.)

_____

_____

SECTION IV: INSTRUCTIONS ABOUT END-OF-LIFE CARE ("LIVING WILL")

(CROSS THROUGH THIS SECTION IV IF YOU DO NOT WANT TO GIVE SPECIFIC INSTRUCTIONS ABOUT YOUR HEALTH CARE IF YOU HAVE A TERMINAL CONDITION.)

If at any time my attending physician should determine that I have a terminal condition where the application of **life-prolonging procedures** – including artificial respiration, cardiopulmonary resuscitation, artificially administered nutrition and artificially administered hydration – would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain. If I am an organ, eye or tissue donor (see Section V below), I want this instruction applied in such a manner as to ensure the medical suitability of my organs, eyes and tissues for donation.

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this advance directive shall be honored by my family and physician as the final expression of my legal right to refuse health care and my acceptance of the consequences of such refusal.

(Cross through Subsections A and/or B below if you do not want to give additional instructions about care at the end of your life.)

A. OTHER DIRECTIONS ABOUT LIFE-PROLONGING PROCEDURES

*(If you wish to provide your own directions about **life-prolonging procedures**, or if you wish to add to the directions you have given above, you may do so in this Subsection A. If you wish to give specific instructions regarding certain life-prolonging procedures, such as artificial respiration, cardiopulmonary resuscitation, artificially administered nutrition and artificially administered hydration, this is where you should write them. If you give specific instructions in this Subsection A, cross through any of the language above in this SECTION IV if your specific instructions that follow are different.)*

I direct that:

B. DIRECTIONS ABOUT CARE OTHER THAN LIFE-PROLONGING PROCEDURES

(You may give here any other instructions about your health care if you have a terminal condition aside from your instructions about life-prolonging procedures, which are addressed in Subsection A above.)

I direct that:

SECTION V: ANATOMICAL GIFTS

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

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

❍ I donate my whole body for research and education.

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

(You must sign below in the presence of two witnesses.)

AFFIRMATION AND RIGHT TO REVOKE: By signing below, I state that I am emotionally and mentally capable of making this advance directive and that I understand the purpose and effect of this document. I understand that I may revoke all or any part of this document at any time (i) with a signed, dated writing; (ii) by physical cancellation or destruction of this advance directive by myself or by directing someone else to destroy it in my presence; or (iii) by my oral expression of intent to revoke.

Signature of Declarant Date

The declarant signed the foregoing advance directive in my presence.

(Witness) (Witness)

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

Inova™

NOTICE OF PRIVACY PRACTICES

Effective Date: November 15, 2014

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

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Inova's Chief Privacy Officer by calling the Compliance Department at 571-472-8187.

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

Inova's Responsibilities

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised copy by accessing our web site www.inova.org, calling 571-472-8187 and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. If any major change is made to this Notice, it will automatically be provided to you at the time of your next visit to an Inova facility. It will also be posted on our website at the time of the change.

Uses and Disclosures

How we may use and disclose Medical Information about you.

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

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

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

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

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

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

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

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

If you do not want to receive the materials described above, please contact our Chief Privacy Officer by calling our Compliance Department at 571-472-8187 and request that these marketing materials not be sent to you.

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

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

If you do not wish to be contacted for fund-raising efforts, please notify the Inova Health System Foundation, at 8095 Innovation Park Drive, Fairfax, VA 22031, or by calling 703-289-2072.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Your Health Information Rights:

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

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

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

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

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

    - You have the right to request a restriction on disclosure of health information about services you paid for out of pocket in full. This request should be made prior to the service being provided and applies only if the disclosure is to a health plan for purposes of payment or health care operations.

    - You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information

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

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

- **Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at a location other than your home or by U.S. Mail. Such requests must be made in writing and must include a mailing address where bills for services and related correspondence regarding payment for services will be received. It is important that you note that Inova reserves the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.
- **Breach Notification:** You have a right to be notified following a breach of your unsecured PHI.
- **A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time, even if you have agreed to receive this notice electronically.

You may obtain a copy of this notice at our web site http://www.inova.org.

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

Changes to this Notice

We reserve the right to change this notice at any time. The revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in Inova's facilities and will include the effective date. In addition, each time you register at or are admitted to Inova for treatment or health care services as an inpatient or outpatient, we will provide access to the most recent version. You may always access the most recent version at our web site http://www.inova.org or may call 571-472-8187 and request that a copy of the most recent version is mailed to you.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Inova by contacting the Compliance Department at 8095 Innovation Park Drive, Fairfax, VA 22031 Attention: Chief Privacy Officer. You may file a complaint with the Secretary of the Department of Health and Human Services. Instructions for filing a complaint with the Secretary are found at: www.hhs.gov/ocr/privacy.

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

Other Uses of Medical Information

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

Chief Privacy Officer

Telephone Number: 571-472-8187

Notice of nondiscrimination

As a recipient of federal financial assistance, Inova Health System (“Inova”) does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, sex, disability, or age in admission to, participation in, or receipt of the services or benefits under any of its programs or activities, whether carried out by !nova directly or through a contractor or any other entity with which Inova arranges to carry out its programs and activities.

This policy is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Section 1557 of the Affordable Care Act, and regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at 45 C.F.R. Parts 80, 84, 91 and 92, respectively.

Inova:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronifcormats, other formats)

Provides free languages services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please let our staff know of your needs for effective communication.

If you believe that Inova has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling **703.205.2175**. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Patient Relations staff is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at OCRPortal.HHS.gov/OCR/Portal/Lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. **20201 1-800-868-1019**, **800-537-7697** (TDD)

Complaint forms are available at **HHS.gov/OCR/Office/File/Index.html**

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Interpreter services are available at no cost to you

Please let our staff know of your needs for effective communication

Spanish	Atención: Si usted habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Por favor infórmele a nuestro personal sobre sus necesidades para lograr una comunicación efectiva.
Korean	알려드립니다: 귀하가 한국어를 구사한다면 무료 언어 도움 서비스가 가능합니다. 효과적인 의사전달을 위해 필요한 것이 있다면 저희 실무자에게 알려주시기 바랍니다.
Vietnamese	Chú ý: Nếu quý vị nói tiếng Việt, dịch vụ hỗ trợ ngôn ngữ có sẵn miễn phí cho quý vị sử dụng. Xin vui lòng thông báo cho nhân viên biết nhu cầu của quý vị để giao tiếp hiệu quả hơn.
Chinese	注意：如果你說中文，可以向你提供免費語言協助服務。請讓我們的員工了解你的需求以進行有 效溝通。
Arabic	انتباه: إذا كنت تتحدث العربية، تتوافر الخدمات المجانية للمساعدة في اللغة. يرجى إعلام فريق العمل باحتياجاتك من أجل الحصول على عملية تواصل فعالة.
Tagalog	Atensyon: Kung nagsasalita ka ng Tagalog, mayroong magagamit na mga libreng serbisyong tulong sa wika para sa iyo. Mangyaring ipaalam sa aming mga kawani ang iyong mga pangangailangan para sa epektibong komunikasyon.
Farsi	توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی به صورت را یگان برای شما فراهم خواهد بود. به منظور برقراری ارتباط موثر، کارکنان ما را از نیازهای خود مطلع کنید.
Amharic	ትኩረት፡ አማርኛ የሚናገሩ ከሆነ ለእርስዎ የቋንቋ ድጋፍ አግልግሎቶች ከክፍያ በነጻ ይቀርብልዎታል። ውጤታማ የሆነ ኮሚዩኒኬሽን የሚፈልጉ ከሆነ ሰራተኛችን እንዲያውቅ ያድርጉ።
Urdu	توجہ: اگر آپ اردو بولتے ہیں تو، زبان امداد خدمات، مفت میں، آپ کو دستیاب ہیں۔ موثر مواصلت کے لیے برائے مہربانی ہمارے عملہ کو اپنی ضروریات کے بارے میں بتلا دیں۔
French	Attention: Si vous parlez Francais, des services d'aide linguistique vous sont proposés gratuitement. Veuillez informer notre personnel de vos besoins pour assurer une communication efficace.
Russian	Внимание: Если вы говорите на русском языке, для вас доступны бесплатные услуги помощи с языком. Для эффективной коммуникации, пожалуйста, дайте персоналу знать о ваших потребностях.
Hindi	कृपया ध्यान दें : यदि आप हिन्दी बोलते है, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। कृपया प्रभावी संचार-संपर्क हेतु अपनी आवश्यकताओं के बारे में हमारे कर्मचारियों को बताएं।
German	Achtung: Wenn Sie Deutsch sprechen, stehen kostenlose Service-Sprachdienstleistungen zu Ihrer Verfügung. Teilen Sie unserem Team bitte Ihre Wünsche für eine effektive Kommunikation mit.
Bengali	দৃষ্টি আকর্ষণ করুন : আপনি যদি বাংলা বলতে পারেন, তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা সেবা পাওয়া যাবে। অনুগ্রহ করে কার্যকরী যোগাযোগের জন্য আপনার প্রয়োজনীয়তার বিষয়ে আমাদের কর্মীদের
Kru (Bassa)	Tò Đùŭ Nɔ̀mɔ̀ Dyíín Cáo: Ɔ jŭ ké m̀ dyi Gɔ̀ɖɔ̀ɔ̀-wùɖù (Ɓăsɔ́ɔ̀-wùɖù) po ní, nlí, à ɓéɖé gbo-kpá-kpá ɓó wuɖu-dù kò-kò po-nyɔ̀ ɓĕ bìl nɔ̄ à gbo ɓó pídyi. M̀ dyi ɖɛ ɖò mɔ́ nɔ̄ à gbo ní, m̀ mɛ nyuɛ ɓɛ́ à kŭà-nyɔ̀ ɓĕɔ̀ kéɛ dyí dyuò, ké à kè mɔ̀ kè muɛ jè cĕ̀n nɔ̀mɔ̀ dyíín.
Ibo	Nrụbama: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịrị gị. Biko mee ka ndị ọrụ anyị mara mkpa gị maka nkwukọrịta ga-aga nke ọma.
Yoruba	Akiyesi: Bi o ba nsọ Yoruba, awọn iṣẹ iranilọwọ ede wa l'ọfẹ fun ọ. Jọwọ jẹ ki ara ibiṣẹ wa mọ nipa awọn aini rẹ fun ibaraẹnisọrọ ti o munadoko.

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3RIGHTS

Patients' Rights and Responsibilities:

The following list of rights and responsibilities does not presume to be all-inclusive, but is intended to show our concern for you and to emphasize the need for observance of these rights and responsibilities.

As a patient, you have the right to . . .

- Considerate and respectful care provided in a safe environment, free from all forms of abuse, harassment or discrimination.
- Participate in the development and implementation of your plan of care and actively participate in decisions regarding your medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
- Upon your request, have a family member, chosen representative and/or your own physician notified promptly of your admission to the facility.
- Not undergo any procedure unless you or your legally authorized representative gives voluntary, competent and understanding consent.
- Be well informed about your illness, possible treatments, and likely outcomes of care (including unanticipated outcomes) and to discuss this information with your doctor. You have the right to designate someone to receive this information on your behalf.
- Have a designated representative present for any updates provided regarding your routine course of care. In an emergency, when you lack decision-making capacity and the need for treatment is urgent, the information is made available to another person on your behalf. We will communicate to your designated representative any significant changes in your status, such as transfer to a higher level of care or need for unplanned emergency procedures as soon as clinical care allows.
- Have an advance directive (such as health care proxy, organ donation or living will) and the expectation that Inova will honor the intent of the directive to the extent permitted by law and facility policy.
- Confidentiality of your treatment records, unless you have given permission to release information or if reporting is permitted or required by law.
- Leave the facility even against the advice of your physician.
- Know the name of the physician, clinical psychologist, or other practitioner who has primary responsibility for coordinating your care, treatment, or services.
- Be told of alternatives when facility care is no longer appropriate.
- Be informed by your physician of the continuing healthcare requirements following your visit to or discharge from the facility.
- Access to interpreter services free of charge.
- The privacy of your medical information. Disclosures regarding you, your rights and our obligations regarding the use and disclosure of your medical information are made in accordance with our Notice of Privacy Practices.
- Have a designated support person if you have a diagnosed disability and need ongoing support and assistance for that disability.
- If you choose, you may also contact the Virginia Department of Health, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, VA 23233, or call 800-955-1819. Additionally, you may contact the Office of Quality Monitoring, The Joint Commission, One Renaissance Blvd., Oakbrook Terrace, IL 60181, or at www.jointcommission.org using the "Action Center" on the home page of the web site.

  File a grievance by calling 703-205-2175, if you believe that Inova has failed to provide these services or discriminated on the basis of race, color, national origin, age, religion, culture, sex, gender, gender identity or expression, sexual orientation, marital status, disability, military status, pregnancy or childbirth, or related medical conditions. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Patient Relations staff or manager is available to help you.

As a patient, you are responsible for:

- Providing complete and accurate information about your health, including past illnesses, facility stays, use of medications, and other matters relating to your health.

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova

Patient Rights and Responsibilities

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH

☐ Outpatient Location: _____

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As a patient, you are responsible for: (continued)

- Asking questions when you do not understand what you have been told about your care or what you are expected to do.
- Following the care, service or treatment plan developed for you.
- Understanding that patients may not photograph, videotape, record or film any person or practice on Inova property without prior permission from Inova. This applies to your visitors as well.
- Recognizing that all medications you will take while in the facility will be prescribed by your doctor, dispensed by the facility Pharmacy and administered by a nurse or therapist.
    - Patients may not take their own medications, unless allowed by facility protocol.
    - Patients may not keep medications at their bedside.
- Telling your doctor if you believe you cannot follow through with your treatment plan and understanding the possible results if you decide not to follow the recommended treatment plan.
- Providing the facility with accurate contact and billing information.
- Having detailed knowledge of your health insurance coverage including deductibles co-pays and network coverage.
- Being respectful to staff. This applies to your visitors as well.
- Being respectful of other patients and facility property and following facility rules and regulations. This applies to your visitors as well.
- Recognizing that the facility cannot accept responsibility for any personal property.
- Abiding by all safety expectations. Inova has zero-tolerance for:
    - Biased, racist, or discriminatory language or behavior from patients and visitors.
    - Destructive or disrespectful patients and visitors.
    - Contraband or weapons of any kind being brought in by patients or visitors. This includes but is not limited to illegal substances, drug paraphernalia, controlled substances, firearms, knives, sharps such as shivs, razors or box-cutters, tasers, or other instruments intended to cause harm.

Notice of Deemed Consent for Infectious Disease Testing:

Virginia Code Section 32.1-45.1 provides that when either a person providing health care or a patient is directly exposed to the bodily fluids of the other in a way that may transmit human immunodeficiency virus (HIV) or Hepatitis B or C virus, such other person is deemed to have consented to testing for those viruses and to release of the test results to the person so exposed, and actual consent is not required.

Consent for Treatment:

- I hereby authorize medical treatment by the physician, the clinical staff and technical employees assigned to my care or the care of my minor child or the patient named below.
- I authorize my treating providers to order any ancillary services, such as laboratory or radiology tests, or any other services or treatments deemed necessary for my care and safety. Laboratory tests may include testing for HIV and I understand that I have the right to decline testing for HIV.
- I understand that Inova utilizes an electronic medical record system.
- I authorize the release of my prescription history to my Inova physician from any pharmacy or drug monitoring agency.
- By signing below, I acknowledge and accept the patient rights and responsibilities outlined above and consent to treatment.

SIGNATURE NOT REQUIRED

Patient/Guardian/etc. (signature)	**Patient/Guardian/etc.** (print name)	Date	Time

Relationship to Patient (if not signed by patient)

Witness (signature)	**Witness** (print name)	Date	Time

Interpreter Information (To be completed by Inova staff, if applicable): ☐ **No Interpreter Required**

☐In person ☐Telephonic ☐Video Interpreter name/ID number (if applicable) _____

☐Patient/Designated Decision Maker was offered and refused interpreter ☐Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova

Patient Rights and Responsibilities

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C2C Coverage to Care

WHAT IS CHRONIC CARE MANAGEMENT?

If you have Medicare or are dually eligible (Medicare and Medicaid) and live with two or more chronic conditions that worsen your quality of life and put your health at risk, chronic care management (CCM) services can help connect the dots so you can spend more time doing what you love. Examples of these chronic conditions include—but are not limited to—arthritis, cancer, depression, diabetes, and high blood pressure. Services may include:

- **At least 20 minutes a month** of care coordination from a health care professional outside of in-person office visits, such as phone check-ins and access to a secure electronic patient portal
- **Personalized assistance** from a dedicated health care professional who will work with you to create your care plan
- **Coordination of care** between your pharmacy, specialists, testing centers, hospitals, and more
- **24/7 emergency access** to a qualified health care professional and expert assistance with setting and meeting your health goals

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DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

WHAT ARE THE BENEFITS OF CCM?

CCM allows you to better manage your care and spend more time focusing on your health by helping you work toward your health and quality of life goals. CCM can help you avoid trips to the emergency department, falls, or worsening health.

Coordinated care means you will receive personal attention and help from a provider you know and who knows about your health conditions and helps to keep you healthy. You will receive a comprehensive care plan to support your goals, along with more frequent communication and support between visits, resources, community services, and other educational information.

WHAT IS REQUIRED TO PARTICIPATE IN CCM?

As a CCM participant, you must give written or verbal consent to ensure you are involved with your care plan and aware of any applicable cost sharing. You will need to provide informed consent only once unless you switch to a different CCM practitioner, and you can disenroll from CCM services at any time by speaking to your health care provider.

You should also be aware that only one health care practitioner and/or hospital can provide CCM services each calendar month.

Talk to your provider about CCM services and your coverage. The usual cost-sharing rules apply to CCM services, so you may be responsible for the usual Medicare Part B cost sharing (deductible and copayment/coinsurance) if you do not have supplemental, or wraparound, insurance. Most dually eligible individuals are not responsible for cost sharing. Medigap plans provide wraparound coverage of cost sharing for CCM, and many individuals have Medigap or other supplemental insurance.

For more information visit: go.CMS.gov/ccm

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